

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 19, 2024

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

Re: Reinspection Results

Event ID: 9NGV12

Dear Administrator:

On January 2, 2024, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on November 15, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

Orville L. Freeman Building | HRD 3A 3rd Floor

PO Box 64900

625 Robert Street North

St. Paul, MN 55155

Office: 651-201-4384

Email: holly.zahler@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered January 19, 2024

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

RE: CCN: 245316

Cycle Start Date: November 15, 2023

Dear Administrator:

On January 2, 2024, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Holly Zahler, Compliance Analyst

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

Orville L. Freeman Building | HRD 3A 3rd Floor

PO Box 64900

625 Robert Street North

St. Paul, MN 55155 Phone: 651-201-4384

Email: holly.zahler@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered December 1, 2023

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

RE: CCN: 245316

Cycle Start Date: November 15, 2023

Dear Administrator:

On November 15, 2023, 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.

New Richland Care Center December 1, 2023 Page 2

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, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 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

New Richland Care Center December 1, 2023 Page 3

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 February 15, 2024 (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 May 15, 2024 (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) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, 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:

Nursing Home Informal Dispute Process Minnesota Department of Health Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04 8.html

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.

New Richland Care Center December 1, 2023 Page 4

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
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
travis.ahrens@state.mn.us

Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

P.O. Box 64900

Saint Paul, MN 55164-0900

Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

PRINTED: 12/24/2023 FORM APPROVED OMB NO. 0938-0391

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
	245316		B. WING		1.	C 11/15/2023	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	<u> </u>	17 10/2020	
NEW DIO				312 NORTHEAST 1ST STREET			
NEW RIC	HLAND CARE CENTI	EK		NEW RICHLAND, MN 56072			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
E 000	Initial Comments		E 0	00			
	with Appendix Z, Er Requirements, §483	/23, a survey for compliance nergency Preparedness 3.73 was conducted during a tion survey. The facility was IN					
F 000	signature is not required page of the CMS-25 correction is required	ed in ePOC and therefore a uired at the bottom of the first 567 form. Although no plan of ed, it is required that the facility of the electronic documents.	F 0	00			
	survey was conduction was all was NOT in complication	/23, a standard recertification ted at your facility. A complaint so conducted. Your facility ance with the requirements of art B, Requirements for Long s.					
	•	laints were reviewed with NO H53167182C (MN00092891) MN00090020).					
	as your allegation of Departments accepted in ePOC, you at the bottom of the	f correction (POC) will serve f compliance upon the stance. Because you are our signature is not required first page of the CMS-2567 ic submission of the POC will tion of compliance.					
	onsite revisit of you validate substantial regulations has been						
F 688		ecrease in ROM/Mobility	F 6			12/22/23	
_ABORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Electronically Signed

12/11/2023

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:	` ′	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED	
		245316	B. WING			C 15/2023
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 312 NORTHEAST 1ST STREET NEW RICHLAND, MN 56072		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDERSE ACT	JLD BE	(X5) COMPLETION DATE
	resident who enters range of motion do range of motion un condition demonstr of motion is unavoid §483.25(c)(2) A resemble motion receives apprevent further deceives appropriate assistance to main the maximum practice reduction in mobility. Based on observative review, the facility from the services to maintain received for 1 of 2 mobility. Findings include:	1)-(3) facility must ensure that a s the facility without limited es not experience reduction in less the resident's clinical rates that a reduction in range	F 6		reviewed cated on 7/2023 on e affected Nsg staff	
	intact cognition, no person physical asswalking in room and off unit, dressing, to hygiene, utilized a verse.	9/19/23, indicated R27 had rejection of care, required one sist with bed mobility, transfer, d corridor, locomotion on and bilet use, and personal walker and wheelchair, I fractured femur, dementia,		All staff not able to attend the factoring will sign off that they received/reviewed the training, p working on the floor. The Walking program policy was and revised to read: during care	2023. cility rior to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245316	B. WING _		I	C 1 5/2023
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CO 312 NORTHEAST 1ST STREET NEW RICHLAND, MN 56072	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 688	required staff assis (activities of daily living fx (fracture) L (lumb interventions include extensive staff assist bearing as tolerated belt, notes: another wheelchair, walk 75 (certified nursing as program to maintai often refuse to walk fun and complete ewalking program, walker) and one as behind with wheelchair assist with another wheelchair, walk 75 medical record) do and time indicated evening shift, and 125 opportunities for as R27 not available R27's document Program to as R27 not available R27's document Program to as R27 not available R27's document Program to a R27's docum	ted 6/30/23, indicated R27 tance with some ADL's ving) d/t (due/to) compression bar) 1, L2, L4, and weakness; led: ambulation assist, stance: of one, wbat (weight d) device used: fww and gait staff to follow behind with 5-100 ft, on the daily CNA ssistant) restorative walking n current level of mobility, x, encourage to attend fitness exercise handout in my room, yalk with FWW (front wheeled sist with another staff to follow hair, walk 75-100 ft twice daily. I identified document titled evey Report dated 11/23, ex every day and p.m. shift: na/restorative staff to assist ng twice daily, use fww and one staff to follow behind with 5-100 ft. R27's EMR (electronic cumentation with staff initials R27 refused on 11/8/23 11/11/23 evening the other documentation were charted e or not applicable. F/OT/ST recommendations to f/23, indicated R27 was bulate with FWW and assist x nother to follow behind with f/. Iking list 200 hall indicated		conference (and PRN with of status), the IDT will review the progress, and revise the rest PRN for the next Quarter. DON/designee will conduct audits of the resident samprograms 2-3 X week for 4 v 2 X week for 4 weeks, and remonths. Audit results will be brought committee for review and fur recommendations. The DON will be responsible this is completed.	he resident sident sident soldent sold	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245316	B. WING			C 11/15/2023
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP C 312 NORTHEAST 1ST STREET NEW RICHLAND, MN 56072	CODE	
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F 688	Continued From pa	ige 3	F 6	88		
	walking lists: need even with COVID if may walk in hall with room, also can guid this while they are wisignatures indicated 11/9/23. On 11/13/23 at 2:52 seated in a wheelch was supposed to whadn't walked for a stated staff were nown as a sickness in the against the wall in had not used the with a not used the with a not used the with covid and in the stated my legs need. On 11/14/23 at 12:4 aide (TMA)-A stated my legs need. It is not not used the with covid aware when R27 laworked for a week. It is facility in a COVID walk with staff. On 11/14/23 at 12:4 (NA)-A stated the facility in a COVID walk with staff.	inutes dated 11/9/23, indicated to continue walking resident they are not positive, they they are not positive may walk in the agency staff in completing working in our facility, staff deducation was received on the palk the hallway daily and bout three or four days, and out walking him because there he facility. R27 walker was his room and R27 stated he alker for a few days. 144 p.m., R27 was seated a soom and stated staff had not or do exercise, and R27 d the excise to stay strong. 145 p.m., trained medication do residents have not walked at the facility and was not est walked as she had not TMA-A stated prior to the outbreak R27 was expected to the walking program lity COVID outbreak, and so on the walking program.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG	` '	(X3) DATE SURVEY COMPLETED	
		245316	B. WING _		,	C 11/15/2023	
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CO 312 NORTHEAST 1ST STREET NEW RICHLAND, MN 56072	<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ACTION DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 688	the facility as a NA. walking program ar COVID outbreak st R27. RN-A further scurrently due to COR27's room did not he utilized the wheeroom. On 11/14/23 at 1:00 the director of nursithe case manager on walking program either the hallway was program and was etwice a day. The Donursing meeting last educated residents mask on in the hall EMR documentation and RN-B and confexpected. On 11/15/23 at 2:50 administrator stated with the walking program and was expected. On 11/15/23 at 2:50 administrator stated with the walking program and stated he was and fell of his radar. The facility Walking indicated: Policy: Ambulate walking indicated:	was a RN however worked at RN-A stated R27 was on the ad prior to the facility in a aff were expected to walk stated residents are not walked VID in the building, and stated enough room to walk him and elchair to get around in his D. p.m., during an interview with any (DON) and RN-B who was at the facility, stated residents a were expected to walk in with mask or in their room. The affirmed R27 was on walking expected to walk with staff DN further stated she held a st week and staff were were expected to walk with a ways. R27's walking program on was reviewed with the DON firmed R27 was not walked as D. p.m., during an interview the done he was aware of concerns or any staff not walking ted. The administrator stated staff seemed to be doing a neg the residents were walked aware that it was a concern	F 6	88			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		·			OMPLETED	
		245316	B. WING			C 15/2023
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 312 NORTHEAST 1ST STREET NEW RICHLAND, MN 56072	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	level of physical and of care for individual Objective: 1. To promote each mental well-being. 2. To provide a wathat established in the stablished in the state of care? 4. To minimize the Procedure: 1. The interdisciple each resident to ach mobility. 2. The PTA, under plan team will beging. 3. The CNAS on the responsible for providentified resident. 4. After walking is the appropriate data in their initials. 5. At the end of the summarize the more information onto the state of the summarize the more information onto the state of the summarize the more information onto the state of the summarize the more information onto the state of the summarize the more information onto the state of the summarize the more information onto the state of the summarize the more information onto the state of the summarize the more information onto the state of the state of the state of the summarize the more information onto the state of t	and maintaining his/her highest of mental ability. Refer to plan alized treatment plan. The resident's physical and alking program in addition to the formal PT program. In ongoing device to measure reaching goals set in the plan are negative effects of immobility inary team will set goals for the highest level of the direction. Of the care in a walking program, the assigned hall will be widing the assist to the completed, CNA will mark in the ed square the distance walked the month, the PTA will inth's progress and carry this enext month.	F 6			40/00/00
F 801 SS=F	appropriate competout the functions of taking into consider	1)(2)	F 8	UT		12/22/23

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245316	B. WING			C 15/2023
	NAME OF PROVIDER OR SUPPLIER NEW RICHLAND CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 312 NORTHEAST 1ST STREET NEW RICHLAND, MN 56072	_ -	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 801	in accordance with required at §483.70 This includes: §483.60(a)(1) A quaclinically qualified in full-time, part-time, qualified dietitian or nutrition professions (i) Holds a bachelor a regionally accredit United States (or arwith completion of the aprogram in nutrition an appropriate nation recognized for this (ii) Has completed a supervised dietetics supervised dietetics supervised or constrained in the complete of a supervised or constrained in the complete of the complete or constrained in the complete of the complete or services are performant or she is recognized the Commission on successor organizated in the complete of particles are performant of particles	the facility's resident population the facility assessment b(e) alified dietitian or other utrition professional either or on a consultant basis. A other clinically qualified al is one who- it's or higher degree granted by ted college or university in the nequivalent foreign degree) the academic requirements of on or dietetics accredited by onal accreditation organization purpose. It least 900 hours of a practice under the gistered dietitian or nutrition ertified as a dietitian or nutrition ertified as a dietitian or nutrition ertified as a dietitian or nutrition ave met this requirement if he d as a "registered dietitian" by Dietetic Registration or its atton, or meets the ragraphs (a)(1)(i) and (ii) of ored or contracted with prior to one is a safter November 28, 2016 or a law.	F 8	01		
	Cirricany quanneu n	utrition professional is not				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI	`	(X3) DATE SURVEY COMPLETED	
		245316	B. WING		C 11/15/2023	
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 312 NORTHEAST 1ST STREET NEW RICHLAND, MN 56072		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 801	person to serve as nutrition services. (i) The director of frust at a minimum qualifications- (A) A certified dieta (B) A certified food (C) Has similar natiservice manageme certifying body; or D) Has an associate service management, from higher learning; or (E) Has 2 or more position of director in a nursing facility course of study in five topics integral to mincluding, but not line sanitation procedure purchasing/receiving (ii) In States that has food service managements or dietar (iii) Receives frequently from a qualified of the public facility failed to ensitully failed to	the facility must designate a the director of food and food and nutrition services meet one of the following ry manager; or service manager; or sonal certification for food and and safety from a national re's or higher degree in food and or in hospitality, if the les food service or restaurant an accredited institution of years of experience in the of food and nutrition services setting and has completed a food safety and management, tober 1, 2023, that includes anaging dietary operations mited to, foodborne illness, res, and food ag; and ave established standards for gers or dietary managers, ements for food service y managers, and ently scheduled consultations titian or other clinically rofessional. NT is not met as evidenced or and document review, the ure that in the absence of a dietician (RD), the dietary	F 8	F801 (Qualified Dietary staff) The facility will put out an advertisem for a full-time Certified Dietary Manag		
	. ,	certified to oversee nutrition This had potential to affect all		RD. (DM)-C is enrolled in a course (120 h	nrs)	

