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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: EBZN

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: **7** (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 **5/23/2016** (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:

x A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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: A (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 :
Kathryn Serie, Unit Supervisor 05/27/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 6/6/2016 (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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245316

June 6, 2016

Mr. Donald Alexander, Administrator
New Richland Care Center
312 Northeast 1st Street
New Richland, MN 56072

Dear Mr. Alexander:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective May 18, 2016 the above facility is certified for:

50 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 50 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 27, 2016

Mr. Donald Alexander, Administrator
New Richland Care Center
312 Northeast 1st Street
New Richland, MN 56072

RE: Project Number S5316025 and Complaint H5316010

Dear Mr. Alexander:

On April 15, 2016, we informed you that the following Category 1 remedy was being imposed:

- State Monitoring effective April 19, 2016. (42 CFR 488.422)

In addition, on April 15, 2016 the department recommended to the CMS Region V office that the following enforcement remedy be imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective May 25, 2016. (42 CFR 488.417 (b))

Further, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 25, 2016.

This was based on the deficiencies cited by the Minnesota Departments of Health, Office of Health Facility Complaints for an abbreviated standard survey completed on February 25, 2016 and on the deficiencies cited by the Departments of Health and Public Safety for a standard survey completed on March 31, 2016 and lack of verification of substantial compliance with the health deficiencies at the time of our April 15, 2016 notice. The most serious health deficiencies in your facility at the time of the surveys were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On April 28, 2016 a Post Certification Revisit (PCR) was completed by this Department's Office of Health Facility Complaints and on May 4, 2016 and May 23, 2016 a PCR by review of your plan of correction was completed by the Departments of Health and Public Safety to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an abbreviated standard survey, completed on February 25, 2016 and the standard survey completed on

March 31, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 18, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to the abbreviated standard survey, completed on February 25, 2016 and standard survey completed on March 31, 2016, as of May 18, 2016.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of April 15, 2016. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective May 25, 2016, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective May 25, 2016, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective May 25, 2016, is to be rescinded.

In our letter of April 15, 2016, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 25, 2016, due to denial of payment for new admissions. Since your facility attained substantial compliance on May 18, 2016, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245316 Y1	A. Building B. Wing Y2	5/23/2016 Y3

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

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0225	Correction	ID Prefix F0226	Correction	ID Prefix F0309	Correction
Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - (4)	Completed	Reg. # 483.13(c)	Completed	Reg. # 483.25	Completed
LSC	05/05/2016	LSC	05/05/2016	LSC	05/18/2016
ID Prefix F0314	Correction	ID Prefix F0322	Correction	ID Prefix F0323	Correction
Reg. # 483.25(c)	Completed	Reg. # 483.25(g)(2)	Completed	Reg. # 483.25(h)	Completed
LSC	05/18/2016	LSC	05/18/2016	LSC	04/01/2016
ID Prefix F0334	Correction	ID Prefix F0356	Correction	ID Prefix F0441	Correction
Reg. # 483.25(n)	Completed	Reg. # 483.30(e)	Completed	Reg. # 483.65	Completed
LSC	05/18/2016	LSC	04/01/2016	LSC	05/18/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	KS/kfd	05/26/2016	03048	5/23/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
3/31/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245316 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	5/4/2016 Y3

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

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed
LSC	K0025	04/19/2016	LSC	K0069	04/19/2016	LSC	K0154	04/28/2016
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #		Completed	Reg. #		Completed
LSC	K0155	04/28/2016	LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	TL/kfd	05/26/2016	37008	5/4/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
3/30/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: EBZN

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 **03/31/2016** (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 :
Wendy Buckholz, HFE NE II 04/26/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 05/20/2016 (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

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

April 15, 2016

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

RE: Project Number S5316025

Dear Mr. Alexander:

On March 3, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by the Minnesota Department of Health, Office of Health Facility Complaints for an abbreviated standard survey, completed on February 25, 2016. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On March 31, 2016, the Minnesota Departments of Health and Public Safety completed a standard survey to verify that your facility had achieved and maintained compliance with federal certification deficiencies. This standard survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required. As a result of our finding that the facility has not achieved substantial compliance. This Department is imposing the following Category 1 remedy:

- State Monitoring effective April 19, 2016. (42 CFR 488.422)

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective May 25, 2016. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective May 25, 2016. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 25, 2016. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, New Richland Care Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective May 25, 2016. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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 a "F" tag, from **the survey completed February 25, 2016**), i.e., the plan of correction should be directed to:

Michelle Ness, Investigation Unit Supervisor
Office of Health Facility Complaints
Health Regulation Division
Telephone: (651) 201-4217
Fax: (651) 281-9796

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag, from **the survey completed March 31, 2016**), i.e., the plan of correction should be directed to:

Kathryn Serie, Unit Supervisor
Health Regulation Division
Minnesota Department of Health
1400 E. Lyon Street
Marshall, Minnesota 56258
Kathryn.serie@state.mn.us
Office: (507) 476-4233
Fax: (507) 537-7194

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. 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit 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.than the latest correction date on the ePoC.

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 May 25, 2016 (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 August 25, 2016 (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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Jan.Suzuki@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division

330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Jan Suzuki, Principal Program Representative by phone at (312)886-5209 or by e-mail at Jan.Suzuki@cms.hhs.gov .

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
444 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, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

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 _____	03/31/2016

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
F 000	INITIAL COMMENTS 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 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).	F 225		5/5/16

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

Electronically Signed | 04/25/2016

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	Continued From page 1 The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report allegations of abuse to the administrator and designated State agency and thoroughly investigate the allegations for 2 of 5 resident reports (R27, R17) reviewed. Findings include: The facility failed to notify the administrator and State agency immediately and failed to thoroughly investigate an allegation of maltreatment/abuse for R27. Review of an incident report for R27, dated 9/18/15, revealed a nursing description: "CNA [nursing assistant] was assisting resident into shower in the [hallway] shower room. CNA came out and told RN [registered nurse] that resident had 2 skin tears on left upper arm above the elbow. 'They were there when we undressed her.' The skin tears are--lower 1.6 cm [centimeters]	F 225	1. R27 and R17 were not found to have been negatively affected by this practice. Employees were trained on our abuse policy and on the need to immediately report all incidents to the administrator and Director of Nursing on March 15, 18 and April 13. 2. A review of all allegations of abuse found that no other residents have been negatively affected by this practice. 3. The Social Worker and Director of Nursing are now able to do an initial report all allegations of abuse from their home if needed after receiving the details of the incident from the facility in order to immediately report all allegations of abuse. Investigations will now include the complete name of staff, date and time of the interview along with full statements of	

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F 225	Continued From page 2 and 1 cm and the upper 2.3 x 1 cm and they are in the shape of triangles. Review of the resident description revealed 'All the bruising and these skin tears are from fingernails and people grabbing me hard.' Resident then grabber [sic] her left forearm enough to make indents in edema to show RN how she is grabbed." The incident report did not indicate a date and time the administrator was notified of the incident. Review of the incident report submitted to the State agency revealed the allegation of mistreatment reported by R27 on 9/18/15 was reported to the State agency on 9/21/15. The investigative report, submitted to the state on 9/27/15, and accompanying investigative documents include interviews from staff. However, the complete name of staff, date and time of interview and full statements of staff were not documented for all interviews. No other resident interviews were completed or documented regarding their experiences of staff treatment of them during cares to ascertain if residents on the unit were experiencing similar concerns. On 3/31/16, at 9:19 a.m. the director of social services (DSS) and administrator reported nursing assistants and nurses were interviewed regarding the incident. Notes were taken of the interviews. However, the notes did not include the complete names of staff, date and time of interview and full statements of staff. No other residents were interviewed regarding their experiences of staff treatment of them during cares to ascertain if residents on the unit were experiencing similar concerns. The DSS and administrator reported the administrator may not have been notified until the interdisciplinary team	F 225	staff. In addition, during the investigative process, Social Services will interview other residents as needed to determine if others have experienced similar treatment. 4. All incidents will be audited the next business day to determine if policy was followed and if further action needs to be taken. The results of these audits will be discussed at the next 6 monthly QAIP meeting.	

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F 225	Continued From page 3	F 225		

reviewed the incident on 9/21/15. The DSS and the administrator confirmed the State agency was not notified of the incident until 9/21/15.

The facility failed to immediately notify the State agency of an allegation and observation of potential exploitation and mistreatment of R17 by a facility visitor, (V)-A.

