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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 9P0B

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00748

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245316**
2.STATE VENDOR OR MEDICAID NO.
(L2) **825340400**

3. NAME AND ADDRESS OF FACILITY
(L3) **NEW RICHLAND CARE CENTER**
(L4) **312 NORTHEAST 1ST STREET**
(L5) **NEW RICHLAND, MN** (L6) **56072**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/21/2018** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **50** (L18)
13.Total Certified Beds **50** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Vicky Hamersma, HFE NE II 07/18/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 08/03/2018 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
06/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 3, 2018

Mr. Larry Passel, Administrator
New Richland Care Center
312 Northeast 1st Street
New Richland, MN 56072

RE: Project Number S5316027

Dear Mr. Passel:

On June 21, 2018, a standard 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 constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the

attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Holly Kranz, 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: holly.kranz@state.mn.us
Phone: (507) 344-2742
Fax: (507) 344-2723

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by July 31, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by July 31, 2018 the following remedy will be imposed:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. 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, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 September 21, 2018 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original

statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 21, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us

Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Enclosure

cc: Licensing and Certification File

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 _____	06/21/2018

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 A survey with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 6/18/18 thru 6/21/18 during a recertification survey. The facility is NOT in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
E 024 SS=C	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. This REQUIREMENT is not met as evidenced by: Based on interview and policy review, the facility failed to ensure their emergency preparedness policies and procedures addressed the use of	E 024	E024 Policies/Procedures-Volunteers and Staffing Our emergency preparedness policies	7/27/18

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

Electronically Signed | 07/12/2018

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E 024	Continued From page 1 volunteers in an emergency, or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. This had the potential to affect all 47 residents residing in the facility. Findings include: The facility's Emergency Preparedness Plan updated 7/17, lacked protocols for the use of volunteers or other personnel in the facility during an emergency. On 6/21/18, at 1:15 p.m. the administrator and director of nursing verified this information.	E 024	and procedures were updated to address the use of volunteers in an emergency, or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. The Policies and Procedures will be updated by 7/27/2018. They will be reviewed yearly by QAPI and IDT and updated as State and Federal Laws/Rules change.	
E 026 SS=C	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and	E 026		7/27/18

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E 026	Continued From page 2 procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by: Based on interview and policy review, the facility failed to ensure their policies and procedures addressed the role of the facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. This had the potential to affect all 47 residents in the facility. Findings include: The facility policy and procedure for Emergency Preparedness failed to address the role of the facility under a waiver by the Secretary in a different facility or evacuation site. On 6/21/18, at 1:20 p.m. the administrator and director of nursing verified their Emergency Preparedness Plan updated 7/17, lacked direction regarding the facility's role in providing care and treatment at alternate care sites under an 1135 waiver.	E 026	E026 Roles under a Waiver Declared by Secretary Our emergency preparedness policies and procedures were updated to address the role of the facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. The policies and Procedures will be updated by 7/27/2018. They will be reviewed yearly by QAPI and IDT and updated as State and Federal Laws/Rules change.	
E 034 SS=C	Information on Occupancy/Needs CFR(s): 483.73(c)(7) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following:	E 034		7/27/18

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E 034	Continued From page 3 (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For Inpatient Hospice at §418.113:] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure their emergency preparedness communication plan included a means of providing information about the facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. This had the potential to affect all 47 residents residing in the facility. Findings include: During interview on 6/21/18, at 1:25 p.m., with the administrator and director of nursing regarding the facility's emergency plan last updated November, 2017. who confirmed the plan lacked a policy/procedure related to the communication of the facility's occupancy, needs and ability to	E 034	E034 Information on Occupancy/Needs Our emergency preparedness policies and procedures were updated to address our emergency preparedness communication plan included a means of providing information about the facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. The policies and Procedures will be updated by 7/27/2018. They will be reviewed yearly by QAPI and IDT and updated as State and Federal Laws/Rules change.	

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E 034	Continued From page 4 provide assistance as required.	E 034		
E 035 SS=C	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8) [(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure their emergency preparedness communication plan included a method for sharing information the facility had determined appropriate, with residents and their families or representatives. This had the potential to affect all 47 residents currently residing in the facility and their families/representatives. Findings include: During interview on 6/21/18, at 1:30 p.m., with the administrator and director of nursing regarding the facility's emergency plan. Review of preparedness plan last updated November, 2017, revealed the facility had not not developed a system to communicate the emergency plan to the residents or representatives. The director of nursing confirmed the facility had not developed a system to communicate the emergency plan to the residents or representatives.	E 035	E035 Sharing Plans with Patients Our emergency preparedness policies and procedures were updated to create a communication plan and have a method for sharing information the facility had determined appropriate, with residents and their families or representatives. The policies and Procedures will be updated by 7/27/2018. They will be reviewed yearly by QAPI and IDT and updated as State and Federal Laws/Rules change.	7/27/18

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E 041 SS=F	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source	E 041		7/12/18

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	245316	A. BUILDING _____ B. WING _____	06/21/2018

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

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E 041	Continued From page 6	E 041		

to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates.

*[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):]
The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.
If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes.
(1) National Fire Protection Association, 1 Batterymarch Park,
Quincy, MA 02169, www.nfpa.org, 1.617.770.3000.
(i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011.
(ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011.
(iii) TIA 12-3 to NFPA 99, issued August 9, 2012.
(iv) TIA 12-4 to NFPA 99, issued March 7, 2013.
(v) TIA 12-5 to NFPA 99, issued August 1, 2013.
(vi) TIA 12-6 to NFPA 99, issued March 3, 2014.
(vii) NFPA 101, Life Safety Code, 2012 edition,

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E 041	Continued From page 7 issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and documentation review the facility did not provide an essential electrical system in accordance with NFPA 99 (2012) Health Care Facilities Code and NFPA 110 (2010) Standard for Emergency and Standby Power Systems. Further more the facility failed to ensure they had implemented emergency generator inspection/testing in accordance with the requirements. This had the potential to affect all 47 residents residing in the facility. Findings include: During an inspection of the facility on 6/19/18, between the hours of 10:00 a.m. and 1:00 p.m. the Fire Marshal with the facility Maintenance Director (MD) identified that the facility did not have an external e-stop emergency shutdown switch for the outdoor emergency generator. On 6/19/18, between the hours of 10:00 a.m. and 1:00 p.m., the MD verified during interview there was no external shut off switch for the generator. The maintenance director also verified there were	E 041	E041 Emergency Power Emergency E-stop was added on July 3rd 2018. Weekly generator checks added to TELS and started immediately as of 7/11/2018.	