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE COM	E SURVEY PLETED
		245316	B. WING				C I 5/2023
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1	
				3	12 NORTHEAST 1ST STREET		
NEW RIC	HLAND CARE CENT	ER		١	NEW RICHLAND, MN 56072		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	_	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 801	Continued From pa	ge 8	F 8	801			
	36 residents who re	sided in the facility.			through UND on 11/27/2023. Once		
	Findings include:				coursework is complete, DM-C will the CDM test.	take	
	(DM)-C, who had we position for six year certified dietary may on taking the course contracted with a Ronce per month. During document redescription was Certified an individual through the Associational requindicated an individual through the Associational Foodservice Professible Dietary Manager. During a telephone a.m., (RD)-D stated month and had been CDM. RD-D stated	on 11/13/23 at 1:32 p.m., rorked in the dietary manager is, stated he was not a mager (CDM) but had planned ie. DM-C stated the facility D who came to the facility D who came to the facility irement for the position wal must possess certification ation of Nutrition and issionals and be a Certified interview on 11/15/23 at 8:56 I she went to the facility once a she had encouraged DM-C to die had offered to be a		the CDM test. Administrator/designee will receive (DM)-C course progress report/completion monthly and certification once the test is complete wi a passing score. The Registered Dietician (RD) will continue to write the Assessments and visit the facility weekly until CDM course completion. Administrator/designee will conduct random audits 2X/week for 4 weeks, the 1X week X 4 weeks to ensure Nutritional Assessments are reviewed and signed by the RD. Audit results will be brought to the QAPI Committee for review and further recommendations. The Administrator will be responsible for ensuring this is completed.		and ourse t cs, then itional ned off	
	preceptor. RD-D sta about DM-C not bei previous administra	ated her last conversationing a CDM had been with the tor. RD-D stated she solely isits at the facility per her					
	when informed DM- dietary manager pe per the facility dieta the administrator st acceptable since th dietician. The admin	on 11/15/23 at 2:28 p.m., -C had not been a qualified regulatory requirements and ry manager job description, ated he thought that was e facility contracted with a histrator was informed the d to be employed full-time at					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	(X2) MUL [*] A. BUILDI	TIPLE CONSTRUCTION ING	COM	(X3) DATE SURVEY COMPLETED	
		245316	B. WING			C /15/2023	
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 312 NORTHEAST 1ST STREET NEW RICHLAND, MN 56072	<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIES DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 812	The facility Job Des Director/Certified Dindicated the culinal certification through and Foodservice Production of the training in cost control diet therapy. Knowled and procedures as guidelines governing long-term care facility and procedures as guidelines governing long-term care facility signed by DM-C and Food Procurement, CFR(s): 483.60(i) (1) Section 1.5 (ii) This may include from local producer and local laws or refusion of the facilities from using the section of the sectio	stance. The administrator een aware of that. scription for Culinary ietary Manager (CDM) ry director must possess the Association of Nutrition rofessionals and be a certified ave a minimum of two years in ity in a hospital, skilled nursing related medical facility, have crol, food management and edgeable of dietary practices well as laws, regulations and g dietary functions in the ity. The job description was d dated 10/6/17. Store/Prepare/Serve-Sanitary)(2) fety requirements. sure food from sources ered satisfactory by federal, rities. In food items obtained directly its, subject to applicable State	F 8	01		12/22/23	
	(iii) This provision of from consuming for §483.60(i)(2) - Stor	ood-handling practices. loes not preclude residents ods not procured by the facility. e, prepare, distribute and dance with professional					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A. BU		PLE CONSTRUCTION G	` '	(X3) DATE SURVEY COMPLETED	
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F 812	by: Based on observatoreview, the facility facility facility facility facility facility facility failed to more temperature in the regulatory requirem affect all 36 resider the kitchen. Findings include: During an observatory facility facility failed to more temperature in the regulatory requirem affect all 36 resider the kitchen. Findings include: During an observatory facility faci		F 812		nediately. I of open d diments ed nittee for ons. n the 2023. ed to ure of nt sink. nimum e g side 10 ith a		
	relish with approxing written in black man that date was Febru 2022. DM-C stated condiments could be would find out. DM-he would discard the DM-C stated he loopickle relish could be after opening and stated USDA (United States).	en a one gallon jar of pickle nately half left, with 2/22 ker on the lid. DM-C stated uary 22, this year, not February he did not know how long be stored after opening, but C removed both jars stating tem. on 11/13/23 at 5:12 p.m., sked up how long olives and be stored in the refrigerator stated it was three months per States Department of acknowledged the pickle		Water temperature will be checked a compartment sink daily to ensure temperature is at 110 degrees Firsink, and in the 3rd sink the water temperature for sanitizing should 75-100 degrees. These temperature be checked on daily. Temperature results will be broug QAPI Committee for review and for recommendations. The Administrator will be responsions ensuring this is completed.	re wash n the 1st r be at tures will ht to the urther		

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F 812	During an observat at 11:15 a.m., with 3-compartment sin three sinks and large end countertop dry 3-compartment sin pans. DM-C stated sink 3 were not moknow they needed. During a telephone a.m., registered die to the facility once regulatory compliar stating her contract audits. RD-D stated upon request but h stated she solely confacility. During an interview at 9:28 a.m., in the he was now aware 3-compartment sin DM-C pointed to a the sink he had recregarding use of the including water term the interview, cook and stated she had years and no one had be at a certain term.	ened nine months ago and the ened seven months ago. ion and interview on 11/14/23 DM-C, observed the k. There had been water in all ge sheet pans standing on the ing. DM-C stated the k was used daily for large the temperature in sink 1 and nitored; adding he did not to be. interview on 11/15/23 at 8:56 etician (RD)-D stated she came a month. RD-D did not conduct nee audits in the kitchen, a had not included scheduled dishe would have done them ad not been asked. RD-D conducted clinical visits at the example of the conduction of the conversation of th	F 81	2		

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F 867	that DM-C had beed monitored. In additional informed of condimination had been opened in when the USDA recomposition of both of these finds of both of	r regulation and facility policy; in unaware it needed to be ion, the administrator was nents in the refrigerator that seven and nine months ago commendations were no nonths. The administrator DM-C would have been aware dings. In a Dishes - Manual of dated 2017, indicated the later temperature should be at such theit (F). Change water the effective cleaning of dishes. Water should be 75 to 100 to a torage policy dated 2017, did torage policy dated 201		367		12/22/23

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′		l \ '	(X3) DATE SURVEY COMPLETED	
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(EACH DEFICIENCY	MUST BE PRECEDED BY FULL		(EACH CORRECTIVE ACTION S	HOULD BE	(X5) COMPLETION DATE	
information will be used high risk, high wopportunities for im §483.75(c)(2) Facilial systems to identify, information from all not limited to the fact §483.70(e) and including the method development, monitored will be used to develop will be use	used to identify problems that folume, or problem-prone, and provement. Ity maintenance of effective collect, and use data and departments, including but cility assessment required at uding how such information elop and monitor performance ty development, monitoring, erformance indicators, indology and frequency for such toring, and evaluation. Ity adverse event monitoring, and evaluation. Ity adverse event monitoring, indicators, investigate, it and information relating to the facility, including how the data to develop activities to ents. In systematic analysis and Facility must take actions are improvement and, after a actions, measure its success, ince to ensure that realized and sustained. Facility will develop and addressing:		367			
	Continued From parents in the systematically idents and evaluation of parents including the method development, monitorially will use the continued provements are not systematically idents and evaluation of parents in the systematically idents and the systematically idents ar	PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 13 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 §483.70(e) 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 facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and	PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 13 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 §483.75(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 facility will use the data to develop activities to prevent adverse events. §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	TOUTH TOUTH TO THE PROVIDER OR SUPPLIER 245316 245316 245316 245316 245316 245316 245316 245316 245316 245316 25 STREET ADDRESS, CITY, STATE, ZIP COI 312 NORTHEAST 1ST STREET NEW RICHLAND, MN 56072 25 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION) 26 Continued From page 13 information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. 3483.75(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 \$483.70(e) and including how such information will be used to develop and monitor performance indicators, including the methodology and frequency for such development, monitoring, and evaluation of performance indicators, including the methodos 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 facility will use the data to develop activities to prevent adverse events. 3483.75(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. 3483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to	TOOLOGER OR SUPPLIER 245316 245316 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 312 NORTHEAST 1ST STREET NEW RICHLAND, MN 56072 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 13 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 \$483.70(e) and including how such information will be used to develop and monitor performance indicators, including the methodology and frequency for such development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation of performance indicators, including the methodos 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 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	

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F 867	will be designed to level to prevent quasafety problems; and (iii) How the facility of its performance in ensure that improve §483.75(e) (1) The faction of problems in those outcomes, resident resident choice, and §483.75(e) (2) Performance improvement activities must track resident events, and implement prevention that include feedback facility. §483.75(e) (3) As paint include feedback facility. §483.75(e) (3) As paint include feedback facility.	stems; velop corrective actions that effect change at the systems dity of care, quality of life, or ad will monitor the effectiveness mprovement activities to ements are sustained. facility must set priorities for its vement activities that focus on me, or problem-prone areas; nce, prevalence, and severity e areas; and affect health safety, resident autonomy, d quality of care. facility must set priorities for its vement activities that focus on me, or problem-prone areas; nce, prevalence, and severity e areas; and affect health safety, resident autonomy, d quality of care. formance improvement and adverse alyze their causes, and we actions and mechanisms ack and learning throughout the ent of their performance ties, the facility must conduct the improvement projects. The ncy of improvement projects acility must reflect the scope the facility's services and	F 8	367		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 867	§483.75(g)(2) The assurance committed governing body, or functioning as a go activities, including program required use (e) of this section. (ii) Develop and improved the collected under resulting from drug available data to make the collected under resulting from drug available data to make the potential to affect the collection, analysis identified concern (so and Performance Improved the potential to affect the potential the potential to affect the poten	assessment and assurance. quality assessment and ee reports to the facility's designated person(s) verning body regarding its implementation of the QAPI inder paragraphs (a) through The committee must: plement appropriate plans of entified quality deficiencies; w and analyze data, including er the QAPI program and data regimen reviews, and act on ake improvements. NT is not met as evidenced tion, interview and document failed to have evidence of a ovement Project (PIP) which k or problem-prone areas, and appropriate data and evaluation of the s) during Quality Assurance emprovement (QAPI). This had	F 8	F867 (QAPI/QAA Improvem The facility QAPI team will m 12/12/2023 to analyze and ic performance improvement p work on A PIP will be chosen from an improve quality of care and/o life for our residents, the Qua Indicators, Quality Measures Survey results will be the are contribute to our PIP. A team will be selected to wo project, with a team leader th accountable to the QAPI Cor team will use a systematic al identify the root cause and co	heet on dentify a project (PIP) to reas that could or quality of ality and/or eas of study to mat will be mmittee. The pproach to		
	improvement withir	the facility. The administrator		factors to the problem, ensur	re planned		

