Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 27, 2025

Administrator
New Richland Care Center
312 Northeast 1st Street
New Richland, MN 56072

RE: CCN: 245316
Cycle Start Date:

Dear Administrator:

On February 19, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, 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 widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

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.

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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Elizabeth Silkey, Regional Operations Supervisor
Mankato District Office
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by May 19, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by August 19, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 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.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245316	A. BUILDING _____ B. WING _____	C 02/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW RICHLAND CARE CENTER	312 NORTHEAST 1ST STREET NEW RICHLAND, MN 56072

(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
E 000	Initial Comments On 2/18/25 to 2/19/24, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 2/18/25, to 2/19/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H53167722C (MN00108281) H53167723C (MN00107919) H53167724C (MN 00108292) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/07/2025

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.

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F 000	Continued From page 1 regulations has been attained.	F 000		
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure most recent survey results were readily accessible for residents or visitors to view. This had the potential to affect all residents who resided in the facility and visitors.	F 577	F577 Corrective action for affected residents: CMS Form 2567 was placed in the survey book at the front door on 2/18/2025. Residents will be informed of survey	3/7/25

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F 577	Continued From page 2 Findings include: During observation on 2/18/25 at 1:42 p.m., a black three-ring binder labeled Survey Results was observed in a hanging bin on a wall near the front entrance of the facility. The survey results in the binder were dated 9/14/2022. The results of the most recent federal recertification survey were not included. There was no posted information indicating any other results were available. During interview on 2/18/25 at 2:24 p.m., social services director (SS-A) verified the most current survey results were not in the binder and stated she would have to find them and put them in the binder. SS-A further stated she was unsure why the results were not in the binder and they were not posted anywhere else in the facility for residents or visitors to access. During interview on 2/19/25 at 1:40 p.m., administrator stated he was unaware the most recent survey results were not in the binder for residents and visitors to view and they should have been available. No policy regarding posting of survey results was provided.	F 577	results, the binder holding the results and the location near the front door at Resident Council on 3/18/25. Facility will notify all Residents by way of a letter written by the Administrator of the placement and availability of the 2567 and Plan of Correction. New Residents will receive this information upon admission. Identifying other residents having the potential to be affected: Any resident, family member, and/or legal representatives of the resident have the potential to be affected by this deficient practice. What measures will be put into place, and what systemic changes will be made to ensure that the deficient practice does not recur? Administrator/designee will place the CMS form 2567 and Plan of Corrections in the binder upon approval, marking off the checklist that the task is complete. Plan to monitor performance: A monthly compliance log will be used to track compliance with the survey book regarding placement in the front door as well as the most recent survey and plans of correction being in place. A monitoring tool to track compliance will be maintained by the administrator, and results will be reported to the quality assurance team monthly for a minimum of three months and then as determined by the committee.	

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F 689 SS=D	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 record review the facility failed to assess the ability to safely operate power lift reclining chair and develop and implement policies and procedures related to the operation/use of power lift chairs for 1 of 1 (R137) resident reviewed for accidents. R137's admission Minimum Data Set (MDS) dated 2/3/25, indicated R137 was admitted to the facility on 1/28/25, no cognitive impairment, utilized a wheelchair, dependent on staff for toileting, lower body dressing, toilet transfer, sit to stand, chair transfer; required substantial/maximal assistance with personal hygiene, roll left to right, sit to lying and diagnoses included need for assistance with personal care, obesity, and surgery on the digestive system. R137's care plan dated 2/5/25, indicated history of falling, unsteady on feet, difficulty walking and interventions dated 2/19/25, indicated lift chair assessment completed; care plan revision on 1/31/25, bed in lowest position, call light within reach at all times, fall 2/14/25, R137 was reeducated on the importance of using call light for assistance; fall risk assessment completed 1/27/25, moderate risk for falls.	F 689	Corrective action for affected residents: The resident(R137) was identified and was assessed by the RN manager for the safe use of power recliner. DON completed the lift chair assessment in PCC with the input of RN nurse manager. Identifying other residents having the potential to be affected: All residents that have a power lift chair have the potential to be affected by this deficient practice. Measures put into place or systemic changes: The RN nurse manager identified all residents with power lift chairs in the building by physically going to each room. 2/19/25 RN nurse manager completed new power lift assessments for all residents identified to have a power lift chair on 2/19/25. RN nurse updated care plans with	3/7/25

