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.

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

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

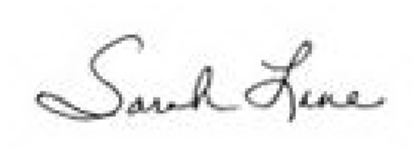
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245316	A. BUILDING _____ B. WING _____	C 11/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 11/13/23-11/15/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 11/13/23-11/15/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H53167182C (MN00092891) and H53167203C (MN00090020). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 688	Increase/Prevent Decrease in ROM/Mobility	F 688		12/22/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (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.

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F 688 SS=D	Continued From page 1 CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure restorative services to maintain and/or improve mobility was received for 1 of 2 residents (R27) reviewed for mobility. Findings include: R27's quarterly Minimum Data Set (MDS) assessment dated 9/19/23, indicated R27 had intact cognition, no rejection of care, required one person physical assist with bed mobility, transfer, walking in room and corridor, locomotion on and off unit, dressing, toilet use, and personal hygiene, utilized a walker and wheelchair, diagnoses included fractured femur, dementia, and edema.	F 688	F688 (Restorative Ambulation Program) R27□s ambulation program was reviewed by the IDT. Staff caring for R27 were re-educated on his ambulation program, by 12/07/2023 All other residents with ambulation programs have the potential to be affected and were reviewed by the IDT. Nsg staff were re-educated on all other resident□s ambulation programs, by 12/22/2023. All staff not able to attend the facility training will sign off that they received/reviewed the training, prior to working on the floor. The Walking program policy was reviewed and revised to read: during care	

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F 688	Continued From page 2 R27's care plan dated 6/30/23, indicated R27 required staff assistance with some ADL's (activities of daily living) d/t (due/to) compression fx (fracture) L (lumbar) 1, L2, L4, and weakness; interventions included: ambulation assist, extensive staff assistance: of one, wbat (weight bearing as tolerated) device used: fww and gait belt, notes: another staff to follow behind with wheelchair, walk 75-100 ft, on the daily CNA (certified nursing assistant) restorative walking program to maintain current level of mobility, often refuse to walk, encourage to attend fitness fun and complete exercise handout in my room, walking program, walk with FWW (front wheeled walker) and one assist with another staff to follow behind with wheelchair, walk 75-100 ft twice daily. R27's record review identified document titled Documentation Survey Report dated 11/23, indicated a staff task every day and p.m. shift: walking program: cna/restorative staff to assist resident with walking twice daily, use fww and one assist with another staff to follow behind with wheelchair, walk 75-100 ft. R27's EMR (electronic medical record) documentation with staff initials and time indicated R27 refused on 11/8/23 evening shift, and 11/11/23 evening ... the other 25 opportunities for documentation were charted as R27 not available or not applicable. R27's document PT/OT/ST recommendations to nursing dated 4/21/23, indicated R27 was recommended ambulate with FWW and assist x 1 (75-100 ft) and another to follow behind with wheelchair, 2x daily. Document titled walking list 200 hall indicated R27 two assist with walker.	F 688	conference (and PRN with change in status), the IDT will review the resident□s progress, and revise the resident□s goal PRN for the next Quarter. DON/designee will conduct random audits of the resident□s ambulation programs 2-3 X week for 4 weeks, then 1-2 X week for 4 weeks, and monthly for 3 months. Audit results will be brought to the QAPI committee for review and further recommendations. The DON will be responsible for ensuring this is completed.	

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F 688	Continued From page 3 Nursing meeting minutes dated 11/9/23, indicated walking lists: need to continue walking resident even with COVID if they are not positive, they may walk in hall with mask, if positive may walk in room, also can guide agency staff in completing this while they are working in our facility, staff signatures indicated education was received on 11/9/23. On 11/13/23 at 2:52 p.m., R27 was observed seated in a wheelchair in his room and stated he was supposed to walk the hallway daily and hadn't walked for about three or four days, and stated staff were not walking him because there was a sickness in the facility. R27 walker was against the wall in his room and R27 stated he had not used the walker for a few days. On 11/14/23 at 12:44 p.m., R27 was seated a wheelchair in his room and stated staff had not offered to walk him or do exercise, and R27 stated my legs need the excise to stay strong. On 11/14/23 at 12:45 p.m., trained medication aide (TMA)-A stated residents have not walked much with COVID at the facility and was not aware when R27 last walked as she had not worked for a week. TMA-A stated prior to the facility in a COVID outbreak R27 was expected to walk with staff. On 11/14/23 at 12:52 p.m., nursing assistant (NA)-A stated the facility was currently not walking residents on the walking program because of the facility COVID outbreak, and confirmed R27 was on the walking program. On 11/14/23 at 12:52 p.m., registered nurse	F 688		

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F 688	Continued From page 4 (RN)-A stated she was a RN however worked at the facility as a NA. RN-A stated R27 was on the walking program and prior to the facility in a COVID outbreak staff were expected to walk R27. RN-A further stated residents are not walked currently due to COVID in the building, and stated R27's room did not enough room to walk him and he utilized the wheelchair to get around in his room. On 11/14/23 at 1:00 p.m., during an interview with the director of nursing (DON) and RN-B who was the case manager at the facility, stated residents on walking program were expected to walk in either the hallway with mask or in their room. The DON and RN-B confirmed R27 was on walking program and was expected to walk with staff twice a day. The DON further stated she held a nursing meeting last week and staff were educated residents were expected to walk with a mask on in the hallways. R27's walking program EMR documentation was reviewed with the DON and RN-B and confirmed R27 was not walked as expected. On 11/15/23 at 2:50 p.m., during an interview the administrator stated he was aware of concerns with the walking program and staff not walking residents as expected. The administrator stated during the summer staff seemed to be doing a better job at ensuring the residents were walked and stated he was aware that it was a concern and fell of his radar. The facility Walking Program policy dated 10/23, indicated: Policy: Ambulate with a resident utilizing 1-2 assist with/without a device to facilitate the	F 688		

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F 688	Continued From page 5 resident reaching and maintaining his/her highest level of physical and mental ability. Refer to plan of care for individualized treatment plan. Objective: 1. To promote each resident's physical and mental well-being. 2. To provide a walking program in addition to that established in the formal PT program. 3. Do you have an ongoing device to measure resident status and reaching goals set in the plan of care? 4. To minimize the negative effects of immobility Procedure: 1. The interdisciplinary team will set goals for each resident to achieve the highest level of mobility. 2. The PTA, under the direction. Of the care plan team will begin a walking program. 3. The CNAS on the assigned hall will be responsible for providing the assist to the identified resident. 4. After walking is completed, CNA will mark in the appropriate dated square the distance walked in their initials. 5. At the end of the month, the PTA will summarize the month's progress and carry this information onto the next month.	F 688		
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity	F 801		12/22/23

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F 801	Continued From page 6 and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not	F 801		

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F 801	Continued From page 7 employed full-time, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure that in the absence of a full-time registered dietician (RD), the dietary manager (DM) was certified to oversee nutrition and food services. This had potential to affect all	F 801	F801 (Qualified Dietary staff) The facility will put out an advertisement for a full-time Certified Dietary Manager or RD. (DM)-C is enrolled in a course (120 hrs)	