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 880 SS=F	During a follow up in administrator stated and QAPI minutes of there was no documidentified or perform. On 11/15/23 at 3:00 facility identified the about any PIP project working on. On 11/15/23 at 3:13 the director of nursinurse (RN)-B, who manager, they stated PIP project the facility policy titted place. 2. Provide a means performance improvidentified negative of the facility must eximple the facility must	interview at 3:35 p.m., the d he reviewed the facility QAA for the last year and verified mentation to support a PIP was med. O p.m., an observation of the ere was no information posted ect the facility was actively O p.m., during an interview with ing (DON) and registered was known as the facility case ed they were unaware of any lities QAPI committee had in Itled Quality Assurance and ovement (QAPI) Program dicated: Is to establish and implement ovement projects to correct or problematic indicators in & Control (1)(2)(4)(e)(f) Control cases a safe, sanitary and ment and control program e a safe, sanitary and ment and to help prevent the ransmission of communicable		880	and to review to ensure the new actare being implemented. Information on the PIP project will be shared with facility staff, residents a families via meetings, newsletters postings. DON/designee will conduct random on the project simplementation or weekly basis. Results of the audits and PIP project be brought to the QAPI Committee review and further recommendation.	e and or audits a ct will for	12/22/23

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F 880	and control program a minimum, the follows \$483.80(a)(1) A system of conducted according accepted national system of survey possible communications before the persons in the facili (ii) When and to who communicable diserported; (iii) Standard and trato be followed to program upon the involved, and (B) A requirement to be circumstances. (v) The circumstances. (v) The circumstances. (v) The circumstances.	tablish an infection prevention in (IPCP) that must include, at owing elements: Item for preventing, identifying, ting, and controlling infections diseases for all residents, sitors, and other individuals under a contractual upon the facility assessment in the facility and following the facility of the faci		380			

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F 880	Continued From pa	ge 18	F 8	80			
		ne procedures to be followed direct resident contact.					
		stem for recording incidents facility's IPCP and the aken by the facility.					
		ndle, store, process, and as to prevent the spread of					
	IPCP and update the This REQUIREMEN	eview. duct an annual review of its eir program, as necessary. NT is not met as evidenced					
	review, the facility	cion, interview and document ailed to follow Centers for caid Services (CMS) and e Control (CDC) guidelines to of Covid-19 when during a failed to ensure appropriate tective equipment (PPE) when		F880 (Infection Prevention and Co The facility staff will be re-educated 12/07/2023 on the IPCP program p for the following areas: 1)appropriate use of personal prote equipment (PPE), 2) appropriate signage on the doo	d by olicies ective		
	staff were observed wearing appropriate residents (R1, R6, I in transmission bas	not wearing PPE or not PPE, in rooms of 8 of 8 R9, R21, R25, R27, R28, R87) ed precautions (TBP) for emove masks after caring for		 3) equipment needed on the PPE outside the residents □ door when isolation, 4) guidelines on duration of Isolation 5) the need for a closed door on a 	carts in strict on,		
	residents in TBP fo R27, R28, R87) on residents on TBP h	r 5 of 5 residents (R6, R21, TBP; failed to ensure ad a PPE cart outside of their		that is in isolation, and 6) ensuring catheter bags do not to the floor	ouch		
	ensure PPE carts h hand sanitizer and	dents (R8, R25); failed to ad antimicrobial's such as disinfectant wipes readily e rooms of residents for 7 of 7		All staff not able to attend the facility training will sign off that they received/reviewed the training, prictions working on the floor.			
	residents (R6, R9, I failed to ensure res	R10, R11, R21, R26, R28); idents in TBP for Covid-19 r the required duration for 1 of		Policy and Procedures have been reviewed and revised to include the education of staff and the addition			

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F 880	closed doors of res residents (R6, R8, Ithe potential to affe in the facility. In addresidents' urinary of floor during random resident, (R9) revies Finding include: During an observation when entering the fonthe door indication During the entrance nursing (DON) state residents in TBP for identified on the cell Midnight Census R indicated the follow for Covid-19: R6, R R26, R28, and R87. During an observation at 2:51 p.m., on the where some reside based upon droplet doors and/or PPE of these two findings of these two findings of these two findings of the small plastic contained N95 mas of the small plastic contained N95 mas of the small plastic	n TBP; and failed to maintain idents in TBP for 4 of 4 R25, R28) on TBP. This had ct all 36 residents who resided dition, failed to ensure atheter bag remained off the nobservations for 1 of 1 wed for urinary catheters. ion on 11/13/23 at 10:45 a.m., acility, there had been a signing masks were required. The conference, the director of ed there were 10 of 36 recovid-19 and they would be nous sheet. eport dated 11/13/23, ing 10 residents were in TBP 8, R9, R10, R11, R21, R25,	F 8	Isolation cart checklists for e and accuracy of stocked sup Infection Control Nurse/Desig conduct Random Audits of a Strict isolation and/or resider catheter bag 2Xweek for 4 w weekly thereafter. Audit results will be brought to Committee for review and fur recommendations. DON will be responsible for eleducation and the audits are completed.	plies. gnee will resident in ts with a reeks, then to the QAPI rther ensuring this	

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F 880	other surface on who disinfectant wipes, medications or mean before entering the set eye protection is wipe to clean them room 101, R28 in reall observed to be indicating droplet/or directed staff to keep were wide open. In PPE cart outside R During an interview nursing assistant (Nowas in TBP, their deprevent the spread some residents did they asked her to k NA-D acknowledge but felt she should NA-D had been unaresidents on the reactlosed. During an observating R26's door was closed. During an observating R26's door was closed. During an observating R26's door was closed.	top of it. There had been no nich to put hand sanitizer, or for staff to set things (e.g., al tray) as they donned PPE room, and no place for staff to norder to obtain a disinfectant after exiting a room. R10 in from 114, and R8 in 108 were in TBP with signs on the door contact precautions. The signs ep the door closed. The doors addition, there had been no 8's room. Ton 11/13/23 at 3:08 p.m., NA)-D stated when a resident for needed to be closed to of Covid-19. NA-D stated not like their door closed so if eep it open, she complied. If the door should be closed do what the resident asked. It is aware if anyone had educated ason their door should be kept in ion on 11/13/23 at 3:13 p.m., seed and a sign posted on the		380		
	R25's door was ope	en and a sign was posted on special droplet /contact structions to wear face mask,				

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		245316	B. WING		11	C / 15/2023
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP COD 312 NORTHEAST 1ST STREET NEW RICHLAND, MN 56072	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOWS CROSS-REFERENCED TO THE APPLICATION OF CORRECTIVE ACTION SHOWS CROSS-REFERENCED TO THE APPLICATION OF CORRECTIVE ACTION OF CORRECTIVE	HOULD BE	(X5) COMPLETION DATE
F 880	gloves. NA-E stated room 205: R25 and isolation but off preeither. NA-E further 205 could not leave NA-E stated a sign the residents were isolation. NA-E stated wear PPE when the only required to we and registered nurs with only a regular No PPE cart with sof R25's room. NA not sure why the sign door with droplet property of the pro	e shield or goggles, gown and at there were two resident's in R2. NA-E stated R25 was on cautions, and R2 was not on stated the residents in room e their rooms due to isolation. At the nurses station indicated off precautions, and still on ed staff were not required to ey entered R25's room and ar a regular face mask. NA-E (RN)-A entered room R25's face mask and no other PPE. Applies was observed outside and RN-A stated they were gns were still posted on R25's recautions and required PPE. And observation on 11/13/23 ed practical nurse (LPN)-A effection preventionist, stated it ack to work after seven days, positive for Covid-19. A, walked the 100 wing with to of residents in TBP. R10 had tested positive for ng of 11/13/23. His door had PN-A stated he was a fall risk ne door was open. LPN-A stated R87 had tested 9 on 11/5/23, and should have ntil 11/15/23. There has been	F 8	80		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245316	B. WING			C 1/15/2023
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CO 312 NORTHEAST 1ST STREET NEW RICHLAND, MN 56072	<u> </u>	17 13/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
F 880	11/20/23. The doorR8 in room 108. L positive for Covid-1 remain in TBP until wide open. In addition to makin regarding residents of concerns regard disinfectant wipes a outside resident roos stated the findings she had not yet had provide staff re-trail expected the DON to have taken over monitor staff compliguidelines for Covid During an interview LPN-A stated the faresidents remained precautions for ten test and stated staff required PPE when room on TBP. LPN included N95 mask gloves, and a gown expected to remove exited the room, an facility. During an interview RN-A stated R25 was tested positive for Coprecautions. RN-A stated R25 was tested positive for Coprecautions. RN-A	oth were to be in TBP until had been wide open. PN-A stated R8 had tested 9 on 11/5/23 and had was to 11/15/23. The door had been ng observations of her own in TBP, LPN-A was informed ing the lack of hand sanitizer, and work surface for staff oms who were in TBP. LPN-A had taken her by surprise and time to make corrections or ning. LPN-A stated she had and registered nurse (RN)-B her duties in her absence and liance for adherence to CDC		880		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245316	B. WING		11	C / 15/2023
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP COE 312 NORTHEAST 1ST STREET NEW RICHLAND, MN 56072	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) COMPLETION DATE
F 880	enter R25's room wastaff were not required gloves or eye proter N95 mask and did room and confirmed mask in an isolation the N95 mask and room with the same was not aware or puring an interview LPN-A confirmed RapPE cart to be lost that included gown N95 masks. During an interview LPN-A provided a little tested positive for Cart to the list included day and end dates for The list included day and end dates for The list included day and tested positive During an interview DON and LPN-A was Covid-19 findings. RN-B had been rescompliance for adh for Covid-19. The Estimate residents had monitored employed precautions, but adobservations made DON did not know been removed from	stated staff were allowed to with only a regular mask, and red to wear a N95, gown, ction. RN-A stated she wore a not remove it from room to d she wore the same N95 n room, and did not remove would enter another resident e N95 mask. RN-A stated she rovided education the N95 anged when she exited a was in isolation. You on 11/13/23 at 3:34 p.m., 225 was on TBP and expected cated outside of R25's room gloves, eye protection and on 11/13/23 at 3:49 p.m., ast of 10 residents who had covid-19 starting on 11/4/23. At tested positive, and start TBP. Three additional residents		380		