An incident report dated 8/25/15, revised 8/27/15 revealed V-A unexpectedly visited R17 in her room. R17 was heard yelling at V-A to "get out of my room". Review of the incident report and progress notes, dated 8/25/15 through 8/27/15 revealed the facility (including the director of nursing DON, administrator and DSS) were informed on 8/25/16 by R17 and V-A about allegations of financial exploitation committed by V-A against R17. V-A was at the facility to confront R17 about these allegations and a verbal altercation occurred. R17 reported to staff she did not feel safe at the facility. A review of the incident report submitted to the State agency, dated 8/27/15 revealed the facility did not notify the State agency of the 8/25/15 incident and allegations until 8/27/15 (2 days later).

On 3/31/16, the DSS and administrator confirmed the allegation and incident of potential exploitation and mistreatment involving R17 was not immediately reported to the State agency.

The Vulnerable Adult Reporting for New Richland Care Center, undated, directed staff :
"We need to report Vulnerable Adult incidents to [name of administrator] administrator immediately and to the Minnesota Department of Health electronically." and "Who ever starts the incident, or has it reported to them, should be the Nurse in

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F 225	Continued From page 4 Charge of The Resident or RN on Duty or on call can assist you with the process, if Administrator, Director of Nursing or Social Services are not present in the building. You need to start the investigation as well, talk to the residents involved, staff witnesses, etc. Please do not pass it on to someone else coming on duty. If you were here at the time the incident happened, you need to start the process. Please remember we have to report this immediately or as soon as were are able, after the resident is safe to the Minnesota Department of Health, and then we have 5 days to investigate and send this in, which will be done by [name of administrator, DON and DSS]." The policy further directed staff "All reports of resident abuse, neglect, injuries of unknown source, resident to resident abuse and resident to staff abuse are promptly and thoroughly investigated by facility management." Steps of investigation included: "7. Interview the staff. Use the Incident Witness Interview Form." and "You need to complete the interviewing and record their statements rather than allowing them to write the statement. This gives you a chance to ask questions that may help determine the cause. This should include the person who reported the incident and other staff working at the time the incident occurred." and "b. Interview other residents that the accused employee has provided care to determine if they have a complaint about the employee."	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226		5/5/16

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F 226	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement their policy related to immediate reporting allegations of abuse to the administrator and State agency and thoroughly investigating allegations for 2 of 5 resident reports (R27, R17) reviewed. Findings include: The Vulnerable Adult Reporting for New Richland Care Center, undated, directed staff : "We need to report Vulnerable Adult incidents to [name of administrator] administrator immediately and to the Minnesota Department of Health electronically." and "Who ever starts the incident, or has it reported to them, should be the Nurse in Charge of The Resident or RN on Duty or on call can assist you with the process, if Administrator, Director of Nursing or Social Services are not present in the building. You need to start the investigation as well, talk to the residents involved, staff witnesses, etc. Please do not pass it on to someone else coming on duty. If you were here at the time the incident happened, you need to start the process. Please remember we have to report this immediately or as soon as were are able, after the resident is safe to the Minnesota Department of Health, and then we have 5 days to investigate and send this in, which will be done by [name of administrator, DON and DSS]." The policy further directed staff "All reports of resident abuse, neglect, injuries of unknown source, resident to resident abuse and resident to staff abuse are promptly and thoroughly investigated	F 226	1. R27 and R17 were not found to have been negatively affected by this practice. Employees were trained on our abuse policy and on the need to immediately report all incidents to the administrator and Director of Nursing on March 15, 18 and April 13. 2. A review of all allegations of abuse found that no other residents have been negatively affected by this practice. 3. The Social Worker and Director of Nursing are now able to do an initial report all allegations of abuse from their home if needed after receiving the details of the incident from the facility in order to immediately report all allegations of abuse. Investigations will now include the complete name of staff, date and time of the interview along with full statements of staff. In addition, during the investigative process, Social Services will interview other residents as needed to determine if others have experienced similar treatment. 4. All incidents will be audited the next business day to determine if policy was followed and if further action needs to be taken. The results of these audits will be discussed at the next 6 monthly QAIP meeting.	

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F 226	Continued From page 6	F 226		

by facility management." Steps of investigation included: "7. Interview the staff. Use the Incident Witness Interview Form." and "You need to complete the interviewing and record their statements rather than allowing them to write the statement. This gives you a chance to ask questions that may help determine the cause. This should include the person who reported the incident and other staff working at the time the incident occurred." and "b. Interview other residents that the accused employee has provided care to determine if they have a complaint about the employee."

The facility failed to notify the administrator and State agency immediately and thoroughly investigate an allegation of physical abuse for R27.

Review of an incident report for R27, dated 9/18/15, revealed a nursing description: "CNA [nursing assistant] was assisting resident into shower in the [hallway] shower room. CNA came out and told RN [registered nurse] that resident had 2 skin tears on left upper arm above the elbow. 'They were there when we undressed her.' The skin tears are Lower 1.6 cm [centimeters] and 1 cm and the upper 2.3 x 1 cm and they are in the shape of triangles." Review of the resident description revealed "'All the bruising and these skin tears are from fingernails and people grabbing me hard.' Resident then grabber [sic] her left forearm enough to make indents in edema to show RN how she is grabbed." The incident report did not indicate a date and time the administrator was notified of the incident.

Review of the incident report submitted to the State agency revealed the allegation of

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F 226	Continued From page 7	F 226		

mistreatment reported by R27 on 9/18/15 was reported to the state agency on 9/21/15. The investigative report, submitted to the State on 9/27/15, and accompanying investigative documents include interviews from staff. However, the complete name of staff, date and time of interview and full statements of staff were not documented for all interviews. No other resident interviews were completed or documented regarding their experiences of staff treatment of them during cares to ascertain if residents on the unit were experiencing similar concerns.

On 3/31/16 at 9:19 a.m. the director of social services (DSS) and administrator reported nursing assistants and nurses were interviewed regarding the incident. Notes were taken of the interviews. However, the notes did not include the complete name of staff, date and time of interview and full statements of staff. No other residents were interviewed regarding their experiences of staff treatment of them during cares to ascertain if residents on the unit were experiencing similar concerns. The DSS and administrator reported the administrator may not have been notified until the interdisciplinary team reviewed the incident on 9/21/15. The DSS and the administrator confirmed the state agency was not notified of the incident until 9/21/15.

The facility failed to immediately notify the state agency of an allegation and observation of potential exploitation and mistreatment of R17 by a facility visitor, (V)-A.

An incident report, dated 8/25, revised 8/27/15 revealed V-A unexpectedly visited R17 in her room. R17 was heard yelling at V-A to "'get out of

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F 226	Continued From page 8 my room'" Review of the incident report and progress notes, dated 8/25/15 through 8/27/15 revealed the facility (including the director of nursing (DON, administrator and DSS) were informed on 8/25/16 by R17 and V-A about allegations of financial exploitation committed by V-A against R17. V-A was at the facility to confront R17 about these allegations and a verbal altercation occurred. R17 reported to staff she did not feel safe at the facility. A review of the incident report submitted to the state, dated 8/27/15 revealed the facility did not notify the state agency of the 8/25/15 incident and allegations until 8/27/15. On 3/31/16 the DSS and administrator confirmed the allegation and incident of potential exploitation and mistreatment involving R17 was not immediately reported to the State agency.	F 226		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure neurological checks were completed after a fall with a possible head injury for 1 of 1 resident (R39) reviewed for accidents with falls.	F 309	1. Resident 39 was assessed and found to have not suffered neurologically as a result of this incident. 2. No other residents were found to have	5/18/16

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F 309	Continued From page 9 Findings include: R39's face sheet, dated 3/31/16 identified active diagnoses of heart failure and major depressive disorder. R39's admission Minimum Data Set (MDS), dated 2/22/16 identified R39 required extensive assistance of two staff for transfers and bed mobility. R39's Care Area Assessment (CAA) dated 3/6/16, indicated R39 had a risk of falls related to impaired mobility, and her family stated she had not fallen recently. The CAA indicated falls interventions should be care planned. R39's care plan last revised 3/11/16, indicated R39 was at risk for falls r/t (related to) unaware of safety needs, poor communication/comprehension, gait/balance problems and incontinence. Review of R39's incident reports included two falls, one on 3/23/16 out of bed which was unwitnessed and a second fall on 3/26/16. The 3/23/16 incident report indicated R39 had been found lying on the floor next to her bed and did not indicate whether neurological checks were started. No obvious obvious injuries were noted with the fall, R39 stated "I fell," but could not provide any further information about why she had fallen. The 3/26/16 incident report indicated R39 was found on the floor next to her bed and was unable to state why she fell. The report indicated passive range of motion was performed with no indications of pain in the extremities. The report further indicated R39 sustained facial	F 309	been affected by this practice. 3. Nurses will be re-trained on the falls policy which involves possible head injury by the DON on May 18th. All incidents involving potential head injuries will have neurological checks initiated by the charge nurse on duty at the time of the incident in accordance with our policy. All incidents involving possible head injuries will be audited by the DON or her designee to ensure neurological checks are performed per policy. 4. The DON or her designee will review the result of these audits at the next 6 QAIP meetings.	