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E 041	Continued From page 8 no weekly generator inspection records available to review.	E 041		
F 000	INITIAL COMMENTS On June 18 through June 21, 2018, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or	F 550		7/30/18

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F 550	Continued From page 9 her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 residents (R36) reviewed for dignity received assistance to the bathroom in a timely manner. Findings include: R36's Electronic medical record dated 4/2/18, included diagnoses of: cerebral infarction,	F 550	F550: Resident Rights/Exercise of Rights: R36's Call Light Response Times will be reviewed daily by the Nurse Manager on 100 Wing. The Nurse Manager will identify excessive call light response times and follow up to determine possible causes and interventions/changes needed	

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F 550	Continued From page 10 congestive heart failure, polyneuropathy, type two diabetes, benign prostatic hyperplasia, hypertension and history of falling. R36's 60 day Minimum Data Set (MDS) assessment, dated 5/28/18, indicated R36's cognition was intact. The MDS activities of daily living (ADL) assessment further indicated R36 required extensive assistance of two for bed mobility, transfers, and toileting and was continent of bowel and bladder. R36's care plan, dated 4/11/18, indicated a history of incontinence and required assistance of one for toileting. The care plan further indicated R36 was at high risk for falls, impulsive and would attempt self-transfer. During interview on 6/20/18, at 8:55 a.m., registered nurse (RN)-B stated R36 complained of his call light not being answered quickly enough. RN-B further stated R36 had a near miss fall when he self transferred due to an extended wait for his call light to be answered. RN-B stated she had reported R36's complaint to management. During interview with nursing assistant (NA)-A on 6/21/18, at 9:03 a.m. NA-A described the function of the call light system as: NA's have pagers that vibrate when call light is activated. If they did not answer within 45 minutes the charge nurse pager vibrated, if the light was not answered after ten minutes then the office nurse pager vibrated, if the light was still not answered after twenty minutes then the director of nursing and the administrator's pager went off. NA-A further stated due to how the system is set up there was no way to determine who's light comes on first if	F 550	and inform resident of any new interventions. The Nurse Manager will meet with R36 weekly and when needed to ensure resident does not have concerns. Nursing Management Staff will run daily Call Light Response Times and identify other residents who have excessive call light response times and follow up to determine possible causes and interventions or changes needed. Residents who are unable to use a standard call light will be given a call light pad or other options that allow the resident to summon assistance. Residents unable to use any options will be checked q2h and more frequently if needed. Care Plans for residents using non-traditional call lights or no call light will be updated by the Nurse Manager. The pager policy and procedure has been changed. Nursing staff now receive a pager when they come on duty and return it to the nurse's desk/nurse when their shift is done. Charge Nurses are expected to track the pagers to ensure nursing assistants are carrying a pager and answering call lights in a timely manner. Charge Nurses were re-educated and are expected to carry pagers at all times. Their pagers go off after 5 minutes. Nurse Managers and the Staffing Coordinator were re-educated and instructed to carry pagers and respond when their pagers go off—after 10 minutes. The DON will receive pages after 15 minutes and the Administrator will receive pages after 20 minutes. The DON and Administrator will respond to the	

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F 550	Continued From page 11 more than one light is activated. During interview on 6/21/18, at 9:38 a.m., R36 indicated he had experienced accidents due to excessive wait times for his call light. When asked how he felt about this, R36 replied, "embarrassed." R36 stated he had waited 45 minutes for staff to return to assist him off the toilet this morning, 6/21/18, and indicated sometimes his legs would fall asleep if he sat too long. Review of the call light log for R36's room on 6/21/18, confirmed the call light was activated at 6:21 a.m. and cleared at 7:04 a.m. (42 minutes later). Review of the facility call light documentation for the dates of 5/22/18 - 6/18/18 documented R36's call light as on for 30 minutes or longer 20 times during this time frame. On 6/6/18, the call light was activated at 8:50 p.m. and cleared at 10:23 p.m. (93 minutes later). During interview on 6/21/18, at 12:55 p.m., NA-A indicated R36 was usually continent of bladder. During interview on 6/21/18, at 1:10 p.m., physical therapist assistant (PTA) indicated R36 needed assistance of one staff as they had been informed he would self transfer at times. During interview on 6/21/18, at 10:13 a.m. the social services director (SS) acknowledged receiving a complaint about R36 call light being on too long on 6/14/18. SS further indicated IDT discussed at morning meeting and identified some problem area's and put a plan into place. The facility call light policy/procedure was requested, none was provided.	F 550	call light and determine why the call light was not answered sooner. Non-Nursing staff have been educated and will be responsible for responding to call lights when they are in the resident wings. They have been educated to answer the call light and if able to fulfill the resident's request, to shut the call light off. If the resident's request cannot be completed by them, they are expected to turn the call light off, and then turn it back on while they find nursing staff to assist the resident. They have also been asked to return to the resident's room to inform the resident that nursing staff have been notified. Pager audits will be completed to ensure staff are carrying and using their pagers. Audits will be done 3 times per week for 2 months, if compliance is good, audits will be reduced to weekly for 2 months, and if compliance continues to be good, audits will be reduced to random monthly audits. The QAPI Committee will review results of the audits and give recommendations as needed. Nursing Meetings were held on July 2nd, 3rd and 12th to educate nursing staff on: Dignity and Neglect, Call Light Policy and Procedure, ADL's related to nail care, excessive toileting times, preventing pressure injuries, hand-washing and changing a brief. An All Staff Meeting is planned for July 19th to review the facility's deficiencies and plan of correction, and new policies and procedures. The Social Worker will review Resident Rights including Respect	

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F 550	Continued From page 12	F 550	and Dignity and how these rights are related to ADL's and other aspects of resident care. The Director of Nursing or designee will review the results of the daily call light response times and complete a report for the monthly QAPI Meetings. Reports will be reviewed by the QAPI Committee and recommendations given as needed. Corrective Actions will be completed by July 30, 2018.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure nail care was provided for 1 of 1 resident (R9) reviewed for activities of daily living, who was dependent upon staff for assistance with grooming. Findings include: R9's quarterly Minimum Data Set (MDS) assessment dated 4/3/18, indicated R9 had severe cognitive impairment, and required extensive assistance with bed mobility, transfer, locomotion on/off unit, toilet use, dressing, and personal hygiene. R9's care plan reviewed 4/22/18 indicated the resident required extensive assistance of 1 staff with personal hygiene.	F 677	F667: ADL Care Provided for Dependent Residents: Resident R9 is resistive to having his nails trimmed and states he does not want them short. Ongoing attempts have been made by multiple nursing staff to trim his nails. Resident was willing to let a NA/R trim two nails only before becoming upset and agitated. Nursing staff will continue to attempt to clean and trim the resident's nails, but the plan may need to be flexible and nursing staff has been instructed to trim and clean as many nails as he allows each day. R9's fingernails will be checked by the NA/R's daily for cleanliness and length during cares. The resident should be asked daily if he will allow staff to trim or	7/30/18