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F 801	Continued From page 8 36 residents who resided in the facility. Findings include: During an interview on 11/13/23 at 1:32 p.m., (DM)-C, who had worked in the dietary manager position for six years, stated he was not a certified dietary manager (CDM) but had planned on taking the course. DM-C stated the facility contracted with a RD who came to the facility once per month. During document review, the title of DM-C's job description was Certified Dietary Manager, and the educational requirement for the position indicated an individual must possess certification through the Association of Nutrition and Foodservice Professionals and be a Certified Dietary Manager. During a telephone interview on 11/15/23 at 8:56 a.m., (RD)-D stated she went to the facility once a month and had been aware DM-C had not been a CDM. RD-D stated she had encouraged DM-C to take the course and had offered to be a preceptor. RD-D stated her last conversation about DM-C not being a CDM had been with the previous administrator. RD-D stated she solely conducted clinical visits at the facility per her contract. During an interview on 11/15/23 at 2:28 p.m., when informed DM-C had not been a qualified dietary manager per regulatory requirements and per the facility dietary manager job description, the administrator stated he thought that was acceptable since the facility contracted with a dietician. The administrator was informed the dietician would need to be employed full-time at	F 801	through UND on 11/27/2023. Once coursework is complete, DM-C will take the CDM test. Administrator/designee will receive (DM)-C course progress report/completion monthly and certification once the test is complete with 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, then 1X week X 4 weeks to ensure Nutritional Assessments are reviewed and signed off 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.	

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F 801	Continued From page 9 the facility in that instance. The administrator stated he had not been aware of that. The facility Job Description for Culinary Director/Certified Dietary Manager (CDM) indicated the culinary director must possess certification through the Association of Nutrition and Foodservice Professionals and be a certified dietary manager, have a minimum of two years in a supervisor capacity in a hospital, skilled nursing care facility or other related medical facility, have training in cost control, food management and diet therapy. Knowledgeable of dietary practices and procedures as well as laws, regulations and guidelines governing dietary functions in the long-term care facility. The job description was signed by DM-C and dated 10/6/17.	F 801		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional	F 812		12/22/23

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F 812	Continued From page 10 standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure condiments were used or discarded in a timely manager to maintain freshness and quality. In addition, the facility failed to monitor and ensure water temperature in the 3-compartment sink met regulatory requirements. This had the potential to affect all 36 residents who were served food from the kitchen. Findings include: During an observation and interview on 11/13/23 at 1:32 p.m., with dietary manager (DM)-C in the walk-in refrigerator, observed a one gallon jar of sliced green olives with approximately half remaining in the jar. The upper portion of the jar had a cloudy film on the inside. On the lid in black marker had been written 4/6 (the year was not indicated). DM-C stated that was the date opened - April 6, this year. Also in the walk-in refrigerator had been a one gallon jar of pickle relish with approximately half left, with 2/22 written in black marker on the lid. DM-C stated that date was February 22, this year, not February 2022. DM-C stated he did not know how long condiments could be stored after opening, but would find out. DM-C removed both jars stating he would discard them. During an interview on 11/13/23 at 5:12 p.m., DM-C stated he looked up how long olives and pickle relish could be stored in the refrigerator after opening and stated it was three months per the USDA (United States Department of Agriculture). DM-C acknowledged the pickle	F 812	F812 (Food sanitation) Condiments in question, pickle relish and sliced olives, were discarded immediately. DM-C/designee will conduct audit of open condiments weekly x 4 weeks and monthly thereafter to ensure condiments are dated and within recommended storage dates. Audits will be sent to QAPI Committee for review and further recommendations. DM-C will educate Dietary Staff on the shelf life of condiments by 12/15/2023. Thermometers have been installed to consistently monitor the temperature of the water in the three compartment sink. DM-C will educate staff on the minimum temperatures allowed for the three compartment sink for the washing side with a minimum temperature of 110 degrees and the sanitizing side with a minimum temperature of 75 degrees by 12/15/2023. Water temperature will be checked in the 3 compartment sink daily to ensure wash temperature is at 110 degrees F in the 1st sink, and in the 3rd sink the water temperature for sanitizing should be at 75-100 degrees. These temperatures will be checked on daily. Temperature results will be brought to the QAPI Committee for review and further recommendations. The Administrator will be responsible for ensuring this is completed.	

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F 812	Continued From page 11	F 812		

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 temperature in the 3-compartment sink had not

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F 812	Continued From page 12 been monitored per regulation and facility policy; that DM-C had been unaware it needed to be monitored. In addition, the administrator was informed of condiments in the refrigerator that had been opened seven and nine months ago when the USDA recommendations were no longer than three months. The administrator stated he thought DM-C would have been aware of both of these findings. The facility Cleaning Dishes - Manual Dishwashing policy dated 2017, indicated the following: --Sink 1: Wash. Water temperature should be at 110 degrees Fahrenheit (F). Change water frequently to assure effective cleaning of dishes. --Sink 3: Sanitize. Water should be 75 to 100 degrees F. The facility Food Storage policy dated 2017, did not address the length of time condiments could remain open in the refrigerator.	F 812		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such	F 867		12/22/23

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F 867	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 systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems	F 867		

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F 867	Continued From page 14 impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs	F 867		

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F 867	Continued From page 15 (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to have evidence of a Performance Improvement Project (PIP) which focused on high risk or problem-prone areas, identified thorough and appropriate data collection, analysis and evaluation of the identified concern(s) during Quality Assurance and Performance Improvement (QAPI). This had the potential to affect all 36 residents. Findings include: On 11/15/23 at 2:50 p.m., during an interview the facility administrator stated the facility QAA (Quality Assessment and Assurance) and QAPI group met on a regular basis with the Medical Director to review areas identified as needing improvement within the facility. The administrator stated he could not recall the facility PIP project.	F 867	F867 (QAPI/QAA Improvement Activities) The facility QAPI team will meet on 12/12/2023 to analyze and identify a performance improvement project (PIP) to work on.. A PIP will be chosen from areas that could improve quality of care and/or quality of life for our residents, the Quality Indicators, Quality Measures, and/or Survey results will be the areas of study to contribute to our PIP. A team will be selected to work on the project, with a team leader that will be accountable to the QAPI Committee. The team will use a systematic approach to identify the root cause and contributing factors to the problem, ensure planned changes/interventions are implemented	

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F 867	Continued From page 16 During a follow up interview at 3:35 p.m., the administrator stated he reviewed the facility QAA and QAPI minutes for the last year and verified there was no documentation to support a PIP was identified or performed. On 11/15/23 at 3:00 p.m., an observation of the facility identified there was no information posted about any PIP project the facility was actively working on. On 11/15/23 at 3:13 p.m., during an interview with the director of nursing (DON) and registered nurse (RN)-B, who was known as the facility case manager, they stated they were unaware of any PIP project the facilities QAPI committee had in place. The facility policy titled Quality Assurance and Performance Improvement (QAPI) Program dated 10/21/21, indicated: 2. Provide a means to establish and implement performance improvement projects to correct identified negative or problematic indicators	F 867	and to review to ensure the new action(s) are being implemented. Information on the PIP project will be shared with facility staff, residents and families via meetings, newsletters or postings. DON/designee will conduct random audits on the project□s implementation on a weekly basis. Results of the audits and PIP project will be brought to the QAPI Committee for review and further recommendations.	
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program.	F 880		12/22/23