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bruising to the left side of the nose, an abrasion to the mid-forehead and had bright blood coming from the nares at the time of the incident. The incident report did not indicate whether neurological checks were started.

R39's nursing progress notes, dated 3/26/16 at 2:12 a.m. indicated R39 was found laying on the floor beside her bed, on her left side. An abrasion was noted on the forehead with blood at the nares present. R39's family was notified of the incident regarding the fall and a fax was sent to her primary doctor. The note did not indicate any neurological checks were done on R39 at the time of the incident. The note was recorded by RN-D.

A follow up nursing noted, dated 3/16/16 at 3:36 a.m. indicated R39's pupils were normal and reactive and she had normal movement in her extremities. No further notes regarding R39's neurological checks were recorded for the overnight shift.

A subsequent nursing progress notes, dated 3/26/16 at 1:13 p.m. indicated R39 had bruising on the bridge of her nose from the fall, and received Tylenol 1000 milligrams for discomfort. Neurological checks were noted to be within normal limits at this time. A secondary nursing progress note was recorded at 9:30 p.m. and indicated R39's neurological checks were gd (good). No further neurological checks were recorded.

Observation on 3/29/16, at 12:13 p.m. revealed R39 was resting in bed with a magnetic alarm clipped to her shoulder. A falls mat was noted on either side of her bed. R39 opened her eyes

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when spoken to, but did not respond when asked how she was feeling. R39 was noted to have purple bruising along the inside of the right eye and left eye, and a swollen nose and was pale in color.

During interview on 3/29/16, at 3:37 p.m. LPN-A. stated she thought there had been neurological checks conducted for R39 after her fall, and that a flow sheet was initiated to record the results. LPN-A located a neurological flowsheet for R39 which was dated 3/24/16 and included a total of six entries; beginning at 3/24/16 at 11:00 p.m. and ending at 1:00 p.m. on 3/27/16. The dates and times of the neurological checks did not correspond with the timing of R36's fall (3/26/16, at 2:12 a.m.).

During interview on 3/30/16, at 12:30 p.m. registered nurse (RN)-C, indicated she was R39's nurse manager and was aware of the fall dated 3/26/16 and that R39 hit her head during the incident. RN-C reviewed R39's neurological flow sheet and indicated the dates and times of the neurological checks did not match up with the timing of the incident. When questioned about the facility neurological check policy, RN-C stated she would check them every 15 minutes for the first half hour, then every half hour four (4) times, then hourly for 4 times and then every four hours for 72 hours. When asked why there were no neurological checks recorded for 3/26/16, for R39 on the flowsheet until 9:00 a.m., RN-C stated "That's a good question."

During interview on 3/30/16 1:53 p.m. R39's medical doctor (MD)-A indicated he was also the facility's medical director and would have expected facility staff to follow their neurological

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check injury policy after an unwitnessed fall, especially if the fall resulted in a bloody nose or suspected head injury.

During interview on 3/31/16, at 6:19 a.m. RN-D indicated she was on duty when R39 fell on 3/26/16. When asked about neurological checks after the fall, RN-D stated she had started a neurological flow sheet and verified that the neurological check sheet dated 3/24/16 was the only one on file for R39. RN-D stated she thought she was confused as to the times when she recorded them and there was a policy for neurological checks, but stated they didn't have to keep doing them if they were stable.

During further interview on 3/31/16, at 7:05 a.m. RN-D provided the facility's neurological check policy and confirmed that she didn't continue with subsequent neurological checks if the initial ones were stable. RN-D further stated "I knew they wouldn't have wanted to do much for her anyway, what are you going to do? Send her to the hospital?"

During interview on 3/31/16, at 8:18 a.m. the director of nursing (DON) stated that RN-D should have conducted neurological checks on R39 in accordance with the facility policy and confirmed the neurological check flowsheet on file did not reflect they were conducted in accordance with her expectations and reiterated this was a concern. When asked if there was a possibility these neurological checks were initiated after the first fall on 3/23/16, the DON indicated that after R39's fall on 3/26/16 she would have expected staff to start a new neurological flowsheet and follow the schedule per facility policy.

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F 309	Continued From page 13 The facility policy entitled Neuro Assessment, last revised 12/2/04 indicated to do neuro check on possible head injuries: any falls where you know the resident hit their head or any unwitnessed falls. Every (Q) 15 minutes x 4. Q 30 minutes x 4. Q hour (HR) x 4. Q 2 HR x 4. Q 4 HR x 2. Vital signs need to only be done on the first set of each neuro assessment, unless the resident is showing signs of being unstable.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to follow the physician prescribed order related to the treatment of a pressure ulcer for 1 of 3 residents (R35) reviewed for pressure ulcers. Findings include: R35 was admitted on 5/20/15. with diagnoses including senile degeneration of the brain and chronic kidney disease per the admission record face sheet.	F 314	1. Clarified doctor□s order for resident 35 with the appropriate nursing staff and ensured all orders are followed as written. 2. A review of all other doctor orders allowed us to verify and correct as needed all orders to ensure they are followed as written. 3. The nursing staff will be re-educated via On Line Training on the need to verify doctor orders to ensure correct	5/18/16

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F 314	Continued From page 14 R35's most recent quarterly Minimum Data Set (MDS) assessment dated 2/9/16, indicated R35 required extensive assistance of two staff with bed mobility, transfer and toilet use. The Brief Interview for Mental Status (BIMS) indicated R35 had a score of 3, indicating severe cognitive impairment. The assessment further identified R35 had an unhealed stage 3 pressure ulcer (PU) measuring 1.0 centimeters (cm) long (L) x 0.2 cm wide (W) x 0.4 cm deep (D). Review of the care plan dated 2/8/16 included: RN Reviewing ulcer weekly. Wound care as ordered. Review of the progress note dated 3/9/16, at 23:36 (11:36 p.m.) indicated: "New treatment order to wound on buttock see physician orders." Review of the faxed physician order dated 3/9/16 included: Cleanse wound on buttock per protocol, pat dry - apply skin prep, pack with collagen, apply thin layer of silver hydrogel, cover with foam dressing. Dressing change twice daily and PRN (as needed). Review of the electronic treatment record (eTAR) revealed the following wound care treatment order: "Order date: 11/25/2015 AM/PM Everyday Cleanse wound per facility protocol. Pat dry. Apply skin prep to the surrounding skin and let it dry. Apply silver hydrogel to the wound bed. Cover with foam. Dressing change daily. WOUND CARE" Although the order indicated a start date of 11/25/15, the eTAR reflected the order had been implemented starting 3/9/16. The order was unchanged from the previous wound care treatment order (dated 11/25/15) other than	F 314	transcription. The DON or designee will audit 1 resident per week during wound rounds who has a pressure ulcer to ensure current treatment is per MD orders, that appropriate interventions are in place to prevent development of future pressure sores and to promote healing. These audits will be reviewed at the next 6 monthly QAIP meetings. 4. The results of these audits will be reviewed at the next 6 QAIP meetings to ensure treatments are as written by MD and within policy and guidelines.	

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the frequency which changed from daily to twice a day. The current order did not include to pack with collagen.

During observation on 3/31/16, at 8:37 a.m. registered nurse (RN)-B performed a treatment to R35's coccyx PU. RN-B cleansed the wound with saline; the wound measured 1.0 cm (L) x 0.4 cm (W) x 0.6 cm (D). RN-B then applied skin prep to the surrounding skin, allowed the skin to dry, then applied a thin layer of silver hydrogel to the wound and covered with a foam dressing. RN-B was not observed to pack the wound with collagen.

When interviewed on 3/31/16, at 12:00 p.m. RN-B revealed she had only performed the treatment to R35's PU one other time as the resident had recently moved from the 100 hall to the 200 hall. RN-B indicated consulting with RN-C prior to performing R35's PU treatment on 3/30/16 as RN-C was the nurse manager on the 100 wing and familiar with R35's PU treatment. RN-B stated she had packed R35's coccyx wound with collagen on 3/30/16 per RN-C's direction. RN-B confirmed she did not pack R35's wound with collagen during the observation on 3/31/16 as had reviewed R35's treatment record which did not include instructions for the wound to be packed with collagen. RN-B reviewed the faxed physician order dated 3/9/16 and confirmed the order indicated to pack the wound with collagen. RN-B stated being unsure whether the nurses were packing R35's coccyx PU wound with collagen when performing the treatment.