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F 677	Continued From page 13 On 6/18/18, at 2:08 p.m. R9 was observed seated in wheelchair (w/c) on the 200 wing hallway with long soiled fingernails. On 6/19/18, at 9:14 a.m. R9 was observed seated in w/c in the dining room eating breakfast independently. R9 continued to have long soiled fingernails. On 6/20/18, at 9:03 a.m. R9 was observed during morning cares with assistance from nursing assistant (NA)-B. While assisting R9 with washing his face and hands, NA-B observed R9's hands and stated needing to clip his fingernails because they were getting long; the resident agreed. When NA-B completed morning cares for R9 she then assisted the resident to the dining room for breakfast; NA-B did not clip R9's fingernails. During observation and interview in R9's room on 6/21/18, at 11:17 a.m. registered nurse (RN)-D confirmed R9's fingernails were too long and needed to be trimmed. A policy on activities of daily living (ADL's) was requested but not provided.	F 677	clean nails as needed. NA/R's will document refusals and acceptance of nail trimming and cleaning in POC and report acceptance of nail trimming to Charge Nurse or Nurse Manager. Charge Nurses are responsible for checking R9's nails for length and cleanliness daily on the day shift. Nurses will document daily on the TAR and also in PCC if needed. The Nurse Manager will be responsible for ongoing monitoring of R9's nails for cleanliness and trimmed nails at least weekly and more often if there are continued issues. Observations and any follow up that was needed should be documented in PCC. Weekly updates should be given at IDT meetings. NA/R's are expected to check all resident's nails during their weekly shower or bath and trim and clean as needed. The Charge Nurse is responsible for trimming nails for Diabetic residents or other residents that the NA/R's are not allowed to trim. The Charge Nurses are responsible for completing weekly skin checks during the resident's bath or shower and documenting problems or concerns and reporting alterations in skin integrity to the Nurse Manager. The Weekly Skin Sheet has been updated to include a section for the Charge Nurses to check fingernails and document results on the form. Completed forms go to the Nurse Managers. The Nurse Managers are responsible for monitoring the Charge Nurses' compliance with doing the weekly skin	

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F 677	Continued From page 14	F 677	checks and following up as needed. Nurse Managers are responsible for keeping a current list of residents who are resistive to nail care and finding options for completing their nail care. This will be documented on the resident's plan of care. The Nurse Manager or designee will complete audits 2 times per week to ensure resident compliance with their plan of care for nails. Frequency of audits will be decreased when there is substantial compliance. All facility staff will be responsible for doing audits on all residents, including observing for trimmed and clean nails, as assigned by the Director of Nursing or designee. The Director of Nursing will be responsible for monitoring compliance with the audits and preparing monthly reports for QAPI meetings. The audits will be done daily for two weeks and frequency reduced or continued, depending on the results of the audits. After 3 months of substantial compliance, the QAPI Committee will decide on frequency of audits going forward. Nursing Meetings were held on July 2, 3 and 12th to educate nursing staff on Dignity and Neglect, Call Light Policy and Procedure, ADL's, specifically the importance of clean, trimmed nails, excessive toileting times, our plan to prevent future pressure injuries, Infection Control topics, including hand-washing and changing a brief properly. An All Staff Meeting is planned for July 19, 2018 to review deficiencies, our plan of correction and new policies and	

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F 677	Continued From page 15	F 677	procedures. The Social Worker will review Resident Rights, including Respect and Dignity, and talk about how resident rights relate to ADL's and other resident cares and services. Corrective Actions will be completed by 7/30/18.	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide the necessary care and services to prevent the development of pressure ulcers and promote healing of current pressure ulcers for 1 of 3 residents (R9) in the sample reviewed. Findings include: R9's quarterly Minimum Data Set (MDS) assessment dated 4/3/18, indicated R9 had severe cognitive impairment, required extensive	F 686	F686: Treatment and Services to Prevent/Heal Pressure Ulcers/Injuries: Resident R9's Plan of Care has been revised to include interventions to reduce the risk of skin breakdown. Resident has a history of preferring to sit on the toilet for long periods of time—up to 30 minutes, to have a BM. Resident is now taken off the toilet after 15 minutes and re-toileted if needed. Nursing staff are expected to check resident every 15 minutes while on the toilet and document he was checked.	7/30/18