· · · · · · · · · · · · · · · · · · ·		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	_ ` <i>'</i>		` '	(X3) DATE SURVEY COMPLETED	
		245316	B. WING		11/	C / 15/2023	
NAME OF PROVIDER OR SUPPLIER NEW RICHLAND CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 312 NORTHEAST 1ST STREET NEW RICHLAND, MN 56072	1 -7		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		JLD BE	(X5) COMPLETION DATE	
F 880	sanitizer or disinfect to staff as they enteresidents in TBP, the down the hall or accept, hand sanitized DON acknowledged with Covid-19 precare immediately available. During an observation to 5:18 p.m., observing a yellow PPE government of the room of NA-C exited the room without changing Platray into the room of NA-C exited the room without performing R21's room who was the room, she chand performing hand hy R87's room who was the room, she chand performing hand hy cart down the hall to both in TBP. When removed her gown hand hygiene. NA-C the N95 mask. During an interview DON who was in the expectations of staff residents in TBP are the same PPE from stated she expected new PPE between the same PPE from stated she expected new PPE between the stated she expected new PPE she tween the stated new PP	heir had been no hand t wipes immediately available red and exited rooms of he DON stated staff could walk ross the hall to access a PPE r, and disinfect wipes. The d that to ensure compliance autions, supplies needed to be		380			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245316	B. WING		11	C / 15/2023	
NAME OF PROVIDER OR SUPPLIER NEW RICHLAND CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 312 NORTHEAST 1ST STREET NEW RICHLAND, MN 56072	<u> </u>	710/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	(X5) COMPLETION DATE	
F 880	During an interview NA-C was asked wabout donning and residents in TBP. Notes that way and did not do that where residents in TBP. Notes and it too. NA-C ack change PPE and claroom in order to preto other residents. During an interview DON stated staff was shield or eye protes after exiting a resident and trash readily available our stated the staff wou hallway to obtain districted if needed. During an observation together with the DON and the staff wou hallway to obtain districted if needed. During an observation together with the DON at the 200 wing nurshad a hand-written 205, 212 were "off prisolation." The DON not know what that but that information confirmed R26, R25	e DON was then informed of -C. on 11/13/23 at 5:27 p.m., hat she recalled from training doffing to go into rooms of IA-C was able to articulate the uding performing hand hygiene her gloves, and admitted she her gloves, and admitted she her gloves, and always dit was they way other staff knowledged it was important to ean hands when exiting a event the spread of Covid-19 on 11/13/23 at 5:35 p.m., the ere required to wash their face cotion with disinfectant wipes ent room who was on TBP. It disinfectant wipes, hand receptacle had not been trained in the sinfectant wipes and a trash	F	380			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245316	B. WING			C 11/15/2023	
NAME OF PROVIDER OR SUPPLIER NEW RICHLAND CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CO 312 NORTHEAST 1ST STREET NEW RICHLAND, MN 56072	<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE	
F 880	Covid-19. NA-A had protection, a regular N-95 mask. NA-A or required when goin forgot. NA-A further was to put the N95 mask to put the N95 mask and continued to wresident rooms. During an interview LPN-A stated state N95 mask should be residents room who mask should not be room. During an observation at 1:40 p.m., observed with a plastated she removed inside the room. Han N95 masks where residents in TBP; a mask between room should wear an N9 in TBP, but the mask between room should wear an N9 in TBP, and not should be room should wear an N9 in TBP, but the mask between room should be room shou	room, who was on TBP for d donned gloves, gown, eye ar mask rather than a required confirmed a N95 mask was ig into R9's room but she restated her routine practice over her regular mask and ask when she exited the room. If not remove the regular mask ear that mask into other of on 11/14/23 at 11:24 a.m., if both the regular mask and one removed when staff exited a powas in TBP, and neither eworn into another residents are worn into another residents. If no and interview on 11/14/23 are worn into another residents are worn into another residents. If no and interview on 11/14/23 are worn into another residents are who was in TBP. H-A was an mask on, not an N95. H-A and the PPE gown and gloves. A admitted she did not wear an she cleaned the rooms of adding she changed the plain ms. H-A stated she knew staff to when in rooms of residents sks were uncomfortable for observed H-A enter R21's room at gloves on and a plain mask. on 11/15/23 at 8:48 a.m., the informed of findings related to recautions. The administrator stated that guidelines had been 19. The administrator was infection control practices		380			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245316	B. WING			11/1	5/2023
NAME OF PROVIDER OR SUPPLIER NEW RICHLAND CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP C 312 NORTHEAST 1ST STREET NEW RICHLAND, MN 56072	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD B	3E	(X5) COMPLETION DATE
F 880	status. The administ that in the absence RN-B would have a Covid-19 precaution. The facility Infection Program policy date would establish and Prevention and Comprevent, identify, into the onset and spreawhenever possible, visitors. These task standards and guid. The facility Isolation Transmission-Base 9/2023, indicated with the DON or Infection PPE (i.e. gloves, goinear the residents in entering the room of Place necessary entering the room of Place necessary entering the isolation resident (or representations. The facility Discont 8/2023, indicated reappropriate precautions. The facility Discont 8/2023, indicated reappropriate precautions.	place, regardless of Covid-19 strator stated he had expected of LPN-A, the DON and ensured the facility adhered to ans and TBP requirements. In Prevention and Control ed 8/2023, indicated the facility dimaintain an Infection and Program (IPCP) to westigate, report and control and of communicable disease, among residents, staff and as are based on national telines of the CDC. In-Initiating and Preventionist would ensure bowns, masks) were maintained from so that everyone can access what they need an access what they need an access what they need equate supply of antiseptic entered is maintained in the room period; and explain to the entative) the reason for the entative) the reason for the entative on preventionist had the and discontinue Isolation		80			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		245316	B. WING		1	1/15/2023	
NAME OF PROVIDER OR SUPPLIER NEW RICHLAND CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP COI 312 NORTHEAST 1ST STREET NEW RICHLAND, MN 56072	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 880	Continued From pa	ge 28	F 8	80			
	indicated use gown into an appropriate leaving the room.	Sowns policy dated 8/2023, sonly once and then discard receptacle directly before					
	Catheter or UTI						
	assessment dated intact cognition, no person physical asswalk in room and counit, dressing, toilet utilized a walker an	nimum Data Set (MDS) 9/14/23, indicated R9 had rejection of care, required one sist with bed mobility, transfer, orridor, locomotion on and off t use, and personal hygiene, d wheelchair, diagnoses failure, muscle weakness, and					
	of bladder/bowel are from staff for toileting catheter, chronic kind hypertensive heart and interventions in urine output amounts.	ed 9/11/23, indicated continent and require some assistance and or peri cares, Foley dney disease stage 3, and chronic kidney disease acluded any changed observed ount, frequency, color or odor to nurse, continence: 16 F					
	and a urinary cathe the tubing and the floor next to R9's be	B p.m., R9 was lying in her bed ter tubing was on her bed and urinary catheter bag laid on the ed. R9 stated staff emptied the eter bags at least twice during					
		8 a.m., R9 was observed er with a urinary catheter bag her recliner.					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	TIPLE CONSTRUCTION ING	` '	(X3) DATE SURVEY COMPLETED	
		245316	B. WING		11/	C /15/2023	
NAME OF PROVIDER OR SUPPLIER NEW RICHLAND CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP COD 312 NORTHEAST 1ST STREET NEW RICHLAND, MN 56072	<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		HOULD BE	(X5) COMPLETION DATE	
F 880	(NA)-A stated R9 w by herself and the a (RN)-A. R9 was obsconfirmed the urina floor. NA-A was obsand remove the cat hooked onto the side of thooked onto the side of thooked onto the side of thooked. On 11/14/23 at 11:2 NA at the facility) st not have contact wiwhen she transfers bag to the side of thoed. On 11/15/23 at 9:29 sleeping in bed and on the floor next to On 11/15/23 at 9:30 licensed practical n infection prevention catheter bags shou avoid contacting the measures. On 11/15/23 at 9:33 offered R9 morning stated the catheter was not aware the example of the last staff to have on 11/15/23 at 9:57 director of nursing (11/15/23 at 9:57 director of nursing (11/15/	9 a.m., nursing assistant as transferred to the recliner assist of registered nurse served with NA-A and ry catheter bag was on the served to go into R9's room heter bag from the floor and le of R9's recliner chair. 6 a.m. RN-A (who works as a ated R9's catheter bag should the floor, and RN-A stated R9 she hooked the catheter he recliner chair or to R9's 9 a.m., R9 was observed her urinary catheter bag was		380			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/24/2023 FORM APPROVED OMB NO. 0938-0391

AND DIANIOE CORRECTIONI INDENTIFICATION NI IMBERI		l ` ´	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245316	B. WING			11/1	C 1 5/2023
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP	CODE		
NFW RIC	HLAND CARE CENTI	FR		312 NORTHEAST 1ST STREET			
IVEVV ICIO	TILAND OAKE OLIVII			NEW RICHLAND, MN 56072			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD E APPROPF	BE	(X5) COMPLETION DATE
F 880		Catheter Care policy dated	F 8	80			
	check frequently to loops in the tubing a	Catheter Tubing and Bag; be sure there are no kinks or and that the resident is not Keep bag off floor, hang on					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

F5316034

PRINTED: 11/17/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICAND PLAN OF CORREC		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION ING 01 - MAIN BUILDING 01	(>	X3) DATE SURVEY COMPLETED
		245316	B. WING			11/14/2023
NAME OF PROVIDER NEW RICHLAND		ER		STREET ADDRESS, CITY, STATE, ZIF 312 NORTHEAST 1ST STREET NEW RICHLAND, MN 56072	² CODE	
	CH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ON SHOULD BI HE APPROPRIA	D ATE
K 000 INITIAL	COMMEN	TS	K 0	000		
An ann conduct Public 11/14/2 Richlar with the Medica 483.70 edition (NFPA) Existing NFPA S NEW F building The ori different one-stoto be of Tomographic Because comparation as one The fact automatic system spaces automatic and the store of	sted by the Nosafety, State 2023. At the decire candidate and the state of the construction of the constru	ety recertification survey was dinnesota Department of e Fire Marshal Division on time of this survey, New ter was found in compliance at 42 CFR, Subpart ety from Fire, and the 2012 Fire Protection Association afety Code (LSC), Chapter 19 and the 2012 edition of the Care Facilities Code. CARE CENTER is a 1 story sement. If was constructed at 2 aginal building in 1975, assement, and was determined assement, and was determined and the construction. In 1992 and an activated and was determined to construction. If building and the addition are constructed throughout by an assement and has a fire alarm and detection in corridors and a corridors that is monitored for artment notification. If apacity of 50 beds and had a series alarm and according the series and had a series and ha				
ABORATORY DIRECTO	R'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIGN	JATURF	TITLE		(X6) DATE

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/17/2023 FORM APPROVED OMB NO. 0938-0391

	AN OF CORRECTION INDENTIFICATION NITINGER		↓ ' '		E SURVEY PLETED		
		245316	B. WING			11/	14/2023
NAME OF PROVIDER OR SUPPLIER NEW RICHLAND CARE CENTER			•	3	STREET ADDRESS, CITY, STATE, ZIP CODE 12 NORTHEAST 1ST STREET NEW RICHLAND, MN 56072		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)) BE	(X5) COMPLETION DATE
K 000	Continued From pacensus of 36 at the		K				



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered December 1, 2023

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

Re: State Nursing Home Licensing Orders

Event ID: 9NGV11

Dear Administrator:

The above facility was surveyed on November 13, 2023 through November 15, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

New Richland Care Center December 1, 2023 Page 2

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001

Email: elizabeth.silkey@state.mn.us

Office: (507) 344-2742 Mobile: (651) 368-3593

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane, Compliance Analyst

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

P.O. Box 64900

Saint Paul, MN 55164-0900

Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

Minnesota Department of Health

AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	E CONSTRUCTION	COMPLETED
	00748	B. WING		C 11/15/2023
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	
NEW RICHLAND CARE CENTI	ER	THEAST 1ST HLAND, MN		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
2 000 Initial Comments		2 000		
****ATTEN	NTION*****			
NH LICENSING	CORRECTION ORDER			
144A.10, this correct pursuant to a surve found that the deficat herein are not correct not corrected shall with a schedule of found the Minnesota Department of the Minnesota Department of the corrected requires of the number and MN Rule When a rule contain comply with any of the pursuant of the comply with any of the pursuant of the comply with any of the pursuant comply with any of the pursuant to a surve pursuant to a s	nether a violation has been			
re-inspection with a result in the assess	ny item of multi-part rule will ment of a fine even if the item iring the initial inspection was			
that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.			
conducted at your facility was NOT in Licensure and the finsured. Please indicates	S: 23, a licensing survey was acility by surveyors from the ent of Health (MDH). Your compliance with the MN State ollowing correction orders are eate in your electronic plan of reviewed these orders and			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