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F 689	Continued From page 4 R137's document titled Fall dated 2/14/25, indicated R137 was found on the floor in her room at 2:45 a.m., lying on her right side when found near her recliner ...call light was attached to recliner and was not on, footrest in the up position, R137 stated she slid to the floor as she was trying to reposition herself in recliner. IDT (interdisciplinary team) met and R137 was reeducated on the importance of using call light for assistance. R137's document review failed to indicate R137 was assessed for the ability to safely operate the power lift reclining chair. On 2/18/25 at 3:25 p.m., R137 was seated in a power lift recliner in her room, the recliner was observed with a remote connected. R137 stated she used the remote to put the feet of the recliner up and down. On 2/19/25 at 9:05 a.m., physical therapy assistant (PTA)-C stated nursing was responsible to complete a resident's electric lift chair initial assessment. PTA-A stated R137 had communicated she had slid from the lift chair and was not injured. PTA-A stated physical therapy was currently working with R137 for strengthening. On 2/19/25 at 9:08 a.m., registered nurse (RN)-A, also known as the nurse manager, stated a resident's electric lift chair and recliners were expected assessed by a RN at the facility. RN-A stated herself or the director of nursing (DON) were responsible for the residents lift chair assessments. RN-A confirmed R137 did not have a lift chair assessment completed. RN-A stated	F 689	assessment date. 2/20/25 DON update admission checklist to have lift chair assessment completed on admission day. 2/26/2025 RN nurse manager or DON will do a lift assessment on admission for all new residents to ensure lift assessment was completed to ensure the safety of residents and the safe use of lift chairs. Plan to monitor performance: This will be audited the day following admission by the DON or RN Nurse Manager to ensure the lift assessment is completed. Then, quarterly, or with a significant change in resident and with a fall from lift chair. Audit results will be reported to QAPI.	

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F 689	Continued From page 5 the lift chair was not expected in R137's room or used by R137 until an assessment was completed. RN-A stated R137 had slid out of her electric recliner and was not injured. On 2/19/25 at 9:10 a.m., the DON stated any RN was responsible to ensure a resident had a lift chair assessment completed prior to the resident using the electric lift chair. The DON stated the assessment was expected completed in the electronic medical record (EMR). The DON confirmed R137 had slid out of the recliner when she was trying to reposition, and an assessment was not done at that time either to ensure R137 was safe to use the electric lift chair. The DON stated the intervention implemented after R137's fall included reeducation on the importance of using the call light. On 2/19/25 at 9:14 a.m., RN-A observed R137's chair and confirmed the chair was an electric lift chair. R137 was seated in the recliner and stated she was not educated on the use of the recliner, further stated she slid out of the recliner and was not hurt, and R137 stated after she slid from the chair nursing educated her to use her call light to reposition. On 2/19/25 at 11:12 a.m., the DON stated the facility did not have a policy on lift chairs. Facility admission packet included, Recliners and lift chairs may need to be looked at on an individual basis due to room lay out equipment needed for your loved one. Lift chairs-residents using these need to be assessed by nursing/therapy to determine if you are to use this.	F 689		

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F 867	Continued From page 6	F 867		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the	F 867		3/26/25

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F 867	Continued From page 7 facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and	F 867		

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F 867	Continued From page 8 implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop a Quality Assurance and Performance Improvement (QAPI) plan to guide	F 867	Corrective action taken for affected residents:	