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F 686	Continued From page 16 assistance with bed mobility, transfer, locomotion on/off unit, toilet use, dressing, and personal hygiene, was frequently incontinent of urine, and occasionally incontinent of bowel. R9's care plan last revised 6/5/18, indicated the resident had a history of pressure ulcers. Interventions included: "Encourage resident to lay down after meals. Monitor and report to nurse any changes in skin such as: redness, rash, irritation or open areas. Monitor skin with daily cares and skin assessment per facility protocol. Pressure reducing cushion in chair. 6/5/18-Ordering Roho cushion. Pressure reducing mattress. Reposition and off load every 2 hours." R9's Braden Scale for Predicting Pressure Sore Risk indicated a score of 13, indicating R9 was at moderate risk for skin breakdown. A turning and repositioning assessment was requested but not provided. R9's nursing progress note dated 6/2/18 at 11:00 a.m. indicated: Weekly Skin Check. Skin Assessment: no areas of concern. R9's facility incident report dated 6/4/18, at 15:30 (3:30 p.m.) included: "...found sitting on the toilet at 1530 (3:30 p.m.) by oncoming shift. Had been placed on the toilet in the shower room by first shift at 1320 (1:20 p.m.) and next shift found him sitting there 2 hours later. No report was given that [R9] was on the toilet." The immediate action taken indicated: "[R9] transferred off the toilet with aide of 2 assist and easy stand. Skin to bottom was purple in color but skin was blanchable.	F 686	Resident now has a ROHO cushion and we are waiting for a higher quality air mattress to be shipped. Resident is encouraged to lay down after meals but often refuses. Care plan will be updated as needed. The physician and a wound nurse were consulted about R9'S changing skin condition on his buttocks. The Nursing Management Team agree the resident has poor perfusion on his buttocks and is also at risk for a deep tissue injury. The resident has been placed on the Nurse Manager's weekly wound round list to ensure ongoing monitoring and timely intervention if needed. R9's buttocks will be checked every shift by the Charge Nurse for 2 weeks for indications of pressure injury and ensuring area is blanchable. Results will be documented in PCC. Checks may be reduced after 2 weeks after consultation with the physician. Charge Nurses will measure any discoloration on R9'S buttocks that occur. Measurements will be done at least weekly if discoloration remains for an extended period of time. NA/R's are expected to look at resident's buttocks after every toileting and report results to the Charge Nurse or Nurse Manager for follow-up if there is discoloration or other skin issues. The procedure for shift to shift report has been changed to improve communication between the NA/R's and staff from the previous shift, and also from the Charge Nurses. Nurse Managers are responsible for monitoring compliance with the	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 17 An incident report submitted to the State Agency on 6/4/18 at 16:57 (4:57 p.m.) included: Resident was left on the toilet for undetermined amount of time by the day shift nursing assistants and was found on the toilet by the evening shift nursing assistants. Resident was yelling for help and asked to get off the toilet and go to bed. R9's had a physician order dated 6/5/18 indicating: "Check resident's buttocks every shift for indications of pressure injury and indicate if purple area is blanchable. Document in PCC (point click care)." R9's nursing progress notes indicated the following: - 6/4/18 at 22:18 (10:18 p.m.): Fax sent to the clinic at this time to make provider aware of recent incident with [R9] being left on the toilet for 2 hours. No open areas or redness noted to buttocks. Skin is blanchable. - 6/5/18 at 14:10 (2:10 p.m.): Assessment of buttock; circular area noted on buttocks posterior to scrotum and anterior to coccyx. Area is intact and blanchable. New care plan interventions added. Encourage to lay down after meals, okay to sit on toilet up to 15 minutes at a time, with every 5 minute checks. Nursing to monitor and document area on buttock every shift. Roho cushion will be ordered, Continue to reposition and off load every two hours. - 6/12/18 at 23:26 (11:26 p.m.): Tissue to buttocks is discolored but blanches well. - 6/19/18 at 3:51 a.m.: Resident repositioned every two hours. Skin to bottom is dry, warm and intact. Area to buttock remains blanchable. On 6/20/18, at 9:03 a.m. R9 was observed receiving assistance by nursing assistant (NA)-B	F 686	procedure for shift to shift report and room checks/report done by the NA/R's. Weekly skin checks are done with all residents when they have their weekly bath or shower. A new procedure was put in place to improve compliance for LPN's doing skin checks. See F550. Nursing Assistants have previously been educated and are expected to report changes in skin condition to the Charge Nurse or Nurse Manager and are encouraged to use the nursing assistant's Change of Condition Form. The Director of Nursing will be starting a PIP for QAPI on changes in skin condition. The PIP will include strategies/interventions to prevent future pressure injuries from occurring/originating in the facility. Skin changes or concerns are on the Weekly IDT Agenda. Prevention of new skin injuries or other related issues will be discussed at IDT. New admissions will be assessed by the weekly IDT committee for level of risk for developing a pressure injury and interventions will be initiated upon admission to the facility. Random repositioning and toileting audits will be done at least 5 times per week on different shifts for the next two months by the Charge Nurses and Nurse Managers. The Director of Nursing will be responsible for giving the audit forms to the nurses, tracking results and completing reports for quarterly QAPI Meetings. Nursing Meetings were held on July 2nd , 3rd and 12th to educate nursing staff on Dignity and Neglect, Call Light Policy and	

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	245316	A. BUILDING _____ B. WING _____	06/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 686	Continued From page 18 with morning cares. After toileting, R9 was transferred off the toilet with a standing lift by NA-B and one other staff. Surveyor visualized R9's buttocks; the entire lower portion of the resident's buttocks on either side was a dusky purplish color. Surveyor asked NA-B if this was the area nursing was monitoring. NA-B stated being unsure and would need to check with the nurse. On 6/21/18, at 9:06 a.m. R9 was observed seated in wheelchair (w/c) in his room. R9 was sitting up to a bedside table and was eating his breakfast independently. At 9:44 a.m., R9 remained in his room and continued to work on finishing his breakfast. At 10:28 a.m. R9 continued to sit in his room in w/c. R9 had finished his breakfast, but his breakfast tray remained on the overbed table. At 10:38 a.m. NA-C and NA-D entered R9's room and asked R9 if he needed to use the bathroom and R9 declined. When interviewed on 6/21/18, at 10:42 a.m. NA-D stated they checked the NA shift to shift report form and confirmed the last time R9 was toileted was at 8:03 a.m. NA-C stated she had asked R9 multiple times if he needed to use the bathroom but R9 declined. NA-C further stated the resident was pretty good about letting staff know when he needed to use the bathroom. NA-C confirmed the resident was to be off-loaded every 2 hours but was unsure when this had been completed last as she was not assigned to the resident and would need to check with NA-E. At 10:49 a.m. NA-C checked with NA-E to see when R9 had last been off-loaded. NA-E indicated it was on "the sheet" which NA-C confirmed was the Nursing Assistant Shift to Shift Report Form. NA-C and surveyor reviewed the form which	F 686	Procedure, ADL's, specifically the importance of clean, trimmed nails, excessive toileting times, our plan to prevent future pressure injuries, Infection Control topics, including hand-washing and changing a brief properly. An All Staff Meeting is planned for July 19, 2018 to review deficiencies, our plan of correction and new policies and procedures. The Social Worker will review Resident Rights, including Respect and Dignity, and talk about how Resident Rights are related to ADL's and other aspects of resident care. Corrective actions will be completed by 7/30/18.	

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F 686	Continued From page 19	F 686		

confirmed the last time R9 was off-loaded was at 8:03 a.m. (2 hours and 46 minutes earlier).

When interviewed on 6/21/18, at 10:54 a.m. RN-D stated the discolored area on 19's buttocks had resolved; as of 6/20/18 there was no longer a pressure area visualized per the charting. RN-D stated R9 was still on the red board (nursing communication board) to check the resident's bottom every shift. After the incident on 6/4/18 when R9 was left on the toilet for 2 hours, NA's were now required to fill out a slip to confirm they had checked on R9 every 5 minutes when on the toilet to have a bowel movement and also needed to document that. NA's were also instructed to only keep R9 on the toilet a maximum of 15 minutes and if no success to try again later, and to reposition/off-load every 2 hours. At 6/21/18, at 11:17 a.m. R9 was transferred from his w/c into bed to off-load. RN-D and surveyor visualized the resident's buttocks at that time. The lower half of R9's buttocks were reddened bilaterally; the left buttock also had an area that was a light purplish color. RN-D confirmed R9's buttocks were more reddened than the last time she had observed them. RN-D further indicated when she had first assessed R9's skin after the incident on 6/4/18, the area on the buttocks was purple, "Like a purple crayon". RN-D stated the physician had looked at the area on 6/6/18 after the incident occurred and R9's buttocks were normal skin color. RN-D confirmed R9 should have been repositioned/off-loaded every 2 hours per the plan of care.