Electronically Signed

12/11/23

Minnesota Department of Health

11/15/2023 (X5) COMPLETE DATE
COMPLETE
COMPLETE
COMPLETE

Minnesota Department of Health

STATE FORM 9NGV11 If continuation sheet 2 of 30

Minnesota Department of Health

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
		00748	B. WING		11/1	5/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
NEW RIC	HLAND CARE CENTI	ER	THEAST 1ST			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	required at the botto form.	om of the first page of state				
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE THIS WILL APPEAL IS NO REQUIREME CORRECTION FOR	N OF CORRECTION." THIS RAL DEFICIENCIES ONLY. R ON EACH PAGE. THERE ENT TO SUBMIT A PLAN OF				
2 255	MN Rule 4658.0070 Assurance Commit	Quality Assessment and tee	2 255			12/22/23
	assessment and as of the administrator services, the medic designated by the nathree other member representing disciplaresident care. The assurance committee respect to which quality deficiencies address, at a minimal and asservices address, at a minimal and asservices.	st maintain a quality surance committee consisting , the director of nursing al director or other physician nedical director, and at least rs of the nursing home's staff, ines directly involved in quality assessment and ee must identify issues with ality assurance activities are elop and implement f action to correct identified The committee must num, incident and accident control, and medications and				
	by: Based on observation review, the facility fa	ent is not met as evidenced on, interview and document ailed to have evidence of a vement Project (PIP) which or problem-prone areas, and appropriate data		Corrected		

Minnesota Department of Health

STATE FORM 9NGV11 If continuation sheet 3 of 30

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE S COMPL		SURVEY	
	00748	B. WING		11/1	5/2023
NAME OF PROVIDER OR SUPPLIER NEW RICHLAND CARE CENTE	R 312 NOR	DRESS, CITY, S THEAST 1S1 HLAND, MN			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
identified concern(s) and Performance In the potential to affect Findings include: On 11/15/23 at 2:50 facility administrator (Quality Assessmen group met on a regulation provement within stated he could not During a follow up in administrator stated and QAPI minutes for there was no documidentified or perform On 11/15/23 at 3:00 facility identified the about any PIP project working on. On 11/15/23 at 3:13 the director of nursin nurse (RN)-B, who was manager, they state PIP project the facility place. The facility policy titl Performance Improved at the analyse of the project and the facility place. The project a means performance improved a means performance improved the provided a means performance improved the facility policy in the facility policy titl performance improved the facility policy in the facility policy titl performance improved the facility policy in the facility policy titl performance improved the facility policy in the facility	and evaluation of the during Quality Assurance approvement (QAPI). This had et all 36 residents. p.m., during an interview the stated the facility QAA at and Assurance) and QAPI clar basis with the Medical reas identified as needing the facility. The administrator recall the facility PIP project. Interview at 3:35 p.m., the later he reviewed the facility QAA for the last year and verified nentation to support a PIP was need. p.m., an observation of the re was no information posted of the facility was actively p.m., during an interview with ng (DON) and registered was known as the facility case and they were unaware of any lities QAPI committee had in led Quality Assurance and wement (QAPI) Program	2 255			

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:		(X3) DATE COMP	SURVEY LETED
			/ BOILDING			;
		00748	B. WING		11/1	5/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
NEW RIC	HLAND CARE CENT	ER	THEAST 1ST S HLAND, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPOSED TO THE	.D BE	(X5) COMPLETE DATE
	quality assurance of with respect to which are necessary and appropriate plans of quality deficiencies, these area on a regrecommendations fradministrator will be implementation. TIME PERIOD FOR (21) days.	THOD OF CORRECTION: The ommittee could identify issues ch quality assurance activities develop and implement f action to correct identified. The committee will monitor pular basis and make for any changes. The expensible for	2 255			12/22/23
2 895	Subp. 2. Range of that is directed towarthrough positioning implemented and more comprehensive resident of nursing services development of a nursing services development development development development development development development de	motion. A supportive program and prevention of deformities and range of motion must be naintained. Based on the ident assessment, the director must coordinate the ursing care plan which ha limited range of motion e treatment and services to notion and to prevent further of motion.	2 895			12/22/23
	by: Based on observation review, the facility fa	ent is not met as evidenced on, interview and document ailed to ensure restorative and/or improve mobility was residents (R27) reviewed for	C	orrected		

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Minnesota Department of Health

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY
		00748	B. WING			5/2023
NIAME OF			DDESS CITY S	TATE ZID CODE	1	0,2020
NAIVIE OF I	PROVIDER OR SUPPLIER		THEAST 1S	STATE, ZIP CODE		
NEW RIC	CHLAND CARE CENT	ER	HLAND, MN			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETE DATE
2 895	Continued From pa	ge 5	2 895			
	Findings include:					
	assessment dated sintact cognition, no person physical ass walking in room and off unit, dressing, to hygiene, utilized a vidagnoses included and edema.	imum Data Set (MDS) 9/19/23, indicated R27 had rejection of care, required one sist with bed mobility, transfer, d corridor, locomotion on and bilet use, and personal valker and wheelchair, fractured femur, dementia,				
	required staff assist (activities of daily live fx (fracture) L (lumber interventions included extensive staff assist bearing as tolerated belt, notes: another wheelchair, walk 75 (certified nursing as program to maintain often refuse to walk fun and complete extensive staff assist bearing as tolerated belt, notes: another wheelchair, walk 75 (certified nursing as program to maintain often refuse to walk fun and complete extensive staff assist bearing as tolerated belt another walk fun and complete extensive staff assist bearing as tolerated belt for the first bearing as tolerated belt for the first bearing as tolerated bearing as tolerated belt for the first bearing as tolerated bearing as to	ed 6/30/23, indicated R27 cance with some ADL's ving) d/t (due/to) compression par) 1, L2, L4, and weakness; ed: ambulation assist, stance: of one, wbat (weight d) device used: fww and gait staff to follow behind with 5-100 ft, on the daily CNA esistant) restorative walking in current level of mobility, and current level of mobility, and current level of mobility, and with FWW (front wheeled sist with another staff to follow hair, walk 75-100 ft twice daily.				
	Documentation Surindicated a staff tas walking program: cresident with walking assist with another wheelchair, walk 75 medical record) document and time indicated I	videntified document titled vey Report dated 11/23, k every day and p.m. shift: na/restorative staff to assist g twice daily, use fww and one staff to follow behind with 5-100 ft. R27's EMR (electronic cumentation with staff initials R27 refused on 11/8/23 1/11/23 evening the other				

Minnesota Department of Health

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00748	B. WING		11/1	5/2023
	PROVIDER OR SUPPLIER	ER 312 NOR	DRESS, CITY, S THEAST 1S HLAND, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 895	R27's document PT nursing dated 4/21/recommended amb 1 (75-100 ft) and ar wheelchair, 2x daily Document titled wa R27 two assist with Nursing meeting mi walking lists: need to even with COVID if may walk in hall with room, also can guid this while they are was ignatures indicated 11/9/23. On 11/13/23 at 2:52 seated in a wheelch was supposed to whadn't walked for all stated staff were now as a sickness in the against the wall in had not used the way offered to walk him stated my legs need. On 11/14/23 at 12:4 wheelchair in his rooffered to walk him stated my legs need. On 11/14/23 at 12:4 aide (TMA)-A stated much with COVID a aware when R27 later was a ware ware ware ware ware ware ware wa	documentation were charted e or not applicable. OT/ST recommendations to 23, indicated R27 was ulate with FWW and assist x other to follow behind with the chartest with the control of t	2 895			

Minnesota Department of Health

STATE FORM 9NGV11 If continuation sheet 7 of 30

Minnesota Department of Health

AND PLAN OF CORRECTION	$lackbox{1}$, $lackbox{2}$		(X3) DATE	SURVEY LETED	
	00748	B. WING		11/1	5/2023
NAME OF PROVIDER OR SUPPLIER NEW RICHLAND CARE CENTER	312 NOR	PRESS, CITY, S THEAST 1ST		-	
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETE DATE
walk with staff. On 11/14/23 at 12:52 (NA)-A stated the facility alking residents on the because of the facility confirmed R27 was oreon on 11/14/23 at 12:52 (RN)-A stated she was the facility as a NA. RI walking program and COVID outbreak staff R27. RN-A further state currently due to COVIR27's room did not enhe utilized the wheelch room. On 11/14/23 at 1:00 puthe director of nursing the case manager at the on walking program we either the hallway with DON and RN-B confir program and was expetimed a day. The DON nursing meeting last we ducated residents we mask on in the hallway EMR documentation wand RN-B and confirm expected. On 11/15/23 at 2:50 put administrator stated he with the walking program residents as expected.	p.m., nursing assistant lity was currently not the walking program COVID outbreak, and in the walking program. p.m., registered nurse is a RN however worked at N-A stated R27 was on the prior to the facility in a fivere expected to walk ited residents are not walked in the building, and stated hough room to walk him and hair to get around in his item., during an interview with a (DON) and RN-B who was the facility, stated residents were expected to walk in mask or in their room. The med R27 was on walking sected to walk with staff I further stated she held a	2 895			

Minnesota Department of Health

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Minnesota Department of Health

	DI AN OF CORRECTION \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00748	B. WING		11/1	5/2023	
	PROVIDER OR SUPPLIER	ER 312 NOR	DRESS, CITY, S THEAST 1S HLAND, MN		·		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
2 895	and stated he was a and fell of his radar. The facility Walking indicated: Policy: Ambulate wi assist with/without a resident reaching a level of physical and of care for individual. Objective: 1. To promote each mental well-being. 2. To provide a wasthat established in the stablished in the st	ng the residents were walked aware that it was a concern aware that it was a concern brogram policy dated 10/23, the aresident utilizing 1-2 a device to facilitate the nd maintaining his/her highest depend mental ability. Refer to plan alized treatment plan. The resident's physical and alking program in addition to the formal PT program. In ongoing device to measure reaching goals set in the plan are negative effects of immobility inary team will set goals for the direction. Of the care in a walking program, the assigned hall will be widing the assist to the completed, CNA will mark in the direction of the direction of the care in a walking program. The assigned hall will be widing the assist to the completed, CNA will mark in the direction of the care in a walking program. The assigned hall will be widing the assist to the completed, CNA will mark in the square the distance walked the month, the PTA will of the progress and carry this an ext month.		DELITOIT)			
	SUGGESTED MET	HOD OF CORRECTION:					

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STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION	S	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00748	B. WING		11/1	5/2023
NAME OF PROVIDER OR SUP		ER 312 NOR	DRESS, CITY, S THEAST 1S HLAND, MN		•	
PREFIX (EACH DEFI	CIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
review and reprogram, educt an auto ensure it is as ordered. In a licensed nure resident on the appropriate. The all audit information and the contract of the	f nurs	ge 9 sing (DON) or designee could colicies related to the walking staff on the policies, and all residents on the program a completed and documented sion, they could audit to ensure aluates the program and each gram periodically to ensure ON or designee should bring to the Quality Assurance evement (QAPI) committee to note or the need for further	2 895			
Subp. 2. Direction dietitian is not administrator service who is minimum, a directives frequentially dietitic consultation in the nursing he hired before Normality for a dietitic complete a dietitic complet	tor ctor of employed etary lay 28 etary view cered	f dietary service. If a qualified oyed full time, the designate a director of dietary lled in or has completed, at a manager course, and who scheduled consultation from a The number of hours of the based upon the needs of Directors of dietary service 3, 1995, are not required to manager course. The number of hours of the based upon the needs of Directors of dietary service 3, 1995, are not required to manager course. The number of hours of hours of the number of hours of the number of hours of hours of the number of hours	2 980	corrected		12/22/23