When interviewed on 3/31/16, at 12:07 p.m. the director of nursing (DON) confirmed R35's 3/9/16

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pressure ulcer treatment order was transcribed incorrectly. DON further stated knowledge that RN-C had been packing R35's PU coccyx wound with collagen when performing the treatment weekly and obtaining measurements. DON stated being unsure if the floor nurses were packing the wound with collagen when performing the treatment in between. DON confirmed the inaccurate transcription was a problem. During interview with the DON, RN-B entered the office and stated RN-C had initially transcribed the new order on 3/9/16 and the electronic record indicated RN-A had edited the transcription.

When interviewed on 3/31/16, at 12:11 p.m. RN-A confirmed she had performed treatments to R35's PU when he resided on the 100 hall, though stated the resident had moved to the 200 hall earlier in the week. RN-A stated the wound at that time was not being packed. RN-A further confirmed that the frequency of the treatment had increased from once to twice daily otherwise no other treatment changes had been ordered.

When interviewed on 3/31/16, at 12:31 p.m. the DON stated the procedure related to transcription of new orders was to have a second nurse verify the order was correct once transcribed. DON further stated that if the second nurse verifying the order made changes to the order, the order again would need to be verified by another nurse. DON confirmed when R35's 3/9/16 PU treatment order had been edited it had not been verified by another nurse. DON further confirmed R35's PU treatment should have included to pack the wound with collagen and there was no documentation to reflect otherwise.

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F 322	Continued From page 17	F 322		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure nursing staff checked placement of a nasogastric tube prior to infusing medication for 1 of 1 resident (R23) who had placement of a nasogastric tube. Findings include: During observation of a medication administration on 3/31/16, at 10:30 a.m. registered nurse (RN)-A had set up R23's medications as ordered. RN-A poured the prepared medications into a 60 cubic	F 322	1. The nurse has been re-trained on April 7th concerning the proper placement of a naso-gastric tube. All nurses will be re-educated on the placement of a naso-gastric tube on May 18th. 2. Since our state review resident 23 has had her naso-gastric tube removed. No other residents in our facility currently uses a naso-gastric tube.	5/18/16

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F 322	Continued From page 18 centimeters (CC) syringe and infused the medication through R23's nasogastric tube. RN-A was not observed to check placement of R23's nasogastric tube prior to infusing the medications. When interviewed at this time, RN-A indicated she checks tube placement by visualizing a black mark located on the tube. RN-A further included if the black mark looks like it is located in the same place as she observed the prior day, she confirms patency. RN-A confirmed she had not measured the length of tube from the black line to the nose nor did she check placement by aspiration and/or listening. Interview with the director of nursing (DON) on 3/31/16, at 2:00 p.m. indicated RN-A should have checked placement prior to the infusion of the medications by measuring from the black mark located on the tube to the resident's nose. The DON explained that R23's medical record included initial measurements taken after the tube was placed. A facility Nasogastric tube feeding policy, undated, identified a procedure which included the administration of medications; check placement of the tube before beginning the feedings/medications by inserting a small amount of air and listening with a stethoscope or aspirate to check for stomach contents. Measure the length of the tubing from the nose and compare length with the recorded length following initial insertion. Do not proceed with feeding/medications if you cannot confirm placement or if tubing measurement has changed.	F 322	3. Will ensure all nursing staff who need to use naso-gastric tube, will have their skills verified by the DON or her designee before being allowed to use the tube. Nurses will read and sign a copy of the policy regarding naso-gastric tube use prior to admitting a resident who use this tube. 4. When we have a resident who is using a naso-gastric tube, The DON or designee will audit the staff and resident for proper use and placement of tube weekly for 4 weeks or until the tube is removed. The results of these audits will be reviewed at the next QAIP meeting.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		4/1/16

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F 323	Continued From page 19 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to determine whether the use of a product called, bed cane rails, were safe for 3 of 4 residents (R1, R25 & R31) who utilized these rails. Findings include: During observation on 3/28/16, at 6:30 p.m. and again at 7:15 p.m. a bed cane rail was observed on the inner right side of R1's bed. This rail was observed to have a wide opening that measured 12 1/4 inches in length and 5 1/4 inches at the widest part (opening) of the rail. The bed rail was in the shape of a cane. Measurements were confirmed by licensed practical nurse (LPN)-A at 7:15 p.m. and she confirmed R1's bed cane rail was wide enough for potential entrapment of the head/neck. There was no fabric material covering the rail opening. The bed cane manufacturer, Stander, also made available guidance to prevent entrapment including: "There is a risk of entrapment associated with bed rail products. Stander Inc. is committed to informing users of potential entrapment conditions when using bed rails as	F 323	1. All resident who utilize grab bars have had them replaced with new ones that meet current safety specifications. 2. No other residents have been found to have been affected by this practice. 3. All grab bars have been replaced with new ones that meet current safety specifications and the old ones have been removed from the building to prevent a reoccurrence of this incident. All residents who need grab bars will be assessed our Rehab Department for safe use before having them installed. Maintenance will verify on an annual basis that the current grab bars in use meets current safety requirements and specifications. 4. Maintenance will verify on an annual basis that the current grab bars in use meets current safety requirements and specifications. The results of these checks will be reviewed at the following Safety Meeting.	

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well as methods to prevent entrapment. Updated versions of this guide are located at www.stander.com. WHAT IS ENTRAPMENT? Entrapment is a situation where an individual can become caught by their head, neck, chest or other body parts in the tight spaces around the bed rail or bedside mobility aid. The below picture shows 2 bed rail products being used on a bed for illustration purposes. ARE THERE ANY GUIDELINES TO HELP PREVENT ENTRAPMENT? The U.S. Food and Drug Administration (FDA) and the Hospital Bed Safety Workgroup (HBSW) have established the following guidelines to help prevent entrapment. These guidelines are categorized by seven zones. ZONE 1 - WITHIN THE RAIL Any open space between the perimeters of the rail can present a risk of head entrapment. The FDA recommended space is less than four and three quarters of an inch 4-3/4"). Some Stander products have included a fabric material cover around part, or all, of the bed rail. This cover helps reduce the risk of entrapment. The product should never be used when the cover is not securely attached. The cover should only be removed to clean it."

Review of R1's physical therapy note dated 9/30/15, identified the resident utilized a bed cane (a type of bed rail) for assistance when transferring out of bed. The progress note did not include whether the bed cane rail had been assessed for safety.

Review of the current plan of care indicated R1 was able to position self in bed but did not include the use of the bed cane rail.

Further review of R1'S medical record did not

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include a determination as to whether the bed rail had been deemed safe for R1's use.

Review of incident reports for the past year did include any injuries or potential injuries related to the bed rail for R1.

When interviewed on 3/28/16, at 7:15 p.m. R1 indicated she utilized the bed rail for positioning and for sitting up in bed.

Interview with the director of nursing (DON) on 3/29/16, at 7:30 p.m. indicated R1 has had a bed rail on her bed since admission on 6/17/14. The DON revealed she was unaware R1's rail could be a safety concern that included potential entrapment.

R1's bed rail was observed to be removed on 3/28/16, at 7:40 p.m. and replaced with a grab bar that was within the recommended safety zones/openings for potential entrapment.

Interview with the DON on 3/30/16, at 9:59 a.m. confirmed nursing does not assess for the safety of bed cane rails, but thought the maintenance department made the determination.

Interview with the maintenance director on 3/30/16, at 10:00 a.m. indicated he had not made any determination about whether bed cane rails utilized on resident beds were safe for use.

During observation on 3/28/16, at 7:20 p.m., a bed cane rail was observed on R31's left side of the bed. The rail was observed to have a wide opening which measured 12 1/4 inches in length and 5 1/4 inches at the widest part (opening) of the rail. Measurements were confirmed by LPN-A

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at 7:20 p.m. LPN-A also confirmed the rail was wide enough for potential entrapment of the head/neck. Fabric material was not covering the opening of the rail.

Review of R31's physical therapy (PT) note dated 2/23/16, identified the resident utilized the bed cane for assistance with repositioning in bed. The progress note did not include a safety assessment related to the use of the bed cane rail.

Review of R31's medical record did not include any additional information related to the use of the residents bed cane rail nor the safety of the rail.

Review of incident reports for R31 in the last year, did not include any injuries or potential injuries related to the bed cane rail.

Interview with the director of nursing (DON) on 3/29/16 at 7:30 p.m. indicated she was unsure of how long the resident had utilized the bed rail. The DON revealed she was unaware R31's rail could pose any potential for entrapment.

Interview with the administrator on 3/29/16 at 7:30 p.m. confirmed R1 and R31's bed cane rails had not been evaluated for safety related to the size of the opening. The administrator indicated he would be removing the rails at this time.

During observation on 3/28/16, at 3:50 p.m. bilateral bed cane rails were observed on either side of R25's bed. The rails were observed to have a wide opening that measured 12 1/4 inches in length and 5 1/4 inches at the widest part

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	245316	A. BUILDING _____ B. WING _____	03/31/2016

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
F 323	Continued From page 23	F 323		

(opening) of the rail.