When interviewed on 6/21/18, at 2:08 p.m. RN-D confirmed though R9's pressure area on the buttocks was observed daily by nursing staff the area had never been measured. RN-D further

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F 686	Continued From page 20	F 686		

confirmed the charting should have been more descriptive rather than simply that the area was blanchable.

When interviewed on 6/21/18, at 3:03 p.m. RN-D stated she had never considered the discolored area on R9's buttocks a deep tissue injury because the skin had always been blanchable. RN-D further stated they were watching the area closely because the potential was there and "It made me nervous".

When interviewed on 6/21/18, at 3:06 p.m. the director of nursing (DON) confirmed looking at the pressure area on R9's buttocks (resulting from the incident on 6/4/18), as a possible deep tissue injury and took it very seriously. DON stated when the physician observed the area on 6/6/18 he wasn't concerned as it had looked so much better. DON stated at times the resident would like to sit on the toilet for up to 30 minutes when he was trying to have a bowel movement but the extended period of time he was left on the toilet was "inexcusable", and if the staff were doing what they were supposed to be doing now he shouldn't have the purple area returning. DON further stated, "I don't know what it is with [resident first name], but they seem to forget him". Related to the charting surrounding the pressure area, DON confirmed nursing was going by whether the area was blanchable or not and needed to look beyond that, including measuring the area at least weekly.

R9's nursing progress note dated 6/21/18 at 14:35 (2:35 p.m.) indicated: Assessment of buttock; circular area on buttocks posterior to scrotum and anterior to coccyx. Area is intact and blanchable. Right side is slightly red in color

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F 686	Continued From page 21 and measures 12cm (centimeters) x (by) 7cm. Left side measures 12cm x 10cm it is red in color and has a 4 cm x 4 cm area in the center that is light purple. The Policy and Procedure for the Prevention and Treatment of Skin Breakdown, dated 2015, included: Initiate Weekly Wound Documentation Progress Sheet which will include: type of wound, location, date, stage (pressure ulcers only) or indicate partial or full-thickness (arterial, venous, neuropathy/diabetic ulcers), length, width and depth; wound base description, wound edge description and if present: drainage, odor, undermining, tunneling, and /or pain.	F 686		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment	F 880		7/30/18

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F 880	Continued From page 22 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 (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	F 880		

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F 880	Continued From page 23 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 ensure appropriate hand hygiene was followed to prevent the spread of infection for 1 of 1 resident (R9) observed during morning cares. Findings include: R9's quarterly Minimum Data Set (MDS) assessment dated 4/3/18, included a brief interview for mental status (BIMS) score of 5 indicating sever cognitive impairment. The MDS also indicated R9 required extensive assistance from staff with bed mobility, transfer, toilet use, locomotion on/off unit, personal hygiene, and dressing, and was frequently incontinent of urine. The care plan last reviewed 4/22/18, indicated R9 required physical assist of two staff with bed mobility, transfers, and dressing and physical assist of 1 staff with personal hygiene. On 6/20/18, at 9:03 a.m. nursing assistant (NA)-B was observed providing morning cares for R19. NA-B was wearing gloves and provided peri-care to R19, using a wet washcloth and then dried the area with a clean towel. NA-B proceeded to fold up the used washcloth, place it on the bed, and re-attached R19's incontinence brief, then brought the standing lift to the beside, while still wearing the same pair of gloves. NA-B then removed her gloves and left the room, without washing her hands, to obtain assistance to	F 880	F880: Infection Prevention and Control: On 7/2, 7/3 and 7/12, education was done at a Mandatory Nursing Meeting. Education included Infection Control/Handwashing and all nursing staff were expected to demonstrate the proper way to change a brief. Staff unable to attend will be required to demonstrate proficiency in Infection Control areas, including how to change a brief properly and proper use of gloves. Mandatory Relias training includes Infection Control Components—including handwashing and the proper use of gloves. The Policy and Procedure for handling dirty linen in a resident's room will be updated and reviewed with all nursing staff. Random audits will be done by the Charge Nurses, Nurse Managers and Director of Nursing to ensure compliance with Infection Control policies, including the proper handling of soiled linen, brief changes, handwashing, and proper use of gloves. Audits will be done 3 times a week on different shifts for the next 2 months. Results of the audits will be reviewed at QAPI and recommendations for further audits will be discussed. Corrective Actions will be completed by July 30, 2018.	

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F 880	Continued From page 24	F 880		

operate the standing lift. NA-B returned with returned to the room with another staff member to transfer R19 from the bed to the bathroom. NA-B applied a new set of gloves, assisted R19 onto the toilet, turned on the faucet in the bathroom to allow the water to warm up, left the bathroom and proceeded to make R19's bed, pick up the soiled washcloth and some clothing at the bedside, then returned to the bathroom at 9:19 a.m. to finish R19's cares, while still wearing the same pair of gloves. NA-B proceeded to assist R19 back into his chair with the help of a second NA (unidentified) and operated the lift controls while still wearing the soiled gloves. At 9:34 a.m., NA-B assisted R19 with oral cares, still wearing the same pair of gloves.

During interview on 6/20/18, at 9:40 a.m. NA-B stated she had not appropriately removed her gloves and washed her hands after providing peri-care to R19 and before touching other clean objects in his room and providing assistance with oral cares. NA-B further stated the soiled washcloth used for peri care should not have been placed directly on R19's bedding.

During interview on 6/21/18, at 3:06 p.m. the director of nursing (DON) confirmed her expectation would be for NA staff to remove soiled gloves and wash their hands after touching blood or body fluids, and confirmed NA-B should not have set soiled linen on R19's bed.