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l `´	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00748	B. WING		11/1	5/2023
	PROVIDER OR SUPPLIER	ER 312 NOR	DRESS, CITY, S THEAST 1S HLAND, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 980	Findings include: During an interview (DM)-C, who had we position for six year certified dietary may on taking the course contracted with a Ronce per month. During document reducational requindicated an individe through the Associated Foodservice Profess Dietary Manager. During a telephone a.m., (RD)-D stated month and had been CDM. RD-D stated take the course and preceptor. RD-D stated take the course and previous administration conducted clinical vectors. During an interview when informed DM-	ge 10 This had potential to affect all esided in the facility. on 11/13/23 at 1:32 p.m., orked in the dietary manager s, stated he was not a mager (CDM) but had planned e. DM-C stated the facility D who came to the facility D who came to the facility beview, the title of DM-C's job riffied Dietary Manager, and uirement for the position ual must possess certification ation of Nutrition and esionals and be a Certified interview on 11/15/23 at 8:56 I she went to the facility once a she had encouraged DM-C to a had offered to be a sted her last conversation and a CDM had been with the lator. RD-D stated she solely risits at the facility per her on 11/15/23 at 2:28 p.m., -C had not been a qualified regulatory requirements and	2 980	DEFICIENCY)		
	per the facility dieta the administrator st acceptable since th dietician. The admin	ry manager job description, ated he thought that was e facility contracted with a nistrator was informed the d to be employed full-time at				

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:		` ′	X3) DATE SURVEY COMPLETED	
		00748	B. WING			5/ 2023	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
NEW RIC	HLAND CARE CENTI	ER	THEAST 1ST				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	HLAND, MN	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE	
2 980	Continued From pa	ge 11	2 980				
	the facility in that instance. The administrator stated he had not been aware of that.						
	Director/Certified Director/Certification through and Foodservice Prodietary manager, has a supervisor capacitor care facility or other training in cost control diet therapy. Knowled and procedures as guidelines governing long-term care facility signed by DM-C and procedures as guidelines governing long-term care facility of the procedures as guidelines governing long-term care facility of the procedures as guidelines governing long-term care facility of the procedures as guidelines governing long-term care facility of the procedures as guidelines governing long-term care facility of the procedures as guidelines governing long-term care facility of the procedures as guidelines governing long-term care facility of the procedures as guidelines governing long-term care facility of the procedures as guidelines governing long-term care facility of the procedures as guidelines governing long-term care facility of the procedures as guidelines governing long-term care facility of the procedures as guidelines governing long-term care facility of the procedures as guidelines governing long-term care facility of the procedures as guidelines governing long-term care facility of the procedures as guidelines governing long-term care facility of the procedures as guidelines governing long-term care facility of the procedures as guidelines governing long-term care facility of the procedures as guidelines governing long-term care facility of the procedures as guidelines governing long-term care facility of the procedures as guidelines governing long-term care facility of the procedures as guidelines governing long-term care facility of the procedures as guidelines governing long-term care facility of the procedures as guidelines governing long-term care facility of the procedures as guidelines governing long-term care facility of the procedures as guidelines governing long-term care facility of the procedures as guidelines governing long-term care facility of the procedures as guidelines governing long-term care facility of the						
	administrator or desident dietary manager had the position. The adprovide guidance to achieve proper quitime frame.	HOD OF CORRECTION: The signee could ensure the d the proper qualifications for dministrator or designee could the dietary manager in effort ualifications within a specified					
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one					
21134	MN RULE 4658.067 Sanitation, storage	70 Supb. 2. Dishwashing;	21134			12/22/23	
	must be thoroughly surfaces of utensils given sanitization tre	e. All utensils and equipment cleaned, and food-contact and equipment must be eatment and must be stored s to be protected from					

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	` ′	(X3) DATE SURVEY COMPLETED	
		00748	B. WING		11/1	5/2023	
	PROVIDER OR SUPPLIER	ER 312 NOR	DRESS, CITY, S THEAST 1S HLAND, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE	
21134	and utensils must be protects them from This MN Requirements: Based on observation review, the facility face were used or discar maintain freshness facility failed to more temperature in the Gregulatory requirements affect all 36 resident the kitchen. Findings include: During an observation at 1:32 p.m., with discard green olives remaining in the jar had a cloudy film or marker had been windicated). DM-C sopened - April 6, this refrigerator had been windicated). DM-C sopened - April 6, this refrigerator had been windicated been with approximately with approximately with approximately with approximately with a point of the would find out. DM-he would find out. DM-he would discard the During an interview DM-C stated he loo	aned and sanitized equipment be handled in a way that contamination. ent is not met as evidenced on, interview and document ailed to ensure condiments ded in a timely manager to and quality. In addition, the litor and ensure water 3-compartment sink met ents. This had the potential to ts who were served food from on and interview on 11/13/23 etary manager (DM)-C in the observed a one gallon jar of with approximately half. The upper portion of the jar in the inside. On the lid in black ritten 4/6 (the year was not tated that was the date is year. Also in the walk-in en a one gallon jar of pickle inately half left, with 2/22 ker on the lid. DM-C stated liary 22, this year, not February he did not know how long e stored after opening, but C removed both jars stating em. on 11/13/23 at 5:12 p.m., ked up how long olives and	21134	corrected			
	DM-C stated he loo pickle relish could b	• •					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE	E SURVEY PLETED
00748	B. WING			C 15/2023
NEW RICHLAND CARE CENTER	DDRESS, CITY, ST RTHEAST 1ST CHLAND, MN	STREET		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
the USDA (United States Department of Agriculture). DM-C acknowledged the pickle relish had been opened nine months ago and the olives had been opened seven months ago. During an observation and interview on 11/14/23 at 11:15 a.m., with DM-C, observed the 3-compartment sink. There had been water in all three sinks and large sheet pans standing on the end countertop drying. DM-C stated the 3-compartment sink was used daily for large pans. DM-C stated the temperature in sink 1 and sink 3 were not monitored; adding he did not know they needed to be. During a telephone interview on 11/15/23 at 8:56				
a.m., registered dietician (RD)-D stated she came to the facility once a month. RD-D did not conduct regulatory compliance audits in the kitchen, stating her contract had not included scheduled audits. RD-D stated she would have done them upon request but had not been asked. RD-D stated she solely conducted clinical visits at the facility.				
During an interview and observation on 11/15/23 at 9:28 a.m., in the kitchen with DM-C, he stated he was now aware water temperature in the 3-compartment sink needed to be monitored. DM-C pointed to a reference sheet posted above the sink he had received from the distributor regarding use of the 3-compartment sink including water temperature monitoring. During the interview, cook (C)-A joined the conversation and stated she had worked in the kitchen for six years and no one had told her the water needed to be at a certain temperature. During an interview on 11/15/23 at 2:28 p.m., the administrator had been informed water				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00748	B. WING		C 11/15/2023
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	11710720
NEW RIC	CHLAND CARE CENTI	ER	THEAST 1ST		
			HLAND, MN		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF CORRECTION SHOULD CROSS-REFERENCED TO THE APPROPERTION OF CORRECTION SHOULD SHO	D BE COMPLETE
21134	Continued From pa	ge 14	21134		
21134	temperature in the 3 been monitored per that DM-C had been monitored. In additional informed of condimination had been opened so when the USDA recommend the USDA recommend in the USDA recommend in the stated he thought Dof both of these find the stated he thought Dof both of these find the stated he thought Dof both of these find the stated he thought Dof both of these find the stated he thought Dof both of these find the stated he thought Dof both of these find the stated he thought to assure the stated he thought to assure the stated he thought to assure the stated he thought to the length of the stated he thought to the Qual Performance Improvements and the stated he thought to the Qual Performance Improvements in the stated he thought to the Qual Performance Improvements and the stated he thought to the Qual Performance Improvements and the stated he thought to the Qual Performance Improvements and the stated he thought to the Qual Performance Improvements and the stated he thought to the Qual Performance Improvements and the stated he thought to the Qual Performance Improvements and the stated he thought Dof the s	B-compartment sink had not regulation and facility policy; in unaware it needed to be on, the administrator was ents in the refrigerator that even and nine months ago commendations were no conths. The administrator M-C would have been aware lings. In Dishes - Manual dated 2017, indicated the ster temperature should be at theit (F). Change water effective cleaning of dishes. Water should be 75 to 100 In orage policy dated 2017, did gth of time condiments could refrigerator. In HOD OF CORRECTION: The or designee could develop by and procedure to ensure all acated, are following regulatory are monitoring dishmachine ents. Audits could be ecompliance and results			
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one			

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l `´	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00748	B. WING		11/1	5/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
NEW RIC	HLAND CARE CENT	ER	THEAST 1ST HLAND, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21390	Continued From pa	ge 15	21390			
21390	MN Rule 4658.0800	Subp. 4 A-I Infection Control	21390			12/22/23
	control program multiprocedures which per A. surveillance collection to identify residents; B. a system for control of outbreaks. C. isolation and reduce risk of trans. D. in-service exprevention and content and content and content and immunization prograte defined in part 465 procedures of resident the prevention and F. the development of the prevention and F. the development of the procedures, including defined in part 4658. G. a system for the products which affer disinfectants, antise incontinence product. In methods for recurrent standards of the products of	ealth program including an am, a tuberculosis program as 8.0810, and policies and ent care practices to assist in treatment of infections; ment and implementation of plicies and infection control a tuberculosis program as 8.0815; reviewing antibiotic use; review and evaluation of ect infection control, such as eptics, gloves, and				
	review, the facility	on, interview and document ailed to follow Centers for caid Services (CMS) and e Control (CDC) guidelines to of Covid-19 when during a failed to ensure appropriate		corrected		