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F 880	Continued From page 17 The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and	F 880		

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F 880	Continued From page 18 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow Centers for Medicare and Medicaid Services (CMS) and Centers for Disease Control (CDC) guidelines to prevent the spread of Covid-19 when during a Covid-19 outbreak, failed to ensure appropriate use of personal protective equipment (PPE) when staff were observed not wearing PPE or not wearing appropriate PPE, in rooms of 8 of 8 residents (R1, R6, R9, R21, R25, R27, R28, R87) in transmission based precautions (TBP) for Covid-19; failed to remove masks after caring for residents in TBP for 5 of 5 residents (R6, R21, R27, R28, R87) on TBP; failed to ensure residents on TBP had a PPE cart outside of their room for 2 of 2 residents (R8, R25); failed to ensure PPE carts had antimicrobial's such as hand sanitizer and disinfectant wipes readily available outside the rooms of residents for 7 of 7 residents (R6, R9, R10, R11, R21, R26, R28); failed to ensure residents in TBP for Covid-19 remained in TBP for the required duration for 1 of	F 880	F880 (Infection Prevention and Control) The facility staff will be re-educated by 12/07/2023 on the IPCP program policies for the following areas: 1)appropriate use of personal protective equipment (PPE), 2) appropriate signage on the door, 3) equipment needed on the PPE carts outside the residents door when in strict isolation, 4) guidelines on duration of Isolation, 5) the need for a closed door on a room that is in isolation, and 6) ensuring catheter bags do not touch the floor All staff not able to attend the facility training will sign off that they received/reviewed the training, prior to working on the floor. Policy and Procedures have been reviewed and revised to include the education of staff and the addition of	

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F 880	Continued From page 19 1 residents (R87) on TBP; and failed to maintain closed doors of residents in TBP for 4 of 4 residents (R6, R8, R25, R28) on TBP. This had the potential to affect all 36 residents who resided in the facility. In addition, failed to ensure residents' urinary catheter bag remained off the floor during random observations for 1 of 1 resident, (R9) reviewed for urinary catheters. Finding include: During an observation on 11/13/23 at 10:45 a.m., when entering the facility, there had been a sign on the door indicating masks were required. During the entrance conference, the director of nursing (DON) stated there were 10 of 36 residents in TBP for Covid-19 and they would be identified on the census sheet. Midnight Census Report dated 11/13/23, indicated the following 10 residents were in TBP for Covid-19: R6, R8, R9, R10, R11, R21, R25, R26, R28, and R87. During an observation and interview on 11/13/23 at 2:51 p.m., on the 100 wing, observed rooms where some residents appeared to be in TBP based upon droplet/contact precautions signs on doors and/or PPE carts outside of room. However these two findings were not consistent - not all rooms that had signs on the door, had a PPE cart outside the room. Further, these rooms did not have hand sanitizer or disinfectant wipes immediately available for staff. Observed multiple small paper bags lining the railing in the corridor near rooms of residents in TBP; the bags contained N95 masks and eye protection. The top of the small plastic PPE cart was the only surface available to staff to set things down and glove	F 880	Isolation cart checklists for easier access and accuracy of stocked supplies. Infection Control Nurse/Designee will conduct Random Audits of a resident in Strict isolation and/or residents with a catheter bag 2Xweek for 4 weeks, then weekly thereafter. Audit results will be brought to the QAPI Committee for review and further recommendations. DON will be responsible for ensuring this education and the audits are being completed.	

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F 880	Continued From page 20 boxes had been on top of it. There had been no other surface on which to put hand sanitizer, disinfectant wipes, or for staff to set things (e.g., medications or meal tray) as they donned PPE before entering the room, and no place for staff to set eye protection in order to obtain a disinfectant wipe to clean them after exiting a room. R10 in room 101, R28 in room 114, and R8 in 108 were all observed to be in TBP with signs on the door indicating droplet/contact precautions. The signs directed staff to keep the door closed. The doors were wide open. In addition, there had been no PPE cart outside R8's room. During an interview on 11/13/23 at 3:08 p.m., nursing assistant (NA)-D stated when a resident was in TBP, their door needed to be closed to prevent the spread of Covid-19. NA-D stated some residents did not like their door closed so if they asked her to keep it open, she complied. NA-D acknowledged the door should be closed but felt she should do what the resident asked. NA-D had been unaware if anyone had educated residents on the reason their door should be kept closed. During an observation on 11/13/23 at 3:13 p.m., R26's door was closed and a sign posted on the door indicated special droplet /contact precautions with instructions to wear face mask, eye protection, face shield or goggles, gown and gloves. There were no disinfectant wipes, hand sanitizer, or trash receptacle located outside of the room. During an observation on 11/13/23 at 3:15 p.m., R25's door was open and a sign was posted on the door indicating special droplet /contact precautions with instructions to wear face mask,	F 880		

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	245316	A. BUILDING _____ B. WING _____	C 11/15/2023

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

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F 880	Continued From page 21 eye protection, face shield or goggles, gown and gloves. NA-E stated there were two resident's in room 205: R25 and R2. NA-E stated R25 was on isolation but off precautions, and R2 was not on either. NA-E further stated the residents in room 205 could not leave their rooms due to isolation. NA-E stated a sign at the nurses station indicated the residents were off precautions, and still on isolation. NA-E stated staff were not required to wear PPE when they entered R25's room and only required to wear a regular face mask. NA-E and registered nurse (RN)-A entered room R25's with only a regular face mask and no other PPE. No PPE cart with supplies was observed outside of R25's room. NA-E and RN-A stated they were not sure why the signs were still posted on R25's door with droplet precautions and required PPE. During an interview and observation on 11/13/23 at 3:19 p.m., licensed practical nurse (LPN)-A who was also the infection preventionist, stated it was her first day back to work after seven days, after having tested positive for Covid-19. Together with LPN-A, walked the 100 wing with to observe the rooms of residents in TBP. --R10 in room 101. R10 had tested positive for Covid-19 the morning of 11/13/23. His door had been wide open. LPN-A stated he was a fall risk and that was why the door was open. --R87 in room 106. LPN-A stated R87 had tested positive for Covid-19 on 11/5/23, and should have remained in TBP until 11/15/23. There has been no PPE cart outside the room and no droplet/contact precautions signs on the door. LPN-A stated R87 had been removed from TBP too early, but did not know who removed her or why. --R28 and R6 in room 114. Both had tested positive for Covid-19 on 11/10/23 and 11/6/23,	F 880		