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	245316	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/19/2018**

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K 000	INITIAL COMMENTS THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey New Richland Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a). Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC) Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/11/2018

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 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. New Richland Care Center is a 1-story building with no basement. The building was constructed at (2) different times. The original building was constructed in 1975 and was determined to be of Type II(111) construction. In 1992, addition was constructed to the New Richland Care Center that was determined to be of Type II(111) construction. Because the original building and the (1) addition are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection 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 census of 48 at the time of the survey.	K 000		

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 311 SS=E	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (19.3.1.1 through 19.3.1.6) This deficient practice could affect the safety of all (24) of the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 10:00 AM and 01:00 PM on 06/19//2018, observations and staff interview revealed the following: Observed during the walk-through inspection - penetrations around escutcheons (Kitchen and Lobby Area ceiling tiles). This deficient practice was confirmed by the	K 311	K311 Vertical Openings – Enclosures Penetrations around escutcheons (Kitchen and Lobby area ceiling tiles) will be closed by the Maintenance Director. Area will be fixed by 7/27/2018. Bi yearly building inspection will be started to check for openings in panels in ceiling.	7/27/18

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K 311	Continued From page 3 Facility Maintenance Director at the time of discovery.	K 311		
K 511 SS=E	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2) This deficient practice could affect the safety of all (48) of the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 10:00 AM and 01:00 PM on 06/19//2018, observations and staff interview revealed the following: Observed during the walk-through inspection of the 1st Floor - electrical panels in resident corridors were unsecured This deficient practice was confirmed by the Facility Maintenance Director at the time of	K 511	K511 Utilities – Gas and electric Electrical Panels in resident corridor are locked. Maintenance Director found key and locked all panels in resident corridor. They will be kept locked at all times. Prior Director did not lock them. We will add to TELS to do bi-yearly inspection to check they are locked. This was fixed already by 7/10/2018.	7/10/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245316	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/19/2018**

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

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K 511	Continued From page 4 discovery.	K 511		
K 712 SS=D	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (19.7.1.4 through 19.7.1.7) This deficient practice could affect the safety of all (48) of the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 10:00 AM and 01:00 PM on 06/19//2018, observation and documenttion review revealed the following: During documentation review, information was not found for a fire drill: 3rd Shift (3rd Quarter - Jul - Sep) This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 712	K712 Missed Fire Drill They missed drill was from prior Maintenance Director and was in paper binder which might have been dropped. We will add to TELS and track electronically. Finished by 7/27/2018.	7/27/18

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K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (6.3.4 (NFPA 99)) This deficient practice could affect the safety of all (48) of the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 10:00 AM and 01:00 PM on 06/19//2018, observations and documentation review revealed the following:	K 914	K914 Electrical Systems – Maintenance and Testing We ordered a tool for testing Hospital grade receptacles. All receptacles in building will be tested once in and we will add to the TELS to check them all yearly. Plan to be finished by 7/27/2018 unless tool does not come in right away	7/27/18

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	245316	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/19/2018**

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K 914	Continued From page 6 During documentation review no information was provided regarding receptacle testing. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 914		
K 915 SS=D	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Categories *Critical care rooms (Category 1) in which electrical system failure is likely to cause major injury or death of patients, including all rooms where electric life support equipment is required, are served by a Type 1 EES. *General care rooms (Category 2) in which electrical system failure is likely to cause minor injury to patients (Category 2) are served by a Type 1 or Type 2 EES. *Basic care rooms (Category 3) in which electrical system failure is not likely to cause injury to patients and rooms other than patient care rooms are not required to be served by an EES. Type 3 EES life safety branch has an alternate source of power that will be effective for 1-1/2 hours. 3.3.138, 6.3.2.2.10, 6.6.2.2.2, 6.6.3.1.1 (NFPA 99), TIA 12-3 This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (3.3.138, 6.3.2.2.10, 6.6.2.2.2, 6.6.3.1.1 (NFPA 99), TIA 12-3) This deficient practice could affect the safety of all (1) of the residents, staff and visitors within the smoke compartment/ Facility.	K 915	K915 Electrical Systems – Essential electric Systems An emergency E-stop was added to the outside of the generator on 7/3/2018	7/3/18

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K 915	Continued From page 7 Findings Include: On facility tour between 10:00 AM and 01:00 PM on 06/19//2018, observations and staff interview revealed the following: Observed during the walk-through inspection of the facility - the emergency generator did not have an externally mounted E-stop (emergency stop) button This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 915		
K 918 SS=D	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder	K 918		7/27/18

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K 918	Continued From page 8 circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)) This deficient practice could affect the safety of all (1) of the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 10:00 AM and 01:00 PM on 06/19//2018, observations and staff interview revealed the following: Observed during documentation review - no records were available associated to weekly inspections of the emergency generator This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 918	K918 Electrical Systems – Essential electric Systems We added TELs weekly inspection of generator. Started immediatel	

Electronically delivered
July 3, 2018

Mr. Larry Passel, Administrator
New Richland Care Center
312 Northeast 1st Street
New Richland, MN 56072

Re: State Nursing Home Licensing Orders - Project Number S5316027

Dear Mr. Passel:

The above facility was surveyed on June 18, 2018 through June 21, 2018 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . 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 contact Holly Kranz, Unit Supervisor at (507) 344-2742 or at holly.kranz@state.mn.us.

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 note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

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 _____	06/21/2018

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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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: 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 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. On dates, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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. 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.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 905	MN Rule 4658.0525 Subp. 4 Rehab - Positioning Subp. 4. Positioning. Residents must be positioned in good body alignment. The position of residents unable to change their own position must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide the necessary care and services to prevent the development of pressure ulcers and promote healing of current pressure ulcers for 1 of 3 residents (R9) in the sample reviewed. Findings include: R9's quarterly Minimum Data Set (MDS) assessment dated 4/3/18, indicated R9 had severe cognitive impairment, required extensive assistance with bed mobility, transfer, locomotion on/off unit, toilet use, dressing, and personal hygiene, was frequently incontinent of urine, and occasionally incontinent of bowel. R9's care plan last revised 6/5/18, indicated the resident had a history of pressure ulcers.	2 905	corrected	7/30/18

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2 905	Continued From page 3 Interventions included: "Encourage resident to lay down after meals. Monitor and report to nurse any changes in skin such as: redness, rash, irritation or open areas. Monitor skin with daily cares and skin assessment per facility protocol. Pressure reducing cushion in chair. 6/5/18-Ordering Roho cushion. Pressure reducing mattress. Reposition and off load every 2 hours." R9's Braden Scale for Predicting Pressure Sore Risk indicated a score of 13, indicating R9 was at moderate risk for skin breakdown. A turning and repositioning assessment was requested but not provided. R9's nursing progress note dated 6/2/18 at 11:00 a.m. indicated: Weekly Skin Check. Skin Assessment: no areas of concern. R9's facility incident report dated 6/4/18, at 15:30 (3:30 p.m.) included: "...found sitting on the toilet at 1530 (3:30 p.m.) by oncoming shift. Had been placed on the toilet in the shower room by first shift at 1320 (1:20 p.m.) and next shift found him sitting there 2 hours later. No report was given that [R9] was on the toilet." The immediate action taken indicated: "[R9] transferred off the toilet with aide of 2 assist and easy stand. Skin to bottom was purple in color but skin was blanchable. An incident report submitted to the State Agency on 6/4/18 at 16:57 (4:57 p.m.) included: Resident was left on the toilet for undetermined amount of time by the day shift nursing assistants and was found on the toilet by the evening shift nursing assistants. Resident was yelling for help and asked to get off the toilet and go to bed.	2 905		