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	COMPI	
		00748	B. WING		C 11/1	; 5/2023
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	ATE, ZIP CODE		
NEW RIC	CHLAND CARE CENT	ER	THEAST 1ST S			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21390	Continued From pa	ge 16	21390			
	use of personal prostaff were observed wearing appropriate residents (R1, R6, Rin transmission base Covid-19; failed to residents in TBP for R27, R28, R87) on residents on TBP has room for 2 of 2 residents on TBP has room for 2 of 2 residents (R6, R9, Railed to ensure residents (R6, R9, Railed to ensure residents (R6, R8, Railed to ensure residents (R9) reviews floor during random resident, (R9) reviews Finding include: During an observation when entering the foor the door indicating During the entrance nursing (DON) states residents in TBP for identified on the certain the following th	tective equipment (PPE) when I not wearing PPE or not PPE, in rooms of 8 of 8 R9, R21, R25, R27, R28, R87) ed precautions (TBP) for remove masks after caring for 5 of 5 residents (R6, R21, TBP; failed to ensure ad a PPE cart outside of their dents (R8, R25); failed to ad antimicrobial's such as disinfectant wipes readily e rooms of residents for 7 of 7 R10, R11, R21, R26, R28); idents in TBP for Covid-19 r the required duration for 1 of n TBP; and failed to maintain idents in TBP for 4 of 4 R25, R28) on TBP. This had ct all 36 residents who resided dition, failed to ensure atheter bag remained off the n observations for 1 of 1 wed for urinary catheters. Son on 11/13/23 at 10:45 a.m., acility, there had been a signing masks were required. The conference, the director of ed there were 10 of 36 recovid-19 and they would be nearly sheet. Seport dated 11/13/23, fing 10 residents were in TBP 8, R9, R10, R11, R21, R25, R25, R25, R26, R21, R21, R25, R25, R25, R26, R21, R21, R21, R25, R25, R26, R31, R31, R31, R31, R31, R325, R31, R31, R31, R31, R321, R35, R31, R31, R31, R31, R31, R31, R325, R31, R31, R31, R31, R31, R325, R31, R31, R31, R31, R31, R31, R31, R31				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		00748	B. WING		11/1	5/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
NEW RIC	CHLAND CARE CENT	ER	THEAST 1ST HLAND, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPERTION (PROVIDER OF CORRECTION)	D BE	(X5) COMPLETE DATE
21390	at 2:51 p.m., on the where some resided based upon droplet doors and/or PPE of these two findings was rooms that had sign outside the room. Find have hand sanitizer immediately available small paper bags limited near rooms of reside contained N95 mass of the small plastic available to staff to boxes had been on other surface on which disinfectant wipes, medications or mean before entering the set eye protection in wipe to clean them room 101, R28 in reall observed to be in indicating droplet/or directed staff to keen were wide open. In PPE cart outside Rand During an interview nursing assistant (Nowas in TBP, their do prevent the spread some residents did they asked her to keen they are th	on and interview on 11/13/23 100 wing, observed rooms ints appeared to be in TBP //contact precautions signs on earts outside of room. However were not consistent - not all is on the door, had a PPE cart urther, these rooms did not or disinfectant wipes ble for staff. Observed multiple ning the railing in the corridor ents in TBP; the bags ks and eye protection. The top PPE cart was the only surface set things down and glove top of it. There had been no nich to put hand sanitizer, or for staff to set things (e.g., all tray) as they donned PPE room, and no place for staff to n order to obtain a disinfectant after exiting a room. R10 in bom 114, and R8 in 108 were on TBP with signs on the door ontact precautions. The signs on the door closed. The doors addition, there had been no 8's room. on 11/13/23 at 3:08 p.m., IA)-D stated when a resident oor needed to be closed to of Covid-19. NA-D stated not like their door closed so if eep it open, she complied. d the door should be closed do what the resident asked.	21390			
		aware if anyone had educated ason their door should be kept				

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	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE	SURVEY PLETED
		00748	B. WING		I	C 1 5/2023
	PROVIDER OR SUPPLIER	ER 312 NOR	DRESS, CITY, STATE THEAST 1ST			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETE DATE
21390	Continued From pa	ge 18	21390			
	R26's door was closed door indicated special precautions with insequence protection, face gloves. There were sanitizer, or trash retained the room.	ion on 11/13/23 at 3:13 p.m., sed and a sign posted on the sial droplet /contact structions to wear face mask, shield or goggles, gown and no disinfectant wipes, hand eceptacle located outside of sign on 11/13/23 at 3:15 p.m., an and a sign was posted on				
	the door indicating a precautions with insequence protection, face gloves. NA-E stated room 205: R25 and isolation but off preceither. NA-E further 205 could not leave NA-E stated a sign the residents were isolation. NA-E state wear PPE when the only required to we and registered nurs with only a regular for No PPE cart with sign of R25's room. NA-not sure why the sign of sure why the sure why the sign of sure why the sur	special droplet /contact structions to wear face mask, e shield or goggles, gown and d there were two resident's in R2. NA-E stated R25 was on cautions, and R2 was not on stated the residents in room their rooms due to isolation, at the nurses station indicated off precautions, and still on ed staff were not required to ey entered R25's room and ar a regular face mask. NA-E are (RN)-A entered room R25's face mask and no other PPE. applies was observed outside E and RN-A stated they were gns were still posted on R25's ecautions and required PPE.				
	at 3:19 p.m., license who was also the inwas her first day bar after having tested Together with LPN-observe the rooms	and observation on 11/13/23 ed practical nurse (LPN)-A fection preventionist, stated it ick to work after seven days, positive for Covid-19. A, walked the 100 wing with to of residents in TBP. R10 had tested positive for				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE	SURVEY LETED
		00748	B. WING		11/1	; 5/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
NEW RIC	CHLAND CARE CENT	ER	THEAST 1ST HLAND, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21390	been wide open. LF and that was why thR87 in room 106. positive for Covid-1 remained in TBP un no PPE cart outside droplet/contact pred LPN-A stated R87 in too early, but did no whyR28 and R6 in roo positive for Covid-1 respectively, and bo 11/20/23. The doorR8 in room 108. L positive for Covid-1 remain in TBP until wide open. In addition to makin regarding residents of concerns regardi disinfectant wipes a outside resident roo stated the findings is she had not yet had provide staff re-train expected the DON to have taken over monitor staff compl guidelines for Covid During an interview LPN-A stated the fa residents remained precautions for ten test and stated staff required PPE when	Ing of 11/13/23. His door had PN-A stated he was a fall risk he door was open. LPN-A stated R87 had tested 9 on 11/5/23, and should have hil 11/15/23. There has been ethe room and no cautions signs on the door. In had been removed from TBP of know who removed her or om 114. Both had tested 9 on 11/10/23 and 11/6/23, but were to be in TBP until had been wide open. PN-A stated R8 had tested 9 on 11/5/23 and had was to 11/15/23. The door had been hig observations of her own in TBP, LPN-A was informed and the lack of hand sanitizer, and work surface for staff oms who were in TBP. LPN-A had taken her by surprise and it time to make corrections or ning. LPN-A stated she had and registered nurse (RN)-B her duties in her absence and itance for adherence to CDC	21390			

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NAME OF PROVIDER OR SUPPLIER O0748 B. WING		NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY. STATE. ZIP CODE			00748	B. WING		1	
NEW RICHLAND CARE CENTER 312 NORTHEAST 1ST STREET NEW RICHLAND, MN 56072			TER 312 NOR	THEAST 1ST	STREET		
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CON	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	LD BE	(X5) COMPLETE DATE
included N95 mask, faceshield or eye protection, gloves, and a gown. LPN-A stated staff were expected to remove the N95 mask when they exited the room, and not wear it throughout the facility. During an interview on 11/13/23 at 3:31 p.m., RN-A stated R25 was in TBP and further explained R25 was past the ten days after she tested positive for COVID, so therefore was off precautions. RN-A stated on sign in the nursing station indicated R25 was off precautions but still on isolation. RN-A stated staff were allowed to enter R25's room with only a regular mask, and staff were not required to wear a N95, gown, gloves or eye protection. RN-A stated she wore a N95 mask and did not remove it from room to room and confirmed she wore the same N95 mask in an isolation room, and did not remove the N95 mask and would enter another resident room with the same N95 mask. RN-A stated she was not aware or provided education the N95 mask had to be changed when she exited a resident room who was in isolation. During an interview on 11/13/23 at 3:34 p.m., LPN-A confirmed R25 was on TBP and expected a PPE cart to be located outside of R25's room that included gown, gloves, eye protection and N95 masks. During an interview on 11/13/23 at 3:49 p.m., LPN-A provided a list of 10 residents who had tested positive of Covid-19 starting on 11/4/23. The list included dates tested positive, and start and end dates for TBP. Three additional residents had tested positive on 11/13/23 at 4:42 p.m., the DON and LPN-A were together informed of		included N95 mask gloves, and a gown expected to remove exited the room, and facility. During an interview RN-A stated R25 we explained R25 was tested positive for Continuous precautions. RN-A station indicated R25 on isolation. RN-A enter R25's room we staff were not required gloves or eye protein N95 mask and did room and confirme mask in an isolation the N95 mask and room with the same was not aware or period mask had to be chartered and to be chartered and included gown N95 masks. During an interview LPN-A confirmed Fare a PPE cart to be loothat included gown N95 masks. During an interview LPN-A provided a little tested positive for Confirmed Fare and end dates for The list included date and end dates for The list included dates for Th	k, faceshield or eye protection, n. LPN-A stated staff were e the N95 mask when they nd not wear it throughout the on 11/13/23 at 3:31 p.m., was in TBP and further a past the ten days after she COVID, so therefore was off stated on sign in the nursing 25 was off precautions but still stated staff were allowed to with only a regular mask, and ired to wear a N95, gown, ection. RN-A stated she wore a not remove it from room to ed she wore the same N95 in room, and did not remove would enter another resident e N95 mask. RN-A stated she provided education the N95 anged when she exited a was in isolation. If on 11/13/23 at 3:34 p.m., R25 was on TBP and expected exated outside of R25's room and on 11/13/23 at 3:49 p.m., list of 10 residents who had Covid-19 starting on 11/4/23. At the stated positive, and start TBP. Three additional residents on 11/13/23.				

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	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		COMPLETED	
		00748	B. WING		11/1	; 5/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
NEW RI	NEW RICHLAND CARE CENTER NEW RICH			T STREET 56072		
(X4) ID PREFIX TAG	PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION DEFICIENCY)	D BE	(X5) COMPLETE DATE
21390	Continued From pa	ge 21	21390			
	RN-B had been rescompliance for adher for Covid-19. The Days sure residents had monitored employed precautions, but adobservations made DON did not know been removed from asked why some reprecautions and why the sanitizer or disinfect to staff as they enteresidents in TBP, the down the hall or acreat, hand sanitizer DON acknowledged	The DON admitted she and ponsible for monitoring staff erence to the CDC guidelines OON stated they had made been tested for Covid-19 and e activity related to Covid PPE mitted they did not notice the by the surveyors. Further, the how or why R87 and R8 had a TBP two days early. When sidents in TBP did not have a heir had been no hand twipes immediately available ered and exited rooms of he DON stated staff could walk ross the hall to access a PPE r, and disinfect wipes. The d that to ensure compliance autions, supplies needed to be ble for staff.				
	to 5:18 p.m., observing a yellow PPE governance, eye protection into multiple resider without changing Platray into the room of NA-C exited the room without performing R21's room who was the room, she chan performing hand hy R87's room who was the room, she chan performing hand hy cart down the hall to both in TBP. When removed her gown	ion on 11/13/23 from 5:14 p.m. ved (NA)-C who was donned wn, N95 mask over a regular on and gloves, take a meal tray at rooms who were in TBP PE. At 5:14 p.m., NA-C took a of R27 who was in TBP. When om, she changed her gloves hand hygiene, then went into as in TBP. When NA-C exited ged her gloves without giene, then took a tray into as in TBP. When NA-C exited ged her gloves without giene, then moved the tray of R6/R28's room who were a NA-C exited the room, she and gloves and performed C did not remove or change				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		` ′	(X3) DATE SURVEY COMPLETED	
		00748	B. WING			C 15/2023
NEW RICHLAND CARE CENTER			DRESS, CITY, ST THEAST 1ST HLAND, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
21390	DON who was in the expectations of state residents in TBP are the same PPE from stated she expected new PPE between precautions as noted residents doors. The observations of NAC During an interview NA-C was asked we about donning and residents in TBP. Note that whe residents in TBP. Note that way and did it too. NA-C ack change PPE and claroom in order to preto other residents. During an interview DON stated staff we shield or eye protect after exiting a resident to other residents. During an interview DON stated staff we shield or eye protect after exiting a resident of the preton of the pool of	on 11/13/23 at 5:25 p.m., the e 100 wing was asked her if delivering meal trays to ad if it was acceptable to wear room to room. The DON d staff to doff PPE and don rooms and to adhere to the ed on the precaution signs on e DON was then informed of C. on 11/13/23 at 5:27 p.m., hat she recalled from training doffing to go into rooms of IA-C was able to articulate the uding performing hand hygiene her gloves, and admitted she in delivering meal trays to IA-C stated she had always dit was they way other staff throwledged it was important to ean hands when exiting a event the spread of Covid-19 on 11/13/23 at 5:35 p.m., the ere required to wash their face of the complex of t	21390			