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F 867	Continued From page 9 facility efforts in assuring care and services were maintained at acceptable levels of performance and continually improved. This had the potential to affect all 38 residents residing in the facility. Findings include: During entrance conference on 2/18/25 at 11:25 a.m., with the administrator and director of nursing (DON), the facility QAPI plan was requested. During an interview on 2/19/25 at 3:00 p.m., the QAPI plan was requested again. The administrator stated the facility did not have a written QAPI plan. The administrator presented a template from TMF Quality Innovation Network, titled Quality Improvement Initiative Plan, which he intended to use to develop the facility QAPI plan but had not done so yet. During an interview on 2/19/25 at 3:20 p.m., the administrator and director of nursing (DON) stated they were both responsible for QAPI program at the facility. The DON stated following recent citations, the QAPI committee was meeting monthly, setting goals, and coming up with measurable outcomes, with falls and pressure wound management being their current performance improvement projects (PIP). The DON and administrator were able to describe work being done for falls, and the DON was able to describe work being done for pressure wounds. The administrator stated he was planning to take an executive management class through a state organization of aging services providers serving older adults to learn more about QAPI.	F 867	Review the Survey findings and POC with Residents at the Resident council meeting on 18 March and Family Council on 26 March. Open dialogue with Residents and Families(essentially becoming a Quality Team) to show how the discussions at our meetings will become a part of the QAPI Plan and become continuous development in our meetings. Identifying other residents having the potential to be affected: Incorporate monthly Quality discussions with the Residents/Families at Resident/Family council meetings. Measures put into place or systematic change: Present initial QAPI Plan to IDT for discussion on 12 March, present the format, initial Purpose/Mission/Vision statements. Build Quality Teams (3-6 members) in Clinical and Non-Clinical capacity to include Admin/DON/Dept Mgr and departmental frontline staff (3-6 month commitment). Meet biweekly to identify and review assignments. Team will drive the analysis and problem solving to forward information to the QAPI Team monthly. Team Assignments driven by QAPI Plan and Quality Indicators identifying problem areas/challenges.	

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	245316	A. BUILDING _____ B. WING _____	C 02/19/2025

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F 867	Continued From page 10 A QAPI plan was requested and a QAPI Program policy was received, updated 10/2024. The policy indicated the administrator was responsible for assuring the facility QAPI program complied with federal, state, and local regulatory requirements. The policy did not include how the facility obtained and used feedback from residents, resident representatives, and staff to identify high-risk, high-volume, or problem prone issues as well as opportunities for improvement. The policy did not indicate how the facility would maintain effective systems to identify, collect, use and monitor data for all departments, and based on the facility assessment. The policy did not identify how the facility would identify, report, track, investigate and analyze adverse events, and high risk, high volume, and/or problem-prone concerns. The policy did not indicate how the facility would develop, monitor and evaluate performance indicators including the frequency of which that would be conducted. The policy did not indicate how the facility developed, monitored, and evaluated its performance indicators. The policy did not describe how the facility would use systematic approaches (such as root cause analysis, reverse tracker methodology, or health-care failure and effects analysis) to assist in determining underlying causes of problems impacting larger systems. The policy did not describe how the facility developed corrective action designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems. The policy did not describe how the facility monitored the effectiveness of its performance improvement activities to ensure improvements are sustained. Facility assessment dated 1/24/25, did not indicate how the QAPI program integrated with	F 867	QAPI Team will identify channels of communication to key stakeholders to include but not limited to: Residents, Families, Staff, Vendors, Advisory Board, and greater Community. QAPI Committee and Quality Teams will use Root Cause Analysis, Brainstorming, and the PDSA cycle to solve problems/challenges. Team leads will meet with QAPI committee monthly to review progress. Plan to monitor performance: Administrator will forward initial QAPI Plan to all department managers, Med Director, Pharm consultant, and Dietitian for review. Quality Plans will be delivered to each team member. Quality Team meetings will be scheduled for 6 months in advance. QAPI meetings will be scheduled for 1 year. QAPI Plan will be a living document to be monitored with the Facility Assessment when changes to either document is warranted.	