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2 905	Continued From page 4 R9's had a physician order dated 6/5/18 indicating: "Check resident's buttocks every shift for indications of pressure injury and indicate if purple area is blanchable. Document in PCC (point click care)." R9's nursing progress notes indicated the following: - 6/4/18 at 22:18 (10:18 p.m.): Fax sent to the clinic at this time to make provider aware of recent incident with [R9] being left on the toilet for 2 hours. No open areas or redness noted to buttocks. Skin is blanchable. - 6/5/18 at 14:10 (2:10 p.m.): Assessment of buttock; circular area noted on buttocks posterior to scrotum and anterior to coccyx. Area is intact and blanchable. New care plan interventions added. Encourage to lay down after meals, okay to sit on toilet up to 15 minutes at a time, with every 5 minute checks. Nursing to monitor and document area on buttock every shift. Roho cushion will be ordered, Continue to reposition and off load every two hours. - 6/12/18 at 23:26 (11:26 p.m.): Tissue to buttocks is discolored but blanches well. - 6/19/18 at 3:51 a.m.: Resident repositioned every two hours. Skin to bottom is dry, warm and intact. Area to buttock remains blanchable. On 6/20/18, at 9:03 a.m. R9 was observed receiving assistance by nursing assistant (NA)-B with morning cares. After toileting, R9 was transferred off the toilet with a standing lift by NA-B and one other staff. Surveyor visualized R9's buttocks; the entire lower portion of the resident's buttocks on either side was a dusky purplish color. Surveyor asked NA-B if this was the area nursing was monitoring. NA-B stated being unsure and would need to check with the nurse.	2 905		

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2 905	Continued From page 5 On 6/21/18, at 9:06 a.m. R9 was observed seated in wheelchair (w/c) in his room. R9 was sitting up to a bedside table and was eating his breakfast independently. At 9:44 a.m., R9 remained in his room and continued to work on finishing his breakfast. At 10:28 a.m. R9 continued to sit in his room in w/c. R9 had finished his breakfast, but his breakfast tray remained on the overbed table. At 10:38 a.m. NA-C and NA-D entered R9's room and asked R9 if he needed to use the bathroom and R9 declined. When interviewed on 6/21/18, at 10:42 a.m. NA-D stated they checked the NA shift to shift report form and confirmed the last time R9 was toileted was at 8:03 a.m. NA-C stated she had asked R9 multiple times if he needed to use the bathroom but R9 declined. NA-C further stated the resident was pretty good about letting staff know when he needed to use the bathroom. NA-C confirmed the resident was to be off-loaded every 2 hours but was unsure when this had been completed last as she was not assigned to the resident and would need to check with NA-E. At 10:49 a.m. NA-C checked with NA-E to see when R9 had last been off-loaded. NA-E indicated it was on "the sheet" which NA-C confirmed was the Nursing Assistant Shift to Shift Report Form. NA-C and surveyor reviewed the form which confirmed the last time R9 was off-loaded was at 8:03 a.m. (2 hours and 46 minutes earlier). When interviewed on 6/21/18, at 10:54 a.m. RN-D stated the discolored area on 19's buttocks had resolved; as of 6/20/18 there was no longer a pressure area visualized per the charting. RN-D stated R9 was still on the red board (nursing communication board) to check the resident's bottom every shift. After the incident on 6/4/18	2 905		

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2 905	Continued From page 6 when R9 was left on the toilet for 2 hours, NA's were now required to fill out a slip to confirm they had checked on R9 every 5 minutes when on the toilet to have a bowel movement and also needed to document that. NA's were also instructed to only keep R9 on the toilet a maximum of 15 minutes and if no success to try again later, and to reposition/off-load every 2 hours. At 6/21/18, at 11:17 a.m. R9 was transferred from his w/c into bed to off-load. RN-D and surveyor visualized the resident's buttocks at that time. The lower half of R9's buttocks were reddened bilaterally; the left buttock also had an area that was a light purplish color. RN-D confirmed R9's buttocks were more reddened than the last time she had observed them. RN-D further indicated when she had first assessed R9's skin after the incident on 6/4/18, the area on the buttocks was purple, "Like a purple crayon". RN-D stated the physician had looked at the area on 6/6/18 after the incident occurred and R9's buttocks were normal skin color. RN-D confirmed R9 should have been repositioned/off-loaded every 2 hours per the plan of care. When interviewed on 6/21/18, at 2:08 p.m. RN-D confirmed though R9's pressure area on the buttocks was observed daily by nursing staff the area had never been measured. RN-D further confirmed the charting should have been more descriptive rather than simply that the area was blanchable. When interviewed on 6/21/18, at 3:03 p.m. RN-D stated she had never considered the discolored area on R9's buttocks a deep tissue injury because the skin had always been blanchable. RN-D further stated they were watching the area closely because the potential was there and "It made me nervous".	2 905		

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2 905	Continued From page 7 When interviewed on 6/21/18, at 3:06 p.m. the director of nursing (DON) confirmed looking at the pressure area on R9's buttocks (resulting from the incident on 6/4/18), as a possible deep tissue injury and took it very seriously. DON stated when the physician observed the area on 6/6/18 he wasn't concerned as it had looked so much better. DON stated at times the resident would like to sit on the toilet for up to 30 minutes when he was trying to have a bowel movement but the extended period of time he was left on the toilet was "inexcusable", and if the staff were doing what they were supposed to be doing now he shouldn't have the purple area returning. DON further stated, "I don't know what it is with [resident first name], but they seem to forget him". Related to the charting surrounding the pressure area, DON confirmed nursing was going by whether the area was blanchable or not and needed to look beyond that, including measuring the area at least weekly. R9's nursing progress note dated 6/21/18 at 14:35 (2:35 p.m.) indicated: Assessment of buttock; circular area on buttocks posterior to scrotum and anterior to coccyx. Area is intact and blanchable. Right side is slightly red in color and measures 12cm (centimeters) x (by) 7cm. Left side measures 12cm x 10cm it is red in color and has a 4 cm x 4 cm area in the center that is light purple. The Policy and Procedure for the Prevention and Treatment of Skin Breakdown, dated 2015, included: Initiate Weekly Wound Documentation Progress Sheet which will include: type of wound, location, date, stage (pressure ulcers only) or indicate partial or full-thickness (arterial, venous, neuropathy/diabetic ulcers), length, width	2 905		