Review of R25's physical therapy note dated 2/8/16, identified the resident as utilizing a bed cane for assistance to safely roll from side to side in bed. The note did not include an assessment related to safety of the bed cane rail.

Review of the current plan of care indicated R25 utilized a trapeze on bed and bed cane on both side of bed to reposition self. Further review of R25's medical record did not include any additional information related to the use of the residents bed rail nor an assessment related to the use of the bed rail.

Review of incident reports for the past year did not reveal any injuries nor potential injuries related to the bed rails attached to R25's bed.

When interviewed on 3/28/16, at 3:50 p.m. R25 indicated he utilized the beds rails for positioning/rolling from side to side in bed.

When interviewed on 3/28/16, at 7:35 p.m. the director of nursing (DON) confirmed the bed rail measurements on R25's bed though indicated she had not realized R25's bed rails could be a safety concern which included potential entrapment; R25's bed rails were subsequently removed from the bed.

On 3/28/16, at approximately 7:45 p.m. when R25 learned of the safety concerns related to the bed cane rails, R25 confirmed he would be able to get his head through the opening in the bed cane rail.

Interview with the DON on 3/30/16 at 9:59 a.m. indicated nursing does not assess the safety of

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F 323	Continued From page 24 bed cane rails, but thought the maintenance department did. Interview with the facility maintenance director on 3/30/16 at 10:00 a.m. indicated he had not been assessing bed cane rails for safety.	F 323		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that --	F 334		5/18/16

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F 334	Continued From page 25 (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide documentation that immunizations were offered and/or administered	F 334	1. Residents R4, R39 and R47 have been discharged.	

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F 334	Continued From page 26 for 3 of 5 residents (R4, R39, R47) reviewed in the sample. This practice had the potential to affect all newly admitted residents. Findings include: R4 was admitted on 11/5/15; the medical record immunization flowsheet failed to identify whether R4 and/or a representative had been notified of the risks and benefits for the pneumococcal vaccine or whether R4 had been offered the vaccine. R39 was admitted on 2/22/16; the medical record lacked any documentation of the immunization history in the immunization record and lacked whether the pneumococcal or influenza vaccines had been offered and/or administered. R47 was admitted on 10/15/15 and the medical record lacked any evidence the influenza vaccine was administered and/or offered. The immunization record did not include any evidence R47 had been offered the vaccine and/or whether the representative had been notified of the risks and benefits for the vaccine. On 3/31/16, at 9:30 a.m. the director of nursing (DON) verified she was unable to produce any evidence that residents received the vaccines and/or that the residents or representative were given information about the risks and benefits of the vaccines. The DON confirmed each resident should be offered the influenza and pneumococcal vaccination per CDC recommendations. The facility policy for vaccinations, revised 10/2005, identified the the Centers for Disease	F 334	2. No other residents were found to have been affected by this practice. 3. The DON or her designee will audit all new admissions to ensure our policy concerning immunization/vaccines is followed as written. The results of these audits will be reviewed at the next 6 QAIP meeting. 4. The results of these audits will be reviewed at the next 6 QAIP meetings and action will be taken as needed to ensure compliance.	

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F 334	Continued From page 27 Control (CDC) recommended all healthcare workers and all persons over the age of 50 to receive annual influenza vaccines. The policy identified it was the policy of the facility to encourage all staff and residents to receive an annual flu shot in an effort to minimize the complications as a result of contracting influenza. The procedure for the policy identified the following: 1. On admission, the nurse manager would discuss with the family and/or the resident previous vaccination history and provide educational information that included the advantages and disadvantages of vaccines. 2. The resident or responsible part will give written permission to receive the vaccination or will give a written denial. 3. The original form will be placed in the chart in the admission section. 4. If the resident or family do not know if they have received the vaccination the nurse manager or assistant DNS will attempt to find the information in their past medical history. 8. Staff will record administration of the vaccine on the medication record including the name of drug, site of injection, time and date given, nurses initials and record on the face sheet.	F 334		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for	F 356		4/1/16

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F 356	Continued From page 28 resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to consistently include current census information and accurate nursing hours worked on the daily nursing hour posting. This had the potential to affect all 47 residents residing at the facility as well as family/visitors. Findings include: During observations on 3/28/16, 3/29/16 and 3/30/16 the facility nursing hour posting did not have the correct daily census. The posting also was incorrect on the actual hours/shifts worked	F 356	1. The posting of nursing hours have been changed to meet state standards. 2. No residents were found to have been negatively affected by this practice. 3. The scheduler has printed a copy of the regulation for posting nursing hours and will follow the directions as written. 4. The format used for posting hours will be audited weekly for the next 16 weeks and the results of these audits will be	

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F 356	Continued From page 29 for the registered nurse (RN), licensed practical nurse (LPN) and nursing assistance (NA). Inaccurate posting of the census and nursing hours worked are listed below: Census posted/actual census: -3/28/16- 48/47 Nursing hours posted vs. actual hours worked: -3/28/16-NA: 48 hrs vs. 32 hrs -3/29/16- NA: 36 hrs vs. 28 hrs -2/30/16- RN: 32 hrs vs. 24 hrs Hours of shift posted vs. actual hours -3/28/16-RN: 6:00 a.m.-2:30 p.m. vs. 8:00-4:30 p.m. LPN: 2:00 p.m.-10:30 p.m. vs. 2:00 p.m.- 8:00 p.m. -3/19/16-RN: 6:00 a.m.-2:30 p.m. vs. 8:00-4:30 p.m. LPN: 2:00 p.m.-10:30 p.m. vs. 2:00 p.m.- 8:00 p.m. NA: 2:00 p.m.- 10:30 p.m. vs. 4:00 p.m.- 8:00 p.m. -3/30/16- RN: 6:00 a.m.-2:30 p.m. vs. 8:00-4:30 p.m. LPN: 2:00 p.m. -10:30 p.m. vs. 2:00 p.m.- 8:00 p.m. NA: 2:00 p.m. -10:30 p.m. vs. 4:00 p.m.- 8:00 p.m. Interview with the facility staffing scheduler on 3/30/16, at 2:00 p.m. confirmed the facility daily nursing hour posting had inaccurate resident census and inaccurate actual nursing hours/shifts worked each day of the survey as listed above.	F 356	reviewed at the next 4 QA meetings to ensure compliance.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		5/18/16

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F 441	Continued From page 30 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by:	F 441		

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F 441	Continued From page 31 Based on observation, interview, and document review the facility failed to ensure proper hand hygiene during a wound treatment for 1 of 3 residents (R35) reviewed for pressure ulcers. Findings include: During observation of wound cares on 3/31/16, at 8:37 a.m. registered nurse (RN)-B was noted to provide treatment to R35's coccyx pressure ulcer. Nursing assistant (NA)-B was also present in the room to assist with turning R35 during the treatment. After NA-B assisted with turning R35 onto his right side, RN-B donned gloves and brought a plastic container with dressing supplies to R35's bedside. Prior to starting the treatment RN-B verbalized the resident had some bowel movement "smearing" on his buttocks that she would need to cleanse prior to the PU treatment. RN-B picked up the soiled washcloth NA-B had utilized while assisting R35 with peri care, and wiped the fecal smearing from R35's buttocks. RN-B then proceeded to obtain R35's wound treatment/dressing supplies from the plastic bin and perform the treatment/dressing change with the same gloved hands used to cleanse the resident's soiled buttocks. RN-B failed to remove the soiled gloves and apply new gloves prior to providing treatment and redressing the wound. When interviewed on 3/31/16, at 9:30 a.m. RN-B confirmed she should have changed gloves after cleansing the fecal smearing from the skin and prior to the PU wound treatment. RN-B further stated she realized after she retreived items from the clean treatment basket with the same soiled gloved hands, she should have removed and donned a clean pair.	F 441	1. The nurse in questions was re-trained on the proper use of PPE vie on line training March 31st. The resident was not negatively affected by this practice. 2. No other residents were affected by this practice. 3. All nurses will be re-trained on proper hand hygiene and the use of PPE on May 18th by the DON or her designee. PPE use and hand-washing will be audited weekly during wound rounds by the DON or her designee. 4. The results of these audits will be reviewed at the next 4 QAIP meetings and action taken as needed to ensure compliance with our hand hygiene and PPE policies.	