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F 867	Continued From page 11 the facility assessment.	F 867		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions	F 880		3/26/25

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F 880	Continued From page 12 to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure Centers for Disease Control (CDC) guidance was followed for fit testing for N95 filtering facepiece respirators prior to use and annually. Findings include:	F 880	Corrective Actions A. Immediate Actions (Within 30 Days) ¿ Develop and implement an emergency training program for all staff on proper PAPR use, including donning, doffing, cleaning, disinfection, and maintenance.	

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F 880	Continued From page 13 During observation on 2/18/25 at 11:49 a.m., the facility had signs posted on the front entrance door indicating mask use required due to respiratory outbreak. During observation and interview on 2/18/25 at 12:35 p.m., housekeeping assistant (H-A) was observed putting an N95 mask over a regular surgical mask prior to entering a resident room requiring N95 use due to Covid isolation. H-A stated he was not aware of having fit testing for the N95 mask. During observation and interview on 2/18/24 at 5:40 p.m., nursing assistant (NA)-A was observed putting on an N95 mask to enter a resident room requiring N95 use due to Covid isolation. NA-A stated she could not recall if she had completed fit testing for the N95 respirator. During interview on 2/19/25 at 1:12 p.m., licensed practical nurse (LPN)-A stated she had been fit tested in the past, but did not recall if it was at this facility or with her previous employer. During interview on 2/19/25 at 1:37 p.m., licensed practical nurse (LPN)-B also known as infection preventionist stated the facility had two Power Air-Purifying Respirators (PAPRs), one for each hallway, and those were expected to be worn in the rooms requiring precautions due to Covid. LPN-B stated she does not have staff complete fit testing at the time of hire or annually, and only completes on-the-spot testing when requested by staff. LPN-B further stated staff wearing N95 respirators should be fit tested for them prior to use to ensure a tight seal and staff safety. During interview on 2/19/25 at 2:16 p.m., director	F 880	¿ Ensure medical clearance is obtained and documented for all staff required to use PAPRs, in compliance with OSHA□s respiratory protection requirements. ¿ Audit and inspect all PAPR equipment to ensure functionality, proper storage, and accessibility. ¿ Update infection control policies and procedures to clearly define PAPR use, maintenance, and emergency protocols. ¿ Ensure adequate availability of PAPRs and related accessories, including batteries, hoods, and filters. B. Systemic Changes (Within 30 Days) ¿ Implement a Formal Infection Prevention & Control Program (IPCP) for PAPR Use Designate an Infection Preventionist (IP) responsible for overseeing infection control and PAPR compliance. Establish policies requiring PAPR use in situations where airborne precautions are necessary, as an alternative to N95 respirators when FIT testing is not performed. ¿ Enhance Staff Training & Competency Assessments	

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F 880	Continued From page 14 of nursing (DON) stated she would have expected staff entering Covid isolation rooms to have been fit tested for N95 mask use prior to using the N95 mask. DON further stated she was aware of the PAPRs but was not sure what the plan was for them or how the infection preventionist intended them to be used. During observation on 2/18/25 and 2/19/25, no PAPR use was observed in the facility. During observation and interview on 2/19/25 at 2:12 p.m., NA-B and NA-C were observed putting on N95 masks to enter a resident room requiring N95 masks due to Covid isolation. NA-B and NA-C both stated they had not ever been fit tested for an N95 mask. Further, NA-B and NA-C stated they were not aware of a PAPR in the facility and had not had training on PAPR use. An untitled facility document provided 2/21/25, included a section for staff to decline fit testing and choose the risk of exposure, but did not identify those risks. The facility policy titled Coronavirus Disease (Covid-19)-Occupational Health dated 10/2024, stated the following: Facility practices are in place to protect Healthcare personnel from exposure to Covid-19 to the extent possible, in accordance with Occupational Health and Safety Administration (OSHA) and Center for Disease Control and Prevention (CDC) recommendations. Employee safety and health standards related to Covid-19 are based on the following guidance: https://www.osha.gov/SLTC/covid-19/healthcare-workers.html.	F 880	Require mandatory PAPR training for all staff using respiratory protection to ensure proper use. Conduct competency assessments to confirm staff can correctly use, clean, and maintain PAPRs. ¿ Develop a PAPR Maintenance & Inspection Program Assign designated staff to inspect and document the condition of PAPRs on a scheduled basis. Create a PAPR maintenance log to track battery life, filter changes, and overall condition. ¿ Improve Documentation & Compliance Tracking Implement a centralized tracking system to log PAPR training, medical clearances, and compliance audits. Conduct quarterly reviews of staff compliance to ensure all personnel using PAPRs remain up to date with training and procedures. ¿ Strengthen Infection Control Surveillance & Monitoring Conduct weekly audits of PAPR compliance and maintenance procedures. Require department managers to report compliance rates and deficiencies during	