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2 905	Continued From page 8 and depth; wound base description, wound edge description and if present: drainage, odor, undermining, tunneling, and /or pain. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 905		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure nail care was provided for 1 of 1 resident (R9) reviewed for activities of daily living, who was dependent upon staff for assistance with grooming. Findings include:	2 920	corrected	7/30/18

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2 920	Continued From page 9 R9's quarterly Minimum Data Set (MDS) assessment dated 4/3/18, indicated R9 had severe cognitive impairment, and required extensive assistance with bed mobility, transfer, locomotion on/off unit, toilet use, dressing, and personal hygiene. R9's care plan reviewed 4/22/18 indicated the resident required extensive assistance of 1 staff with personal hygiene. On 6/18/18, at 2:08 p.m. R9 was observed seated in wheelchair (w/c) on the 200 wing hallway with long soiled fingernails. On 6/19/18, at 9:14 a.m. R9 was observed seated in w/c in the dining room eating breakfast independently. R9 continued to have long soiled fingernails. On 6/20/18, at 9:03 a.m. R9 was observed during morning cares with assistance from nursing assistant (NA)-B. While assisting R9 with washing his face and hands, NA-B observed R9's hands and stated needing to clip his fingernails because they were getting long; the resident agreed. When NA-B completed morning cares for R9 she then assisted the resident to the dining room for breakfast; NA-B did not clip R9's fingernails. During observation and interview in R9's room on 6/21/18, at 11:17 a.m. registered nurse (RN)-D confirmed R9's fingernails were too long and needed to be trimmed. A policy on activities of daily living (ADL's) was requested but not provided.	2 920		

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2 920	Continued From page 10 SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could educate responsible staff to provide care to residents' dependant on facility staff, based on residents' comprehensively assessed needs. The DON or designee could conduct audits of dependent resident cares to ensure their personal hygiene needs are met consistently. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
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 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	21426		7/30/18

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21426	Continued From page 11 by: Based on interview and document review, the facility failed to ensure 1 of 5 new employees hired (RN)-C received a two-step mantoux upon hire. Findings include: Registered nurse (RN)-C date of hire was 5/1/18. RN-C employee health file include a serial screening for health care workers completed on 10/20/17, which indicated she had a negative two step tuberculin skin test (TST) on 10/20/17, and 10/27/17 (over six months previous to her date of hire). No further TST results were on file. During interview on , the director of nursing (DON) confirmed RN-C should have been given a TST upon hire as the prior TST result was documented more than 90 days before hire. The facility policy, last revised 3/2017 indicated: 3. Previous documented negative TST results less than 12 months before employment, single TST needed for baseline testing; this will be the second step. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review and revise procedures related to tuberculin skin testing, and ensure all responsible staff are educated on the new procedures. The director of nursing could audit current employee health files to ensure all staff are in compliance with TST skin testing periodically, and report results to the quality assurance committee for recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one	21426	corrected	

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21426	Continued From page 12 (21) days.	21426		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 residents (R36) reviewed for dignity received assistance to the bathroom in a timely manner. Findings include: R36's Electronic medical record dated 4/2/18, included diagnoses of: cerebral infarction, congestive heart failure, polyneuropathy, type two diabetes, benign prostatic hyperplasia, hypertension and history of falling. R36's 60 day Minimum Data Set (MDS) assessment, dated 5/28/18, indicated R36's cognition was intact. The MDS activities of daily living (ADL) assessment further indicated R36 required extensive assistance of two for bed mobility, transfers, and toileting and was continent of bowel and bladder. R36's care plan, dated 4/11/18, indicated a history of incontinence and required assistance of one for toileting. The care plan further indicated R36 was at high risk for falls, impulsive and would	21805	corrected	7/30/18

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21805	Continued From page 13 attempt self-transfer. During interview on 6/20/18, at 8:55 a.m., registered nurse (RN)-B stated R36 complained of his call light not being answered quickly enough. RN-B further stated R36 had a near miss fall when he self transferred due to an extended wait for his call light to be answered. RN-B stated she had reported R36's complaint to management. During interview with nursing assistant (NA)-A on 6/21/18, at 9:03 a.m. NA-A described the function of the call light system as: NA's have pagers that vibrate when call light is activated. If they did not answer within 45 minutes the charge nurse pager vibrated, if the light was not answered after ten minutes then the office nurse pager vibrated, if the light was still not answered after twenty minutes then the director of nursing and the administrator's pager went off. NA-A further stated due to how the system is set up there was no way to determine who's light comes on first if more than one light is activated. During interview on 6/21/18, at 9:38 a.m., R36 indicated he had experienced accidents due to excessive wait times for his call light. When asked how he felt about this, R36 replied, "embarrassed." R36 stated he had waited 45 minutes for staff to return to assist him off the toilet this morning, 6/21/18, and indicated sometimes his legs would fall asleep if he sat too long. Review of the call light log for R36's room on 6/21/18, confirmed the call light was activated at 6:21 a.m. and cleared at 7:04 a.m. (42 minutes later). Review of the facility call light documentation for the dates of 5/22/18 - 6/18/18 documented R36's	21805		

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21805	Continued From page 14 call light as on for 30 minutes or longer 20 times during this time frame. On 6/6/18, the call light was activated at 8:50 p.m. and cleared at 10:23 p.m. (93 minutes later). During interview on 6/21/18, at 12:55 p.m., NA-A indicated R36 was usually continent of bladder. During interview on 6/21/18, at 1:10 p.m., physical therapist assistant (PTA) indicated R36 needed assistance of one staff as they had been informed he would self transfer at times. During interview on 6/21/18, at 10:13 a.m. the social services director (SS) acknowledged receiving a complaint about R36 call light being on too long on 6/14/18. SS further indicated IDT discussed at morning meeting and identified some problem area's and put a plan into place. The facility call light policy/procedure was requested, none was provided. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could revise and implement a plan of care by the interdisciplinary team to ensure residents dignity is being maintained. The facility could update policies and procedures on call light response practices, educate staff on these changes, and audit periodically to ensure resident(s) dignity are maintained. Call light response time audits could be completed, and results of these audits are reviewed by the quality assessment and performance improvement (QAPI) committee could ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		