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		(X3) DATE SURVEY COMPLETED	
00748 B. WING		C 11/15/2023	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STA 312 NORTHEAST 1ST S NEW RICHLAND, MN 56	STREET		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETE	
at the 200 wing nurses station was observed. It had a hand-written note that indicated rooms 201, 205, 212 were "off precautions but sill on isolation." The DON and LPN-A stated they did not know what that meant, or who wrote the note, but that information was incorrect. LPN-A confirmed R26, R25, R9 were still in TBP. During an observation on 11/14/23 at 11:22 a.m., NA-A entered R9's room, who was on TBP for Covid-19. NA-A had donned gloves, gown, eye protection, a regular mask rather than a required N-95 mask. NA-A confirmed a N95 mask was required when going into R9's room but she forgot. NA-A further stated her routine practice was to put the N95 over her regular mask and remove the N95 mask when she exited the room. NA-A stated she did not remove the regular mask and continued to wear that mask into other resident rooms. During an interview on 11/14/23 at 11:24 a.m., LPN-A stated stated both the regular mask and N95 mask should be removed when staff exited a residents room who was in TBP, and neither mask should not be worn into another residents room. During an observation and interview on 11/14/23 at 1:40 p.m., observed housekeeper (H)-A come out of R87's room who was in TBP. H-A was observed with a plain mask on, not an N95. H-A stated she removed the PPE gown and gloves inside the room. H-A admitted she did not wear an N95 masks when she cleaned the rooms of residents in TBP; adding she changed the plain mask between rooms. H-A stated she knew staff should wear an N95 when in rooms of residents in TBP, but the masks were uncomfortable for her. At 1:51 p.m., observed H-A enter R21's room			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
			A. BUILDING:		C	
		00748	B. WING			5/2023
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
NEW RI	NEW RICHLAND CARE CENTER NEW RICH			ΓSTREET 56072		
(X4) ID PREFIX TAG	PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21390	Continued From pa	ge 24	21390			
	with PPE gown and	gloves on and a plain mask.				
	administrator was in breaches in TBP prostated LPN-A had some removed for Covid1 informed that basic would always be instatus. The administration that in the absence RN-B would have encovid-19 precaution. The facility Infection Program policy date would establish and Prevention and Corprevent, identify, invite onset and spread whenever possible,	on 11/15/23 at 8:48 a.m., the aformed of findings related to ecautions. The administrator tated that guidelines had been 9. The administrator was infection control practices place, regardless of Covid-19 strator stated he had expected of LPN-A, the DON and insured the facility adhered to as and TBP requirements. In Prevention and Control and 8/2023, indicated the facility I maintain an Infection introl Program (IPCP) to restigate, report and control and of communicable disease, among residents, staff and is are based on national				
	9/2023, indicated we the DON or Infection PPE (i.e. gloves, go near the residents rentering the room of Place necessary entering the room that will be near that will be near that will be near that and soap and paper town during the isolation resident (or representations).					

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	 ` ′	E CONSTRUCTION	COMPLETED
00748	B. WING		C 11/15/2023
NEW RICHLAND CARE CENTER	ADDRESS, CITY, ST DRTHEAST 1ST CICHLAND, MN	STREET	
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE COMPLETE
21390 Continued From page 25 8/2023, indicated residents would remain on appropriate precautions until the attending physician or the DON or infection preventionist orders them discontinued The DON or infection preventionist had the authority to order and discontinue Isolation precautions when necessary. The facility PPE - Gowns policy dated 8/2023, indicated use gowns only once and then discardinto an appropriate receptacle directly before leaving the room. Catheter or UTI R9's admission Minimum Data Set (MDS) assessment dated 9/14/23, indicated R9 had intact cognition, no rejection of care, required or person physical assist with bed mobility, transfe walk in room and corridor, locomotion on and of unit, dressing, toilet use, and personal hygiene, utilized a walker and wheelchair, diagnoses chronic respiratory failure, muscle weakness, and heart failure. R9's care plan dated 9/11/23, indicated continer of bladder/bowel and require some assistance from staff for toileting or peri cares, Foley catheter, chronic kidney disease stage 3, hypertensive heart and chronic kidney disease and interventions included any changed observe in urine output amount, frequency, color or odor are to be reported to nurse, continence: 16 F Foley catheter. On 11/13/23 at 5:58 p.m., R9 was lying in her be and a urinary catheter tubing was on her bed and the tubing and the urinary catheter bag laid on the floor next to R9's bed. R9 stated staff emptied the staff	ne r, ef ad he		

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		00748	B. WING		11/1	; 5/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
NEW RIC	CHLAND CARE CENTI	ER	THEAST 1ST HLAND, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION DEFICIENCY)	D BE	(X5) COMPLETE DATE
21390	Continued From pa	ge 26	21390			
	the day.					
		8 a.m., R9 was observed er with a urinary catheter bag her recliner.				
	(NA)-A stated R9 was by herself and the a (RN)-A. R9 was obsconfirmed the urina floor. NA-A was obscand remove the cat	9 a.m., nursing assistant as transferred to the recliner assist of registered nurse served with NA-A and ry catheter bag was on the served to go into R9's room heter bag from the floor and le of R9's recliner chair.				
	NA at the facility) standard not have contact with when she transfers	6 a.m. RN-A (who works as a ated R9's catheter bag should the floor, and RN-A stated R9 she hooked the catheter in the recliner chair or to R9's				
		a.m., R9 was observed her urinary catheter bag was her bed.				
	licensed practical noting infection prevention catheter bags should	a.m., during an interview urse (LPN)-A who was the ist at the facility stated ld be positioned in a way to e floor for infection prevention				
	offered R9 morning stated the catheter was not aware the oNA-B stated the over	a.m., NA-B stated she cares, and R9 refused. NA-B was expected off the floor and catheter bag was on the floor. Ernight NA would have been emptied the catheter.				

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l `´´	E CONSTRUCTION	COMPLETED		
	00748		B. WING		11/1	5/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	-	
NEW RIC	HLAND CARE CENTE	ER	THEAST 1ST HLAND, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION (INCOMPAGE OF THE APPROPERT	D BE	(X5) COMPLETE DATE
21390	Continued From page	ge 27	21390			
	On 11/15/23 at 9:57 director of nursing (a.m., during an interview the DON) stated stated urinary dubbe off floor due to the risk				
	11/3/23, indicated: check frequently to loops in the tubing a	Catheter Care policy dated Catheter Tubing and Bag; be sure there are no kinks or and that the resident is not Keep bag off floor, hang on				
	DON (director of nure-educate staff on practices for transmore (TBP) to ensure procequipment (PPE), a immediate access to antimicrobials in order transmission. In additional could re-educate staff practices for care or or designee could pressure staff adhere audits could be take and Performance In	der to mitigate COVID-19 dition, the DON or designee aff on proper infection control f urinary catheter. The DON perform periodic audits to nce and results of those en to the Quality Assurance				
	Time Period for Cordays.	rection: Twenty-one (21)				
21426	MN St. Statute 144/ Prevention And Cor	A.04 Subd. 3 Tuberculosis ntrol	21426			12/22/23
	maintain a compreh	provider must establish and nensive tuberculosis ogram according to the most				

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
		00748	B. WING		C 11/15 /2	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
NEW RIC	CHLAND CARE CENTI	ER	THEAST 1ST HLAND, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPOLICITION (CORRECTION CORRECTION CORRECTI	D BE	(X5) COMPLETE DATE
21426	issued by the United Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control plaunpaid employees, residents, and volume Health shall provide regarding implements.	s infection control guidelines of States Centers for Disease tion (CDC), Division of ation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis in that covers all paid and contractors, students, inteers. The Department of a technical assistance intation of the guidelines.	21426			
	Based on interview facility failed to compassessment. This has residents residing in Findings include: The facility lacked a when asked not one lateral facility infection she had not complete lateral facility infection sh	and document review, the plete an TB (tuberculosis) risk ad the potential to affect all 36 in the facility, staff and visitors. I current TB risk assessment, was provided. The ment review on 11/15/2023 at ensed practical nurse (LPN)-A preventionist (IP) confirmed eted a TB risk assessment. 2023 at 3:49 p.m., with DON) stated her expectations callity to complete an annual TB		corrected		

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NAME OF PROVIDER OR SUPPLIER NEW RICHLAND CARE CENTER SIMMARY STATEMENT OF DEPOSITIONS NEW RICHLAND, MN 56072 PRESIDENCY WINST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRESIDENCY OF A CONTROL OF TAKEN OR SUBJECT OF THE STATE O	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SUI		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 312 NORTHEAST 1ST STREET NEW RICHLAND CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 21426 Continued From page 29 risk assessment as indicated per facility policy. Review of August 2023, Tuberculosis Risk Assessment Policy identified TB risk assessment would be monitored annually for current data and to facilitate protocols for screening TB in the facility through CDC website to evaluate the risk of TB prevalence in the community, state, and country. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and/or revise the current TB policies and procedures to ensure the TB risk assessment is reviewed and updated periodically. The DON or designee could perform periodic audits to ensure staff adherence to policies and procedures, and audits could be taken to the Quality Assurance and Performance Improvement (QAPI) committee to determine compliance and need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one				A. BUILDING:			
NEW RICHLAND CARE CENTER 312 NORTHEAST 1ST STREET NEW RICHLAND, MN 56072 X40 ID SUMMARY STATEMENT OF DEFICIENCIES CROCK DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY TAG CROSS-REFERENCED TO THE APPROPRIATE DATE 21426 Continued From page 29 risk assessment as indicated per facility policy. Review of August 2023, Tuberculosis Risk Assessment Policy identified TB risk assessment would be monitored annually for current data and to facilitate protocols for screening TB in the facility through CDC website to evaluate the risk of TB prevalence in the community, state, and country. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and/or revise the current TB policies and procedures to ensure the TB risk assessment is reviewed and updated periodically. The DON or designee could perform periodic audits to ensure staff adherence to policies and procedures, and audits could be taken to the Quality Assurance and Performance Improvement (QAPI) committee to determine compliance and need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one			00748	B. WING			2023
NEW RICHLAND, MN 56072 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES CACH DEFICIENCY MUST BE PRECEDED BY PULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 21426 Continued From page 29 risk assessment as indicated per facility policy. Review of August 2023, Tuberculosis Risk Assessment Policy identified TB risk assessment would be monitored annually for current data and to facility through CDC website to evaluate the risk of TB prevalence in the community, state, and country. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and/or revise the current TB policies and procedures to ensure the TB risk assessment is reviewed and updated periodically. The DON or designee could perform periodic audits to ensure staff adherence to policies and procedures, and audits could be taken to the Quality Assurance and Performance Improvement (QAPI) committee to determine compliance and need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one	NEW RIC	HLAND CARE CENT	ER				
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	21426	risk assessment as Review of August 2 Assessment Policy would be monitored to facilitate protocol facility through CDC of TB prevalence in country. SUGGESTED MET director of nursing (review and/or revise procedures to ensure reviewed and updat designee could per staff adherence to paudits could be take and Performance In committee to detern further monitoring.	indicated per facility policy. 023, Tuberculosis Risk identified TB risk assessment annually for current data and is for screening TB in the website to evaluate the risk the community, state, and THOD OF CORRECTION: The (DON) or designee could the current TB policies and re the TB risk assessment is ted periodically. The DON or form periodic audits to ensure policies and procedures, and the quality Assurance improvement (QAPI) mine compliance and need for	21426	DEFICIENCY		