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F 880	Continued From page 15 Review of the above referenced link from the facility policy directed use of respiratory protection as part of a comprehensive respiratory protection program that meets the requirements of OSHA's Respiratory Protection standard (29CFR 1910.134) and included medical exams, fit testing, and training. The CDC National Institute for Occupational Safety and Health guidance sheet publication number 2018-129, indicated fit testing must be completed upon initially selecting a model of respirator, annually, and repeated whenever an employee has a change in physical condition that could affect respirator fit.	F 880	Quality Assurance & Performance Improvement (QAPI) meetings. 4. Monitoring & Sustainability Measures ¿ Ongoing Compliance Audits The Infection Control Team will conduct weekly audits for 60 days, then transition to monthly compliance reviews. ¿ Performance Tracking & Reporting Any staff found noncompliant with PAPR infection control policies will undergo immediate retraining. Compliance reports will be included in monthly QAPI meetings and shared with facility leadership. ¿ Annual Infection Control & PAPR Training Infection prevention policies and respiratory protection procedures will be reviewed annually and updated as necessary. Staff will receive annual competency assessments to reinforce infection control and respiratory safety. 5. Completion Timeline Provide PAPR & infection control training Infection Preventionist	

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F 880	Continued From page 16	F 880	Within 30 days Obtain & document medical clearance for PAPR users Infection Control Nurse Within 30 days Audit & inspect PAPR equipment Safety/Facilities Team Within 30 days Implement tracking system for PAPR training & compliance Compliance Officer Within 15 days Develop formal IPCP & update policies Infection Preventionist Within 30 days Conduct weekly compliance audits	

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F 880	Continued From page 17	F 880	Infection Control Team Ongoing for 60 days 6. Conclusion This Corrective Action Plan (CAP) ensures compliance with CMS ¿483.80 Infection Control regulations by implementing a comprehensive infection prevention program, enhancing staff training, and strengthening PAPR use and respiratory protection protocols. These corrective actions will ensure a safe environment for residents, staff, and visitors while meeting all CMS, CDC, and OSHA guidelines for infection prevention.	

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 02/19/2025. At the time of this survey, NEW RICHLAND CARE CENTER found NOT in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/07/2025

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.

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. NEW RICHLAND CARE CENTER is a 1 story building with no basement. The original building was constructed at 2 different times. Original building in 1975, one-story with no basement, and was determined to be of Type II (111) construction. In 1992 an addition was constructed and was determined to be of Type II(111) construction.	K 000		

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K 000	Continued From page 2 Because the original building and the addition are compatible construction types allowed for existing buildings of this height, the facility was surveyed as one building. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 45 beds and had a census of 36 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the	K 324		4/1/25

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K 324	Continued From page 3 corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper inspection and safety measures associate to residential cooking devices in accordance with NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.5.3(9). This deficient finding could have a widespread impact on the residents within the facility. Findings Include: On 02/19/2025 between 10:30 AM and 2:00 PM, it was revealed by observation that the residential stove-range located in the Activities Area was not outfitted with lock-out and maximum 120 minute timeout hardware. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 324	A lock-out and timer device is ordered and scheduled to be installed by our electrician when it arrives. The device will be permanently installed in the area of the stove. Environmental Services will conduct monthly monitoring of the lock-out timer device to ensure safe operation. Environmental Services Manager/designee will monitor compliance and report to QAPI. Date of completion will be on or before 1 April 2025.	
K 753 SS=F	Combustible Decorations CFR(s): NFPA 101 Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701.	K 753		3/7/25