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F 880	Continued From page 22 respectively, and both were to be in TBP until 11/20/23. The door had been wide open. --R8 in room 108. LPN-A stated R8 had tested positive for Covid-19 on 11/5/23 and had was to remain in TBP until 11/15/23. The door had been wide open. In addition to making observations of her own regarding residents in TBP, LPN-A was informed of concerns regarding the lack of hand sanitizer, disinfectant wipes and work surface for staff outside resident rooms who were in TBP. LPN-A stated the findings had taken her by surprise and she had not yet had time to make corrections or provide staff re-training. LPN-A stated she had expected the DON and registered nurse (RN)-B to have taken over her duties in her absence and monitor staff compliance for adherence to CDC guidelines for Covid-19. During an interview on 11/13/23 at 3:23 p.m., LPN-A stated the facility practice was the residents remained in isolation with droplet precautions for ten days after a Covid-19 positive test and stated staff were expected to wear required PPE when they entered a resident's room on TBP. LPN-A stated the required PPE 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	F 880		

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F 880	Continued From page 23 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 for 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. During an interview on 11/13/23 at 4:42 p.m., the DON and LPN-A were together informed of Covid-19 findings. The DON admitted she and RN-B had been responsible for monitoring staff compliance for adherence to the CDC guidelines for Covid-19. The DON stated they had made sure residents had been tested for Covid-19 and monitored employee activity related to Covid PPE precautions, but admitted they did not notice the observations made by the surveyors. Further, the DON did not know how or why R87 and R8 had been removed from TBP two days early. When asked why some residents in TBP did not have a	F 880		

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F 880	Continued From page 24 PPE cart and why their had been no hand sanitizer or disinfect wipes immediately available to staff as they entered and exited rooms of residents in TBP, the DON stated staff could walk down the hall or across the hall to access a PPE cart, hand sanitizer, and disinfect wipes. The DON acknowledged that to ensure compliance with Covid-19 precautions, supplies needed to be immediately available for staff. During an observation on 11/13/23 from 5:14 p.m. to 5:18 p.m., observed (NA)-C who was donned in a yellow PPE gown, N95 mask over a regular mask, eye protection and gloves, take a meal tray into multiple resident rooms who were in TBP without changing PPE. At 5:14 p.m., NA-C took a tray into the room of R27 who was in TBP. When NA-C exited the room, she changed her gloves without performing hand hygiene, then went into R21's room who was in TBP. When NA-C exited the room, she changed her gloves without performing hand hygiene, then took a tray into R87's room who was in TBP. When NA-C exited the room, she changed her gloves without performing hand hygiene, then moved the tray cart down the hall to R6/R28's room who were both in TBP. When NA-C exited the room, she removed her gown and gloves and performed hand hygiene. NA-C did not remove or change the N95 mask. During an interview on 11/13/23 at 5:25 p.m., the DON who was in the 100 wing was asked her expectations of staff delivering meal trays to residents in TBP and if it was acceptable to wear the same PPE from room to room. The DON stated she expected staff to doff PPE and don new PPE between rooms and to adhere to the precautions as noted on the precaution signs on	F 880		

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F 880	Continued From page 25	F 880		

residents doors. The DON was then informed of observations of NA-C.

During an interview on 11/13/23 at 5:27 p.m., NA-C was asked what she recalled from training about donning and doffing to go into rooms of residents in TBP. NA-C was able to articulate the steps properly, including performing hand hygiene when she removed her gloves, and admitted she did not do that when delivering meal trays to residents in TBP. NA-C stated she had always done it that way and it was they way other staff did it too. NA-C acknowledged it was important to change PPE and clean hands when exiting a room in order to prevent the spread of Covid-19 to other residents.

During an interview on 11/13/23 at 5:35 p.m., the DON stated staff were required to wash their face shield or eye protection with disinfectant wipes after exiting a resident room who was on TBP. The DON confirmed disinfectant wipes, hand sanitizer and trash receptacle had not been readily available outside residents rooms, and stated the staff would have to walk down the hallway to obtain disinfectant wipes and a trash receptacle if needed.

During an observation on 11/13/23 at 7:47 p.m., together with the DON and LPN-A, a white board 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.,

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F 880	Continued From page 26 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 with PPE gown and gloves on and a plain mask. During an interview on 11/15/23 at 8:48 a.m., the administrator was informed of findings related to breaches in TBP precautions. The administrator stated LPN-A had stated that guidelines had been removed for Covid19. The administrator was informed that basic infection control practices	F 880		

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F 880	Continued From page 27 would always be in place, regardless of Covid-19 status. The administrator stated he had expected that in the absence of LPN-A, the DON and RN-B would have ensured the facility adhered to Covid-19 precautions and TBP requirements. The facility Infection Prevention and Control Program policy dated 8/2023, indicated the facility would establish and maintain an Infection Prevention and Control Program (IPCP) to prevent, identify, investigate, report and control the onset and spread of communicable disease, whenever possible, among residents, staff and visitors. These tasks are based on national standards and guidelines of the CDC. The facility Isolation- Initiating Transmission-Based Precautions policy dated 9/2023, indicated when TBP were implemented, the DON or Infection Preventionist would ensure PPE (i.e. gloves, gowns, masks) were maintained near the residents room so that everyone entering the room can access what they need. Place necessary equipment and supplies in the room that will be needed during the period of TBP; ensure an adequate supply of antiseptic soap and paper towels is maintained in the room during the isolation period; and explain to the resident (or representative) the reason for the precautions. The facility Discontinuing Isolation policy dated 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.	F 880		

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F 880	Continued From page 28 The facility PPE - Gowns policy dated 8/2023, indicated use gowns only once and then discard into 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 one person physical assist with bed mobility, transfer, walk in room and corridor, locomotion on and off 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 continent 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 observed 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 bed 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 urine from the catheter bags at least twice during the day. On 11/14/23 at 11:18 a.m., R9 was observed seated in her recliner with a urinary catheter bag on the floor next to her recliner.	F 880		

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F 880	Continued From page 29 On 11/14/23 at 11:19 a.m., nursing assistant (NA)-A stated R9 was transferred to the recliner by herself and the assist of registered nurse (RN)-A. R9 was observed with NA-A and confirmed the urinary catheter bag was on the floor. NA-A was observed to go into R9's room and remove the catheter bag from the floor and hooked onto the side of R9's recliner chair. On 11/14/23 at 11:26 a.m. RN-A (who works as a NA at the facility) stated R9's catheter bag should not have contact with the floor, and RN-A stated when she transfers R9 she hooked the catheter bag to the side of the recliner chair or to R9's bed. On 11/15/23 at 9:29 a.m., R9 was observed sleeping in bed and her urinary catheter bag was on the floor next to her bed. On 11/15/23 at 9:30 a.m., during an interview licensed practical nurse (LPN)-A who was the infection preventionist at the facility stated catheter bags should be positioned in a way to avoid contacting the floor for infection prevention measures. On 11/15/23 at 9:33 a.m., NA-B stated she offered R9 morning cares, and R9 refused. NA-B stated the catheter was expected off the floor and was not aware the catheter bag was on the floor. NA-B stated the overnight NA would have been the last staff to have emptied the catheter. On 11/15/23 at 9:57 a.m., during an interview the director of nursing (DON) stated stated urinary catheter bags should be off floor due to the risk for infection.	F 880		

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F 880	Continued From page 30 The facility Urinary Catheter Care policy dated 11/3/23, indicated: Catheter Tubing and Bag; check frequently to be sure there are no kinks or loops in the tubing and that the resident is not lying on the tubing. Keep bag off floor, hang on bed or wheelchair.	F 880		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 11/14/2023. At the time of this survey, New Richland Care Center was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. NEW RICHLAND CARE CENTER is a 1 story building with no basement. The original building was constructed at 2 different times. Original building in 1975, one-story with no basement, and was determined to be of Type II (111) construction. In 1992 an addition was constructed and was determined to be of Type II(111) construction. Because the original building and the addition are compatible construction types allowed for existing buildings of this height, the facility was surveyed as one building. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 50 beds and had a	K 000		

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

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K 000	Continued From page 1 census of 36 at the time of the survey.	K 000		

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 only a suggestion 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.