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F 441	Continued From page 32 When interviewed on 3/31/16, at 11:27 a.m. the DON confirmed RN-B should have changed gloves and performed hand hygiene after washing the resident' buttocks and prior to performing the PU treatment. Review of the Infection Control Standard Precaution policy dated 2010, indicated to perform hand hygiene if hands will be moving from a contaminated body site to a clean body site during patient care. The policy further indicated after removing gloves to wash hands with non-antimicrobial soap and water or with antimicrobial soap and water if contact with spores is likely to have occurred.	F 441		

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	245316	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/30/2016**

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K 000	INITIAL COMMENTS FIRE SAFETY 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 substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 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: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/25/2016

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 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 lower North Wing 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 fully sprinkled. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that are monitored for automatic fire department notification. The facility has a capacity of 50 beds and had a census of 47 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is	K 000		

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K 000	Continued From page 2 NOT MET as evidenced by:	K 000		
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: K25: Based on observations and interview, the facility has failed to properly construct and maintain a required 2-hour fire separation, in accordance with NFPA 101 (2000), Chapter 19, Sections 19.1.1.4 and 19.1.2.1. In a fire emergency, this deficient practice could adversely affect the safety of (50) residents, staff and visitors. FINDINGS INCLUDE: During the facility tour between the hours of 09:30 AM and 11:30 PM on 03/30/2016, observation revealed: 1: Penetration in smoke barrier above ceiling located by room 202 had wires running through walls.	K 025	1. Maintenance Supervisor has filled the penetrations in the smoke barrier with a fire rated caulk on April 19, 2016. 2. The completion date is April 19, 2016. 3. Maintenance or his designee will follow-up on all construction and installation of cables, pipes and wiring to ensure the integrity of smoke barriers are maintained.	4/19/16
K 069 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility's kitchen cooking hood fire extinguishing system was not arranged in accordance with 2000 NFPA 101 - Sections 19.3.5 and 9.7 and 1998 NFPA 96 section 9-1.2.2. The deficient practice could affect 47 residents.	K 069	1. The hood fire suppression system has been inspected in February of 2016 and is set up to be inspected on a Bi-Annual basis with Summit Companies out of Rochester. 2. The completion date is April 19, 2016.	4/19/16

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 _____	**03/30/2016**

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
K 069	Continued From page 3 Findings include: The facility has failed to provide the Bi-annual hood fire suppression system report. This deficient practice was confirmed by Director of Facility Maintenance at the time of discovery.	K 069	3. Maintenance Supervisor has contracted with Summit Companies out of Rochester to inspect the kitchen hood fire suppression system Bi-annually and will monitor the inspection quarterly to ensure they being performed as required by Life Safety regulations.	
K 154 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: K-154: Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 On facility tour between 09:30 AM and 12:30 PM on 03/30/2016, observation and documentation reviewed revealed that there was not a single plan for the out of service plan for the fire sprinkler system. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 154	1. Our disaster plan will be updated to the new standards by April 28, 2016 which will include the information for the sprinkler system. 2. Completion date is April 28, 2016. 3. Maintenance Supervisor will review all life safety policies on an annual to ensure they are current with the latest changes.	4/28/16
K 155 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of	K 155		4/28/16

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	245316	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/30/2016**

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K 155	Continued From page 4 service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: K-155: Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 On facility tour between 09:30 AM and 12:30 PM on 03/30/2016, observation and documentation reviewed revealed that there was not a single plan for the out of service plan for the fire alarm system. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 155	1. Our disaster plan will be updated to the new standards by April 28, 2016 which will include the information for the Fire Alarm system. 2. Completion date is April 28, 2016. 3. Maintenance Supervisor will review all life safety policies on an annual basis to ensure they are current with the latest changes.	

MDH
Minnesota
Department
of Health

Protecting, maintaining and improving the health of all Minnesotans

Electronically submitted
April 15, 2016

Mr. Donald Alexander, Administrator
New Richland Care Center
312 Northeast 1st Street
New Richland, MN 56072

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5316025

Dear Mr. Alexander:

The above facility was surveyed on March 28, 2016 through March 31, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. 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 that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 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 deficiency 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 attached Minnesota Department of Health orders being submitted 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 after the statement, "This Rule 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 Kathryn Serie, Unit Supervisor at (507) 476-4233.

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, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

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 _____	03/31/2016

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 March 28th, 29th, 30th and 31st 2016, 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.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure neurological checks were completed after a fall with a possible head injury for 1 of 1 resident (R39) reviewed for accidents with falls. Findings include: R39's face sheet, dated 3/31/16 identified active diagnoses of heart failure and major depressive disorder. R39's admission Minimum Data Set (MDS), dated	2 830	corrected	5/18/16

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2 830	Continued From page 3 2/22/16 identified R39 required extensive assistance of two staff for transfers and bed mobility. R39's Care Area Assessment (CAA) dated 3/6/16, indicated R39 had a risk of falls related to impaired mobility, and her family stated she had not fallen recently. The CAA indicated falls interventions should be care planned. R39's care plan last revised 3/11/16, indicated R39 was at risk for falls r/t (related to) unaware of safety needs, poor communication/comprehension, gait/balance problems and incontinence. Review of R39's incident reports included two falls, one on 3/23/16 out of bed which was unwitnessed and a second fall on 3/26/16. The 3/23/16 incident report indicated R39 had been found lying on the floor next to her bed and did not indicate whether neurological checks were started. No obvious obvious injuries were noted with the fall, R39 stated "I fell," but could not provide any further information about why she had fallen. The 3/26/16 incident report indicated R39 was found on the floor next to her bed and was unable to state why she fell. The report indicated passive range of motion was performed with no indications of pain in the extremities. The report further indicated R39 sustained facial bruising to the left side of the nose, an abrasion to the mid-forehead and had bright blood coming from the nares at the time of the incident. The incident report did not indicate whether neurological checks were started. R39's nursing progress notes, dated 3/26/16 at 2:12 a.m. indicated R39 was found laying on the floor beside her bed, on her left side. An	2 830		

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2 830	Continued From page 4	2 830		

abrasion was noted on the forehead with blood at the nares present. R39's family was notified of the incident regarding the fall and a fax was sent to her primary doctor. The note did not indicate any neurological checks were done on R39 at the time of the incident. The note was recorded by RN-D.

A follow up nursing noted, dated 3/16/16 at 3:36 a.m. indicated R39's pupils were normal and reactive and she had normal movement in her extremities. No further notes regarding R39's neurological checks were recorded for the overnight shift.

A subsequent nursing progress notes, dated 3/26/16 at 1:13 p.m. indicated R39 had bruising on the bridge of her nose from the fall, and received Tylenol 1000 milligrams for discomfort. Neurological checks were noted to be within normal limits at this time. A secondary nursing progress note was recorded at 9:30 p.m. and indicated R39's neurological checks were gd (good). No further neurological checks were recorded.

Observation on 3/29/16, at 12:13 p.m. revealed R39 was resting in bed with a magnetic alarm clipped to her shoulder. A falls mat was noted on either side of her bed. R39 opened her eyes when spoken to, but did not respond when asked how she was feeling. R39 was noted to have purple bruising along the inside of the right eye and left eye, and a swollen nose and was pale in color.

During interview on 3/29/16, at 3:37 p.m. LPN-A. stated she thought there had been neurological checks conducted for R39 after her fall, and that a flow sheet was initiated to record the results.

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2 830	Continued From page 5 LPN-A located a neurological flowsheet for R39 which was dated 3/24/16 and included a total of six entries; beginning at 3/24/16 at 11:00 p.m. and ending at 1:00 p.m. on 3/27/16. The dates and times of the neurological checks did not correspond with the timing of R36's fall (3/26/16, at 2:12 a.m.). During interview on 3/30/16, at 12:30 p.m. registered nurse (RN)-C, indicated she was R39's nurse manager and was aware of the fall dated 3/26/16 and that R39 hit her head during the incident. RN-C reviewed R39's neurological flow sheet and indicated the dates and times of the neurological checks did not match up with the timing of the incident. When questioned about the facility neurological check policy, RN-C stated she would check them every 15 minutes for the first half hour, then every half hour four (4) times, then hourly for 4 times and then every four hours for 72 hours. When asked why there were no neurological checks recorded for 3/26/16, for R39 on the flowsheet until 9:00 a.m., RN-C stated "That's a good question." During interview on 3/30/16 1:53 p.m. R39's medical doctor (MD)-A indicated he was also the facility's medical director and would have expected facility staff to follow their neurological check injury policy after an unwitnessed fall, especially if the fall resulted in a bloody nose or suspected head injury. During interview on 3/31/16, at 6:19 a.m. RN-D indicated she was on duty when R39 fell on 3/26/16. When asked about neurological checks after the fall, RN-D stated she had started a neurological flow sheet and verified that the neurological check sheet dated 3/24/16 was the only one on file for R39. RN-D stated she	2 830		