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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) COMPLETION DATE
K 753	Continued From page 4 o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to implement proper allowable percentages of combustible decorations in accordance with NFPA 101 (2012 edition), Life Safety Code, section 19.7.5.6(4)(c). This deficient finding could have a widespread impact on the residents within the facility. Findings Include: On 02/19/2025 between 10:30 AM and 2:00 PM, it was revealed by observation that resident room (RM 217) door, surface to the corridor, was more than 30% covered with combustible signage and decorations. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 753	Resident in Room 217 was informed of the violation and the resource from NFPA given in the explanation. On 20 February, the excess decorations were removed from the door of Room 217 to meet standards. To address other residents and families of this regulation, we will inform through an article in our April 2025 newsletter reminding them of the coverage restriction. Administrator will review with Resident Council at the meeting on 18 March. Information is also part of the admission packet when new residents are moved into the building. Environmental Services/designee will monitor and report excess to the Social Worker/Administrator so that they may speak to the resident/family.	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet	K 923		3/7/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245316	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/19/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW RICHLAND CARE CENTER	**312 NORTHEAST 1ST STREET** **NEW RICHLAND, MN 56072**

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K 923	Continued From page 5 Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper medical gas (O2) storage ventilation per NFPA 99 (2012 edition),	K 923	A new ventilation exhaust fan was installed on 25 February in the O2 room.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245316	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/19/2025**

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K 923	Continued From page 6 Health Care Facilities Code, sections 9.3.7, 9.3.7.1, 9.3.7.4, and NFPA 55 (2010 edition), section 6.15. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/19/2025 between 10:30 AM and 2:00 PM, it was revealed by observation that the Med Gas (O2) Storage Room, storing liquid oxygen tanks and used for trans-fill, had an exhaust fan that was not operational. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 923	Environmental Services/designee will add to TELS maintenance schedule to check monthly for proper operation reporting to QAPI any malfunctions.	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 9, 2025

Administrator
New Richland Care Center
312 Northeast 1st Street
New Richland, MN 56072

RE: CCN: 245316
Cycle Start Date: February 19, 2025

Dear Administrator:

On February 27, 2025, we informed you that we may impose enforcement remedies.

On April 4, 2025, the Minnesota Departments of Health and Public Safety completed a revisit and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

The deficiency not corrected is as follows:

K0324 - Cooking Facilities

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 location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective May 19, 2025

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective May 19, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 19, 2025.

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.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

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 $13,343, 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 May 19, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, New Richland Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 19, 2025. 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.

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 August 19, 2025 (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:

Steven.Delich@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
202-795-7490

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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: **https://forms.web.health.state.mn.us/form/NHDisputeResolution**

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity

assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag) i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 24, 2025

Administrator
New Richland Care Center
312 Northeast 1st Street
New Richland, MN 56072

RE: CCN: 245316
Cycle Start Date: February 19, 2025

Dear Administrator:

On April 21, 2025, we notified you a remedy was imposed. On April 4, 2025 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of April 8, 2025.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective May 19, 2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of April 9, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 19, 2025 due to denial of payment for new admissions. Since your facility attained substantial compliance on April 8, 2025, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245316	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	R **04/04/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW RICHLAND CARE CENTER	**312 NORTHEAST 1ST STREET** **NEW RICHLAND, MN 56072**

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{K 000}	INITIAL COMMENTS Based on a review of the facility's plan of correction, the facility is NOT in compliance with the federal requirements identified as deficient at the time of their recertification survey.	{K 000}		
{K 324} SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on a review of the facility's plan of correction, the facility is NOT in compliance with	{K 324}	Electrician installed the time out switch on 04/08/2025.	4/8/25

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

Electronically Signed | 04/21/2025

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{K 324}	Continued From page 1 the federal requirements identified as deficient at the time of their recertification survey.	{K 324}		