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.

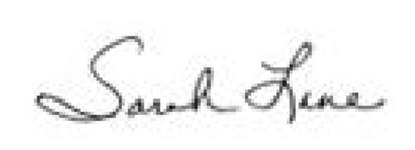
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00748	A. BUILDING: _____ B. WING _____	C 11/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. 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. INITIAL COMMENTS: On 11/13/23-11/15/23, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed during the survey: H53167182C (MN00092891) and H53167203C (MN00090020). and NO licensing orders were issued. 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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. The facility is enrolled in ePOC and therefore a signature is not	2 000		

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2 000	Continued From page 2 required at the bottom of the first page of state form. 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.	2 000		
2 255	MN Rule 4658.0070 Quality Assessment and Assurance Committee A nursing home must maintain a quality assessment and assurance committee consisting of the administrator, the director of nursing services, the medical director or other physician designated by the medical director, and at least three other members of the nursing home's staff, representing disciplines directly involved in resident care. The quality assessment and assurance committee must identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee must address, at a minimum, incident and accident reporting, infection control, and medications and pharmacy services. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to have evidence of a Performance Improvement Project (PIP) which focused on high risk or problem-prone areas, identified thorough and appropriate data	2 255	Corrected	12/22/23

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2 255	Continued From page 3 collection, analysis and evaluation of the identified concern(s) during Quality Assurance and Performance Improvement (QAPI). This had the potential to affect all 36 residents. Findings include: On 11/15/23 at 2:50 p.m., during an interview the facility administrator stated the facility QAA (Quality Assessment and Assurance) and QAPI group met on a regular basis with the Medical Director to review areas identified as needing improvement within the facility. The administrator stated he could not recall the facility PIP project. During a follow up interview at 3:35 p.m., the administrator stated he reviewed the facility QAA and QAPI minutes for the last year and verified there was no documentation to support a PIP was identified or performed. On 11/15/23 at 3:00 p.m., an observation of the facility identified there was no information posted about any PIP project the facility was actively working on. On 11/15/23 at 3:13 p.m., during an interview with the director of nursing (DON) and registered nurse (RN)-B, who was known as the facility case manager, they stated they were unaware of any PIP project the facilities QAPI committee had in place. The facility policy titled Quality Assurance and Performance Improvement (QAPI) Program dated 10/21/21, indicated: 2. Provide a means to establish and implement performance improvement projects to correct identified negative or problematic indicators.	2 255		

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2 255	Continued From page 4 SUGGESTED METHOD OF CORRECTION: The quality assurance committee could identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee will monitor these area on a regular basis and make recommendations for any changes. The administrator will be responsible for implementation. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 255		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure restorative services to maintain and/or improve mobility was received for 1 of 2 residents (R27) reviewed for mobility.	2 895	corrected	12/22/23

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2 895	Continued From page 5 Findings include: R27's quarterly Minimum Data Set (MDS) assessment dated 9/19/23, indicated R27 had intact cognition, no rejection of care, required one person physical assist with bed mobility, transfer, walking in room and corridor, locomotion on and off unit, dressing, toilet use, and personal hygiene, utilized a walker and wheelchair, diagnoses included fractured femur, dementia, and edema. R27's care plan dated 6/30/23, indicated R27 required staff assistance with some ADL's (activities of daily living) d/t (due/to) compression fx (fracture) L (lumbar) 1, L2, L4, and weakness; interventions included: ambulation assist, extensive staff assistance: of one, wbat (weight bearing as tolerated) device used: fww and gait belt, notes: another staff to follow behind with wheelchair, walk 75-100 ft, on the daily CNA (certified nursing assistant) restorative walking program to maintain current level of mobility, often refuse to walk, encourage to attend fitness fun and complete exercise handout in my room, walking program, walk with FWW (front wheeled walker) and one assist with another staff to follow behind with wheelchair, walk 75-100 ft twice daily. R27's record review identified document titled Documentation Survey Report dated 11/23, indicated a staff task every day and p.m. shift: walking program: cna/restorative staff to assist resident with walking twice daily, use fww and one assist with another staff to follow behind with wheelchair, walk 75-100 ft. R27's EMR (electronic medical record) documentation with staff initials and time indicated R27 refused on 11/8/23 evening shift, and 11/11/23 evening ... the other	2 895		

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2 895	Continued From page 6 25 opportunities for documentation were charted as R27 not available or not applicable. R27's document PT/OT/ST recommendations to nursing dated 4/21/23, indicated R27 was recommended ambulate with FWW and assist x 1 (75-100 ft) and another to follow behind with wheelchair, 2x daily. Document titled walking list 200 hall indicated R27 two assist with walker. Nursing meeting minutes dated 11/9/23, indicated walking lists: need to continue walking resident even with COVID if they are not positive, they may walk in hall with mask, if positive may walk in room, also can guide agency staff in completing this while they are working in our facility, staff signatures indicated education was received on 11/9/23. On 11/13/23 at 2:52 p.m., R27 was observed seated in a wheelchair in his room and stated he was supposed to walk the hallway daily and hadn't walked for about three or four days, and stated staff were not walking him because there was a sickness in the facility. R27 walker was against the wall in his room and R27 stated he had not used the walker for a few days. On 11/14/23 at 12:44 p.m., R27 was seated a wheelchair in his room and stated staff had not offered to walk him or do exercise, and R27 stated my legs need the excise to stay strong. On 11/14/23 at 12:45 p.m., trained medication aide (TMA)-A stated residents have not walked much with COVID at the facility and was not aware when R27 last walked as she had not worked for a week. TMA-A stated prior to the	2 895		

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2 895	Continued From page 7 facility in a COVID outbreak R27 was expected to walk with staff. On 11/14/23 at 12:52 p.m., nursing assistant (NA)-A stated the facility was currently not walking residents on the walking program because of the facility COVID outbreak, and confirmed R27 was on the walking program. On 11/14/23 at 12:52 p.m., registered nurse (RN)-A stated she was a RN however worked at the facility as a NA. RN-A stated R27 was on the walking program and prior to the facility in a COVID outbreak staff were expected to walk R27. RN-A further stated residents are not walked currently due to COVID in the building, and stated R27's room did not enough room to walk him and he utilized the wheelchair to get around in his room. On 11/14/23 at 1:00 p.m., during an interview with the director of nursing (DON) and RN-B who was the case manager at the facility, stated residents on walking program were expected to walk in either the hallway with mask or in their room. The DON and RN-B confirmed R27 was on walking program and was expected to walk with staff twice a day. The DON further stated she held a nursing meeting last week and staff were educated residents were expected to walk with a mask on in the hallways. R27's walking program EMR documentation was reviewed with the DON and RN-B and confirmed R27 was not walked as expected. On 11/15/23 at 2:50 p.m., during an interview the administrator stated he was aware of concerns with the walking program and staff not walking residents as expected. The administrator stated during the summer staff seemed to be doing a	2 895		