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2 830	Continued From page 6 thought she was confused as to the times when she recorded them and there was a policy for neurological checks, but stated they didn't have to keep doing them if they were stable. During further interview on 3/31/16, at 7:05 a.m. RN-D provided the facility's neurological check policy and confirmed that she didn't continue with subsequent neurological checks if the initial ones were stable. RN-D further stated "I knew they wouldn't have wanted to do much for her anyway, what are you going to do? Send her to the hospital?" During interview on 3/31/16, at 8:18 a.m. the director of nursing (DON) stated that RN-D should have conducted neurological checks on R39 in accordance with the facility policy and confirmed the neurological check flowsheet on file did not reflect they were conducted in accordance with her expectations and reiterated this was a concern. When asked if there was a possibility these neurological checks were initiated after the first fall on 3/23/16, the DON indicated that after R39's fall on 3/26/16 she would have expected staff to start a new neurological flowsheet and follow the schedule per facility policy. The facility policy entitled Neuro Assessment, last revised 12/2/04 indicated to do neuro check on possible head injuries: any falls where you know the resident hit their head or any unwitnessed falls. Every (Q) 15 minutes x 4. Q 30 minutes x 4. Q hour (HR) x 4. Q 2 HR x 4. Q 4 HR x 2. Vital signs need to only be done on the first set of each neuro assessment, unless the resident is showing signs of being unstable. SUGGESTED METHOD OF CORRECTION:	2 830		

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2 830	Continued From page 7 The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure assessment of resident conditions are conducted, and that interventions including neurological checks, are implemented as directed. The Director of Nursing or designee could educate all appropriate staff to the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to follow the physician	2 900	corrected	5/18/16

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

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2 900	Continued From page 8	2 900		

prescribed order related to the treatment of a pressure ulcer for 1 of 3 residents (R35) reviewed for pressure ulcers.

Findings include:

R35 was admitted on 5/20/15. with diagnoses including senile degeneration of the brain and chronic kidney disease per the admission record face sheet.

R35's most recent quarterly Minimum Data Set (MDS) assessment dated 2/9/16, indicated R35 required extensive assistance of two staff with bed mobility, transfer and toilet use. The Brief Interview for Mental Status (BIMS) indicated R35 had a score of 3, indicating severe cognitive impairment. The assessment further identified R35 had an unhealed stage 3 pressure ulcer (PU) measuring 1.0 centimeters (cm) long (L) x 0.2 cm wide (W) x 0.4 cm deep (D).

Review of the care plan dated 2/8/16 included: RN Reviewing ulcer weekly. Wound care as ordered.

Review of the progress note dated 3/9/16, at 23:36 (11:36 p.m.) indicated: "New treatment order to wound on buttock see physician orders."

Review of the faxed physician order dated 3/9/16 included: Cleanse wound on buttock per protocol, pat dry - apply skin prep, pack with collagen, apply thin layer of silver hydrogel, cover with foam dressing. Dressing change twice daily and PRN (as needed).

Review of the electronic treatment record (eTAR) revealed the following wound care treatment order: "Order date: 11/25/2015 AM/PM

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2 900	Continued From page 9 Everyday Cleanse wound per facility protocol. Pat dry. Apply skin prep to the surrounding skin and let it dry. Apply silver hydrogel to the wound bed. Cover with foam. Dressing change daily. WOUND CARE" Although the order indicated a start date of 11/25/15, the eTAR reflected the order had been implemented starting 3/9/16. The order was unchanged from the previous wound care treatment order (dated 11/25/15) other than the frequency which changed from daily to twice a day. The current order did not include to pack with collagen. During observation on 3/31/16, at 8:37 a.m. registered nurse (RN)-B performed a treatment to R35's coccyx PU. RN-B cleansed the wound with saline; the wound measured 1.0 cm (L) x 0.4 cm (W) x 0.6 cm (D). RN-B then applied skin prep to the surrounding skin, allowed the skin to dry, then applied a thin layer of silver hydrogel to the wound and covered with a foam dressing. RN-B was not observed to pack the wound with collagen. When interviewed on 3/31/16, at 12:00 p.m. RN-B revealed she had only performed the treatment to R35's PU one other time as the resident had recently moved from the 100 hall to the 200 hall. RN-B indicated consulting with RN-C prior to performing R35's PU treatment on 3/30/16 as RN-C was the nurse manager on the 100 wing and familiar with R35's PU treatment. RN-B stated she had packed R35's coccyx wound with collagen on 3/30/16 per RN-C's direction. RN-B confirmed she did not pack R35's wound with collagen during the observation on 3/31/16 as had reviewed R35's treatment record which did not include instructions for the wound to be packed with collagen. RN-B reviewed the faxed physician order dated 3/9/16	2 900		

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2 900	Continued From page 10	2 900		

and confirmed the order indicated to pack the wound with collagen. RN-B stated being unsure whether the nurses were packing R35's coccyx PU wound with collagen when performing the treatment.

When interviewed on 3/31/16, at 12:07 p.m. the director of nursing (DON) confirmed R35's 3/9/16 pressure ulcer treatment order was transcribed incorrectly. DON further stated knowledge that RN-C had been packing R35's PU coccyx wound with collagen when performing the treatment weekly and obtaining measurements. DON stated being unsure if the floor nurses were packing the wound with collagen when performing the treatment in between. DON confirmed the inaccurate transcription was a problem. During interview with the DON, RN-B entered the office and stated RN-C had initially transcribed the new order on 3/9/16 and the electronic record indicated RN-A had edited the transcription.

When interviewed on 3/31/16, at 12:11 p.m. RN-A confirmed she had performed treatments to R35's PU when he resided on the 100 hall, though stated the resident had moved to the 200 hall earlier in the week. RN-A stated the wound at that time was not being packed. RN-A further confirmed that the frequency of the treatment had increased from once to twice daily otherwise no other treatment changes had been ordered.

When interviewed on 3/31/16, at 12:31 p.m. the DON stated the procedure related to transcription of new orders was to have a second nurse verify the order was correct once transcribed. DON further stated that if the second nurse verifying the order made changes to the order, the order again would need to be verified by another nurse.

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2 900	Continued From page 11 DON confirmed when R35's 3/9/16 PU treatment order had been edited it had not been verified by another nurse. DON further confirmed R35's PU treatment should have included to pack the wound with collagen and there was no documentation to reflect otherwise. SUGGESTED METHOD OF CORRECTION: The director of nursing could review and revise policies and procedures to ensure the facility provided pressure ulcer interventions according to the resident's individualized needs. The director of nursing could review all residents at risk for pressure ulcers to assure they received the necessary treatment to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing could in-service all appropriate staff on appropriate pressure ulcer interventions. The director of nursing could conduct random audits of the delivery of care to ensure appropriate care and services were implemented. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
2 930	MN Rule 4658.0525 Subp. 7 B. Rehab - Nasogastric, Gastrostomy tubes Subp. 7. Nasogastric tubes, gastrostomy tubes, and feeding syringes. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is fed by a nasogastric or gastrostomy tube or feeding syringe receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and	2 930		5/18/16

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2 930	Continued From page 12 nasal-pharyngeal ulcers and to restore, if possible, normal feeding function. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure nursing staff checked placement of a nasogastric tube prior to infusing medication for 1 of 1 resident (R23) who had placement of a nasogastric tube. Findings include: During observation of a medication administration on 3/31/16, at 10:30 a.m. registered nurse (RN)-A had set up R23's medications as ordered. RN-A poured the prepared medications into a 60 cubic centimeters (CC) syringe and infused the medication through R23's nasogastric tube. RN-A was not observed to check placement of R23's nasogastric tube prior to infusing the medications. When interviewed at this time, RN-A indicated she checks tube placement by visualizing a black mark located on the tube. RN-A further included if the black mark looks like it is located in the same place as she observed the prior day, she confirms patency. RN-A confirmed she had not measured the length of tube from the black line to the nose nor did she check placement by aspiration and/or listening. Interview with the director of nursing (DON) on 3/31/16, at 2:00 p.m. indicated RN-A should have checked placement prior to the infusion of the medications by measuring from the black mark located on the tube to the resident's nose. The DON explained that R23's medical record	2 930	corrected	

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2 930	Continued From page 13 included initial measurements taken after the tube was placed. A facility Nasogastric tube feeding policy, undated, identified a procedure which included the administration of medications; check placement of the tube before beginning the feedings/medications by inserting a small amount of air and listening with a stethoscope or aspirate to check for stomach contents. Measure the length of the tubing from the nose and compare length with the recorded length following initial insertion. Do not proceed with feeding/medications if you cannot confirm placement or if tubing measurement has changed. SUGGESTED METHOD OF CORRECTION: The director of nursing could review and revise policies and procedures to ensure nursing provided appropriate nasogastric tube care. The director of nursing could inservice licensed staff to provide appropriate nasogastric care. The director of nursing could monitor staff compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 930		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced	21375		5/18/16