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2 895	Continued From page 8 better job at ensuring the residents were walked and stated he was aware that it was a concern and fell of his radar. The facility Walking Program policy dated 10/23, indicated: Policy: Ambulate with a resident utilizing 1-2 assist with/without a device to facilitate the resident reaching and maintaining his/her highest level of physical and mental ability. Refer to plan of care for individualized treatment plan. Objective: 1. To promote each resident's physical and mental well-being. 2. To provide a walking program in addition to that established in the formal PT program. 3. Do you have an ongoing device to measure resident status and reaching goals set in the plan of care? 4. To minimize the negative effects of immobility Procedure: 1. The interdisciplinary team will set goals for each resident to achieve the highest level of mobility. 2. The PTA, under the direction. Of the care plan team will begin a walking program. 3. The CNAS on the assigned hall will be responsible for providing the assist to the identified resident. 4. After walking is completed, CNA will mark in the appropriate dated square the distance walked in their initials. 5. At the end of the month, the PTA will summarize the month's progress and carry this information onto the next month. SUGGESTED METHOD OF CORRECTION:	2 895		

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2 895	Continued From page 9 The director of nursing (DON) or designee could review and revise policies related to the walking program, educate staff on the policies, and conduct an audit of all residents on the program to ensure it is being completed and documented as ordered. In addition, they could audit to ensure a licensed nurse evaluates the program and each resident on the program periodically to ensure appropriate. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 895		
2 980	MN Rule 4658.0605 Subp. 2 Director of dietary service; Director Subp. 2. Director of dietary service. If a qualified dietitian is not employed full time, the administrator must designate a director of dietary service who is enrolled in or has completed, at a minimum, a dietary manager course, and who receives frequently scheduled consultation from a qualified dietitian. The number of hours of consultation must be based upon the needs of the nursing home. Directors of dietary service hired before May 28, 1995, are not required to complete a dietary manager course. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure that in the absence of a full-time registered dietician (RD), the dietary manager (DM) was certified to oversee nutrition	2 980	corrected	12/22/23

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2 980	Continued From page 10 and food services. This had potential to affect all 36 residents who resided in the facility. Findings include: During an interview on 11/13/23 at 1:32 p.m., (DM)-C, who had worked in the dietary manager position for six years, stated he was not a certified dietary manager (CDM) but had planned on taking the course. DM-C stated the facility contracted with a RD who came to the facility once per month. During document review, the title of DM-C's job description was Certified Dietary Manager, and the educational requirement for the position indicated an individual must possess certification through the Association of Nutrition and Foodservice Professionals and be a Certified Dietary Manager. During a telephone interview on 11/15/23 at 8:56 a.m., (RD)-D stated she went to the facility once a month and had been aware DM-C had not been a CDM. RD-D stated she had encouraged DM-C to take the course and had offered to be a preceptor. RD-D stated her last conversation about DM-C not being a CDM had been with the previous administrator. RD-D stated she solely conducted clinical visits at the facility per her contract. During an interview on 11/15/23 at 2:28 p.m., when informed DM-C had not been a qualified dietary manager per regulatory requirements and per the facility dietary manager job description, the administrator stated he thought that was acceptable since the facility contracted with a dietician. The administrator was informed the dietician would need to be employed full-time at	2 980		

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2 980	Continued From page 11 the facility in that instance. The administrator stated he had not been aware of that. The facility Job Description for Culinary Director/Certified Dietary Manager (CDM) indicated the culinary director must possess certification through the Association of Nutrition and Foodservice Professionals and be a certified dietary manager, have a minimum of two years in a supervisor capacity in a hospital, skilled nursing care facility or other related medical facility, have training in cost control, food management and diet therapy. Knowledgeable of dietary practices and procedures as well as laws, regulations and guidelines governing dietary functions in the long-term care facility. The job description was signed by DM-C and dated 10/6/17. SUGGESTED METHOD OF CORRECTION: The administrator or designee could ensure the dietary manager had the proper qualifications for the position. The administrator or designee could provide guidance to the dietary manager in effort to achieve proper qualifications within a specified time frame. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 980		
21134	MN RULE 4658.0670 Supb. 2. Dishwashing; Sanitation, storage Sanitization; storage. All utensils and equipment must be thoroughly cleaned, and food-contact surfaces of utensils and equipment must be given sanitization treatment and must be stored in such a manner as to be protected from	21134		12/22/23

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NEW RICHLAND CARE CENTER	312 NORTHEAST 1ST STREET NEW RICHLAND, MN 56072

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21134	Continued From page 12 contamination. Cleaned and sanitized equipment and utensils must be handled in a way that protects them from contamination. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure condiments were used or discarded in a timely manager to maintain freshness and quality. In addition, the facility failed to monitor and ensure water temperature in the 3-compartment sink met regulatory requirements. This had the potential to affect all 36 residents who were served food from the kitchen. Findings include: During an observation and interview on 11/13/23 at 1:32 p.m., with dietary manager (DM)-C in the walk-in refrigerator, observed a one gallon jar of sliced green olives with approximately half remaining in the jar. The upper portion of the jar had a cloudy film on the inside. On the lid in black marker had been written 4/6 (the year was not indicated). DM-C stated that was the date opened - April 6, this year. Also in the walk-in refrigerator had been a one gallon jar of pickle relish with approximately half left, with 2/22 written in black marker on the lid. DM-C stated that date was February 22, this year, not February 2022. DM-C stated he did not know how long condiments could be stored after opening, but would find out. DM-C removed both jars stating he would discard them. During an interview on 11/13/23 at 5:12 p.m., DM-C stated he looked up how long olives and pickle relish could be stored in the refrigerator after opening and stated it was three months per	21134	corrected	

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21134	Continued From page 13 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	21134		

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21134	Continued From page 14 temperature in the 3-compartment sink had not been monitored per regulation and facility policy; that DM-C had been unaware it needed to be monitored. In addition, the administrator was informed of condiments in the refrigerator that had been opened seven and nine months ago when the USDA recommendations were no longer than three months. The administrator stated he thought DM-C would have been aware of both of these findings. The facility Cleaning Dishes - Manual Dishwashing policy dated 2017, indicated the following: --Sink 1: Wash. Water temperature should be at 110 degrees Fahrenheit (F). Change water frequently to assure effective cleaning of dishes. --Sink 3: Sanitize. Water should be 75 to 100 degrees F. The facility Food Storage policy dated 2017, did not address the length of time condiments could remain open in the refrigerator. SUGGESTED METHOD OF CORRECTION: The dietary manager or designee could develop and implement policy and procedure to ensure all staff have been educated, are following regulatory requirements, and are monitoring dishmachine sanitation requirements. Audits could be conducted to ensure compliance and results brought to the Quality Assurance and Performance Improvement (QAPI) committee to determine compliance and need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21134		

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21390	Continued From page 15	21390		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow Centers for Medicare and Medicaid Services (CMS) and Centers for Disease Control (CDC) guidelines to prevent the spread of Covid-19 when during a Covid-19 outbreak, failed to ensure appropriate	21390	corrected	12/22/23

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21390	Continued From page 16 use of personal protective equipment (PPE) when staff were observed not wearing PPE or not wearing appropriate PPE, in rooms of 8 of 8 residents (R1, R6, R9, R21, R25, R27, R28, R87) in transmission based precautions (TBP) for Covid-19; failed to remove masks after caring for residents in TBP for 5 of 5 residents (R6, R21, R27, R28, R87) on TBP; failed to ensure residents on TBP had a PPE cart outside of their room for 2 of 2 residents (R8, R25); failed to ensure PPE carts had antimicrobial's such as hand sanitizer and disinfectant wipes readily available outside the rooms of residents for 7 of 7 residents (R6, R9, R10, R11, R21, R26, R28); failed to ensure residents in TBP for Covid-19 remained in TBP for the required duration for 1 of 1 residents (R87) on TBP; and failed to maintain closed doors of residents in TBP for 4 of 4 residents (R6, R8, R25, R28) on TBP. This had the potential to affect all 36 residents who resided in the facility. In addition, failed to ensure residents' urinary catheter bag remained off the floor during random observations for 1 of 1 resident, (R9) reviewed for urinary catheters. Finding include: During an observation on 11/13/23 at 10:45 a.m., when entering the facility, there had been a sign on the door indicating masks were required. During the entrance conference, the director of nursing (DON) stated there were 10 of 36 residents in TBP for Covid-19 and they would be identified on the census sheet. Midnight Census Report dated 11/13/23, indicated the following 10 residents were in TBP for Covid-19: R6, R8, R9, R10, R11, R21, R25, R26, R28, and R87.	21390		

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21390	Continued From page 17 During an observation and interview on 11/13/23 at 2:51 p.m., on the 100 wing, observed rooms where some residents appeared to be in TBP based upon droplet/contact precautions signs on doors and/or PPE carts outside of room. However these two findings were not consistent - not all rooms that had signs on the door, had a PPE cart outside the room. Further, these rooms did not have hand sanitizer or disinfectant wipes immediately available for staff. Observed multiple small paper bags lining the railing in the corridor near rooms of residents in TBP; the bags contained N95 masks and eye protection. The top of the small plastic PPE cart was the only surface available to staff to set things down and glove boxes had been on top of it. There had been no other surface on which to put hand sanitizer, disinfectant wipes, or for staff to set things (e.g., medications or meal tray) as they donned PPE before entering the room, and no place for staff to set eye protection in order to obtain a disinfectant wipe to clean them after exiting a room. R10 in room 101, R28 in room 114, and R8 in 108 were all observed to be in TBP with signs on the door indicating droplet/contact precautions. The signs directed staff to keep the door closed. The doors were wide open. In addition, there had been no PPE cart outside R8's room. During an interview on 11/13/23 at 3:08 p.m., nursing assistant (NA)-D stated when a resident was in TBP, their door needed to be closed to prevent the spread of Covid-19. NA-D stated some residents did not like their door closed so if they asked her to keep it open, she complied. NA-D acknowledged the door should be closed but felt she should do what the resident asked. NA-D had been unaware if anyone had educated residents on the reason their door should be kept closed.	21390		

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21390	Continued From page 18 During an observation on 11/13/23 at 3:13 p.m., R26's door was closed and a sign posted on the door indicated special droplet /contact precautions with instructions to wear face mask, eye protection, face shield or goggles, gown and gloves. There were no disinfectant wipes, hand sanitizer, or trash receptacle located outside of the room. During an observation on 11/13/23 at 3:15 p.m., R25's door was open and a sign was posted on the door indicating special droplet /contact precautions with instructions to wear face mask, eye protection, face shield or goggles, gown and gloves. NA-E stated there were two resident's in room 205: R25 and R2. NA-E stated R25 was on isolation but off precautions, and R2 was not on either. NA-E further stated the residents in room 205 could not leave their rooms due to isolation. NA-E stated a sign at the nurses station indicated the residents were off precautions, and still on isolation. NA-E stated staff were not required to wear PPE when they entered R25's room and only required to wear a regular face mask. NA-E and registered nurse (RN)-A entered room R25's with only a regular face mask and no other PPE. No PPE cart with supplies was observed outside of R25's room. NA-E and RN-A stated they were not sure why the signs were still posted on R25's door with droplet precautions and required PPE. During an interview and observation on 11/13/23 at 3:19 p.m., licensed practical nurse (LPN)-A who was also the infection preventionist, stated it was her first day back to work after seven days, after having tested positive for Covid-19. Together with LPN-A, walked the 100 wing with to observe the rooms of residents in TBP. --R10 in room 101. R10 had tested positive for	21390		

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21390	Continued From page 19 Covid-19 the morning of 11/13/23. His door had been wide open. LPN-A stated he was a fall risk and that was why the door was open. --R87 in room 106. LPN-A stated R87 had tested positive for Covid-19 on 11/5/23, and should have remained in TBP until 11/15/23. There has been no PPE cart outside the room and no droplet/contact precautions signs on the door. LPN-A stated R87 had been removed from TBP too early, but did not know who removed her or why. --R28 and R6 in room 114. Both had tested positive for Covid-19 on 11/10/23 and 11/6/23, respectively, and both were to be in TBP until 11/20/23. The door had been wide open. --R8 in room 108. LPN-A stated R8 had tested positive for Covid-19 on 11/5/23 and had was to remain in TBP until 11/15/23. The door had been wide open. In addition to making observations of her own regarding residents in TBP, LPN-A was informed of concerns regarding the lack of hand sanitizer, disinfectant wipes and work surface for staff outside resident rooms who were in TBP. LPN-A stated the findings had taken her by surprise and she had not yet had time to make corrections or provide staff re-training. LPN-A stated she had expected the DON and registered nurse (RN)-B to have taken over her duties in her absence and monitor staff compliance for adherence to CDC guidelines for Covid-19. During an interview on 11/13/23 at 3:23 p.m., LPN-A stated the facility practice was the residents remained in isolation with droplet precautions for ten days after a Covid-19 positive test and stated staff were expected to wear required PPE when they entered a resident's room on TBP. LPN-A stated the required PPE	21390		

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21390	Continued From page 20 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 for 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. During an interview on 11/13/23 at 4:42 p.m., the DON and LPN-A were together informed of	21390		

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21390	Continued From page 21 Covid-19 findings. The DON admitted she and RN-B had been responsible for monitoring staff compliance for adherence to the CDC guidelines for Covid-19. The DON stated they had made sure residents had been tested for Covid-19 and monitored employee activity related to Covid PPE precautions, but admitted they did not notice the observations made by the surveyors. Further, the DON did not know how or why R87 and R8 had been removed from TBP two days early. When asked why some residents in TBP did not have a PPE cart and why their had been no hand sanitizer or disinfect wipes immediately available to staff as they entered and exited rooms of residents in TBP, the DON stated staff could walk down the hall or across the hall to access a PPE cart, hand sanitizer, and disinfect wipes. The DON acknowledged that to ensure compliance with Covid-19 precautions, supplies needed to be immediately available for staff. During an observation on 11/13/23 from 5:14 p.m. to 5:18 p.m., observed (NA)-C who was donned in a yellow PPE gown, N95 mask over a regular mask, eye protection and gloves, take a meal tray into multiple resident rooms who were in TBP without changing PPE. At 5:14 p.m., NA-C took a tray into the room of R27 who was in TBP. When NA-C exited the room, she changed her gloves without performing hand hygiene, then went into R21's room who was in TBP. When NA-C exited the room, she changed her gloves without performing hand hygiene, then took a tray into R87's room who was in TBP. When NA-C exited the room, she changed her gloves without performing hand hygiene, then moved the tray cart down the hall to R6/R28's room who were both in TBP. When NA-C exited the room, she removed her gown and gloves and performed hand hygiene. NA-C did not remove or change	21390		

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21390	Continued From page 22 the N95 mask. During an interview on 11/13/23 at 5:25 p.m., the DON who was in the 100 wing was asked her expectations of staff delivering meal trays to residents in TBP and if it was acceptable to wear the same PPE from room to room. The DON stated she expected staff to doff PPE and don new PPE between rooms and to adhere to the precautions as noted on the precaution signs on residents doors. The DON was then informed of observations of NA-C. During an interview on 11/13/23 at 5:27 p.m., NA-C was asked what she recalled from training about donning and doffing to go into rooms of residents in TBP. NA-C was able to articulate the steps properly, including performing hand hygiene when she removed her gloves, and admitted she did not do that when delivering meal trays to residents in TBP. NA-C stated she had always done it that way and it was they way other staff did it too. NA-C acknowledged it was important to change PPE and clean hands when exiting a room in order to prevent the spread of Covid-19 to other residents. During an interview on 11/13/23 at 5:35 p.m., the DON stated staff were required to wash their face shield or eye protection with disinfectant wipes after exiting a resident room who was on TBP. The DON confirmed disinfectant wipes, hand sanitizer and trash receptacle had not been readily available outside residents rooms, and stated the staff would have to walk down the hallway to obtain disinfectant wipes and a trash receptacle if needed. During an observation on 11/13/23 at 7:47 p.m., together with the DON and LPN-A, a white board	21390		

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21390	Continued From page 23 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	21390		

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21390	Continued From page 24 with PPE gown and gloves on and a plain mask. During an interview on 11/15/23 at 8:48 a.m., the administrator was informed of findings related to breaches in TBP precautions. The administrator stated LPN-A had stated that guidelines had been removed for Covid19. The administrator was informed that basic infection control practices would always be in place, regardless of Covid-19 status. The administrator stated he had expected that in the absence of LPN-A, the DON and RN-B would have ensured the facility adhered to Covid-19 precautions and TBP requirements. The facility Infection Prevention and Control Program policy dated 8/2023, indicated the facility would establish and maintain an Infection Prevention and Control Program (IPCP) to prevent, identify, investigate, report and control the onset and spread of communicable disease, whenever possible, among residents, staff and visitors. These tasks are based on national standards and guidelines of the CDC. The facility Isolation- Initiating Transmission-Based Precautions policy dated 9/2023, indicated when TBP were implemented, the DON or Infection Preventionist would ensure PPE (i.e. gloves, gowns, masks) were maintained near the residents room so that everyone entering the room can access what they need. Place necessary equipment and supplies in the room that will be needed during the period of TBP; ensure an adequate supply of antiseptic soap and paper towels is maintained in the room during the isolation period; and explain to the resident (or representative) the reason for the precautions. The facility Discontinuing Isolation policy dated	21390		

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	00748	A. BUILDING: _____ B. WING _____	C 11/15/2023

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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 discard into 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 one person physical assist with bed mobility, transfer, walk in room and corridor, locomotion on and off 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 continent 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 observed 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 bed 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 urine from the catheter bags at least twice during	21390		

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21390	Continued From page 26 the day. On 11/14/23 at 11:18 a.m., R9 was observed seated in her recliner with a urinary catheter bag on the floor next to her recliner. On 11/14/23 at 11:19 a.m., nursing assistant (NA)-A stated R9 was transferred to the recliner by herself and the assist of registered nurse (RN)-A. R9 was observed with NA-A and confirmed the urinary catheter bag was on the floor. NA-A was observed to go into R9's room and remove the catheter bag from the floor and hooked onto the side of R9's recliner chair. On 11/14/23 at 11:26 a.m. RN-A (who works as a NA at the facility) stated R9's catheter bag should not have contact with the floor, and RN-A stated when she transfers R9 she hooked the catheter bag to the side of the recliner chair or to R9's bed. On 11/15/23 at 9:29 a.m., R9 was observed sleeping in bed and her urinary catheter bag was on the floor next to her bed. On 11/15/23 at 9:30 a.m., during an interview licensed practical nurse (LPN)-A who was the infection preventionist at the facility stated catheter bags should be positioned in a way to avoid contacting the floor for infection prevention measures. On 11/15/23 at 9:33 a.m., NA-B stated she offered R9 morning cares, and R9 refused. NA-B stated the catheter was expected off the floor and was not aware the catheter bag was on the floor. NA-B stated the overnight NA would have been the last staff to have emptied the catheter.	21390		

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21390	Continued From page 27 On 11/15/23 at 9:57 a.m., during an interview the director of nursing (DON) stated stated urinary catheter bags should be off floor due to the risk for infection. The facility Urinary Catheter Care policy dated 11/3/23, indicated: Catheter Tubing and Bag; check frequently to be sure there are no kinks or loops in the tubing and that the resident is not lying on the tubing. Keep bag off floor, hang on bed or wheelchair. SUGGESTED METHOD OF CORRECTION: The DON (director of nursing) or designee could re-educate staff on proper infection control practices for transmission based precautions (TBP) to ensure proper use of personal protective equipment (PPE), and to ensure staff have immediate access to supplies such as antimicrobials in order to mitigate COVID-19 transmission. In addition, the DON or designee could re-educate staff on proper infection control practices for care of urinary catheter. The DON or designee could perform periodic audits to ensure staff adherence and results of those 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 (21) days.	21390		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most	21426		12/22/23

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21426	Continued From page 28 current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to complete an TB (tuberculosis) risk assessment. This had the potential to affect all 36 residents residing in the facility, staff and visitors. Findings include: The facility lacked a current TB risk assessment, when asked not one was provided. Interview and document review on 11/15/2023 at 11:28 a.m., with licensed practical nurse (LPN)-A and facility infection preventionist (IP) confirmed she had not completed a TB risk assessment. Interview on 11/15/2023 at 3:49 p.m., with director of nursing (DON) stated her expectations would be for the facility to complete an annual TB	21426	corrected	

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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 (21) days.	21426		