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21375	Continued From page 14 by: Based on observation, interview, and document review the facility failed to ensure proper hand hygiene during a wound treatment for 1 of 3 residents (R35) reviewed for pressure ulcers. Findings include: During observation of wound cares on 3/31/16, at 8:37 a.m. registered nurse (RN)-B was noted to provide treatment to R35's coccyx pressure ulcer. Nursing assistant (NA)-B was also present in the room to assist with turning R35 during the treatment. After NA-B assisted with turning R35 onto his right side, RN-B donned gloves and brought a plastic container with dressing supplies to R35's bedside. Prior to starting the treatment RN-B verbalized the resident had some bowel movement "smearing" on his buttocks that she would need to cleanse prior to the PU treatment. RN-B picked up the soiled washcloth NA-B had utilized while assisting R35 with peri care, and wiped the fecal smearing from R35's buttocks. RN-B then proceeded to obtain R35's wound treatment/dressing supplies from the plastic bin and perform the treatment/dressing change with the same gloved hands used to cleanse the resident's soiled buttocks. RN-B failed to remove the soiled gloves and apply new gloves prior to providing treatment and redressing the wound. When interviewed on 3/31/16, at 9:30 a.m. RN-B confirmed she should have changed gloves after cleansing the fecal smearing from the skin and prior to the PU wound treatment. RN-B further stated she realized after she retreived items from the clean treatment basket with the same soiled gloved hands, she should have removed and donned a clean pair.	21375	corrected	

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21375	Continued From page 15 When interviewed on 3/31/16, at 11:27 a.m. the DON confirmed RN-B should have changed gloves and performed hand hygiene after washing the resident' buttocks and prior to performing the PU treatment. Review of the Infection Control Standard Precaution policy dated 2010, indicated to perform hand hygiene if hands will be moving from a contaminated body site to a clean body site during patient care. The policy further indicated after removing gloves to wash hands with non-antimicrobial soap and water or with antimicrobial soap and water if contact with spores is likely to have occurred. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee would review and revise the policy and procedures related to infection control concerns while performing wound care, and provide education to staff members. A monitoring system could be developed to ensure staff are providing cares as directed and report the results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
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	21426		5/18/16

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21426	Continued From page 16 Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 4 of 5 newly admitted residents (R4, R39, R47 and R57) had a two step tuberculin skin test (TST) administered. In addition, the facility failed to ensure 3 of 5 staff (DA-A, LPN-A, and NA-A) had a two step TST conducted. Findings include: R4 was admitted to the facility on 10/15/15 and the medical record lacked documentation of R4 receiving a 1st or 2nd step (TST). R4's immunization record lacked any documentation of the test being administered. During interview with the director of nursing services (DNS) on 3/31/16 at 9:30 a.m. it was verified there was no evidence of testing. R39 was admitted to the facility on 2/22/16 and her immunization record along with medical record lacked any evidence of a two-step TST	21426	corrected	

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21426	Continued From page 17 being conducted. R47 was admitted to the facility on 10/15/15 and during review of immunizations and TST administration the medical record lacked any evidence that the TST had occurred. R57 was admitted to the facility on 2/2/16 and the medical record immunization sheet identified R57 received the first step of the two-step TST on 2/2/16 but lacked evidence of the 2nd TST being performed. On 3/31/16, at 9:30 a.m. the DNS was given the names of the resident's whose evidence of TST was requested and at 10:30 a.m. the resident immunization records were returned with no evidence of the information required. The DNS verified there was no further evidence to demonstrate the residents had received TST's per the facility policy. Licensed practical nurse (LPN)-B was hired on 1/28/16 and was administered the first step of the two-step TST on 1/19/16 but failed to have the first step followed up with the two-step. LPN-B's personnel record lacked documentation of the second step and it was verified by the DNS the second-step had not been administered within the facility's parameters based on policy. The facility further did not have record of LPN-A's Mantoux on file and had to request the information from LPN-A's provider. Dietary assistant (DA)-A was hired on 1/4/16 and had step one of the two-step Mantoux conducted on 1/11/16. The personnel record lacked evidence of the second step of the TST was conducted. The DNS verified the second step had not been completed.	21426		

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21426	Continued From page 18 Nursing assistant (NA)-C was hired by the facility on 12/17/15 and her personnel record identified she had received the first step of the two-step TST on 12/17/15. NA-C's personnel record lacked evidence of the second step of the TST being completed. It was verified by the DNS the second step had been missed. SUGGESTED METHOD FOR CORRECTION: The administrator, director of nursing, could review and revise policies and procedures for TB surveillance. The administrator, director of nursing, could monitor resident and TB screening to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to determine whether the use of a product called, bed cane rails, were safe for 3 of 4 residents (R1, R25 & R31) who utilized these rails. Findings include: During observation on 3/28/16, at 6:30 p.m. and again at 7:15 p.m. a bed cane rail was observed	21665	corrected	5/18/16

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21665	Continued From page 19 on the inner right side of R1's bed. This rail was observed to have a wide opening that measured 12 1/4 inches in length and 5 1/4 inches at the widest part (opening) of the rail. The bed rail was in the shape of a cane. Measurements were confirmed by licensed practical nurse (LPN)-A at 7:15 p.m. and she confirmed R1's bed cane rail was wide enough for potential entrapment of the head/neck. There was no fabric material covering the rail opening. The bed cane manufacturer, Stander, also made available guidance to prevent entrapment including: "There is a risk of entrapment associated with bed rail products. Stander Inc. is committed to informing users of potential entrapment conditions when using bed rails as well as methods to prevent entrapment. Updated versions of this guide are located at www.stander.com. WHAT IS ENTRAPMENT? Entrapment is a situation where an individual can become caught by their head, neck, chest or other body parts in the tight spaces around the bed rail or bedside mobility aid. The below picture shows 2 bed rail products being used on a bed for illustration purposes. ARE THERE ANY GUIDELINES TO HELP PREVENT ENTRAPMENT? The U.S. Food and Drug Administration (FDA) and the Hospital Bed Safety Workgroup (HBSW) have established the following guidelines to help prevent entrapment. These guidelines are categorized by seven zones. ZONE 1 - WITHIN THE RAIL Any open space between the perimeters of the rail can present a risk of head entrapment. The FDA recommended space is less than four and three quarters of an inch 4-3/4"). Some Stander products have included a fabric material cover around part, or all, of the bed rail. This cover helps reduce the risk of entrapment. The product	21665		

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21665	Continued From page 20 should never be used when the cover is not securely attached. The cover should only be removed to clean it." Review of R1's physical therapy note dated 9/30/15, identified the resident utilized a bed cane (a type of bed rail) for assistance when transferring out of bed. The progress note did not include whether the bed cane rail had been assessed for safety. Review of the current plan of care indicated R1 was able to position self in bed but did not include the use of the bed cane rail. Further review of R1'S medical record did not include a determination as to whether the bed rail had been deemed safe for R1's use. Review of incident reports for the past year did include any injuries or potential injuries related to the bed rail for R1. When interviewed on 3/28/16, at 7:15 p.m. R1 indicated she utilized the bed rail for positioning and for sitting up in bed. Interview with the director of nursing (DON) on 3/29/16, at 7:30 p.m. indicated R1 has had a bed rail on her bed since admission on 6/17/14. The DON revealed she was unaware R1's rail could be a safety concern that included potential entrapment. R1's bed rail was observed to be removed on 3/28/16, at 7:40 p.m. and replaced with a grab bar that was within the recommended safety zones/openings for potential entrapment. Interview with the DON on 3/30/16, at 9:59 a.m.	21665		

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21665	Continued From page 21 confirmed nursing does not assess for the safety of bed cane rails, but thought the maintenance department made the determination. Interview with the maintenance director on 3/30/16, at 10:00 a.m. indicated he had not made any determination about whether bed cane rails utilized on resident beds were safe for use. During observation on 3/28/16, at 7:20 p.m., a bed cane rail was observed on R31's left side of the bed. The rail was observed to have a wide opening which measured 12 1/4 inches in length and 5 1/4 inches at the widest part (opening) of the rail. Measurements were confirmed by LPN-A at 7:20 p.m. LPN-A also confirmed the rail was wide enough for potential entrapment of the head/neck. Fabric material was not covering the opening of the rail. Review of R31's physical therapy (PT) note dated 2/23/16, identified the resident utilized the bed cane for assistance with repositioning in bed. The progress note did not include a safety assessment related to the use of the bed cane rail. Review of R31's medical record did not include any additional information related to the use of the residents bed cane rail nor the safety of the rail. Review of incident reports for R31 in the last year, did not include any injuries or potential injuries related to the bed cane rail. Interview with the director of nursing (DON) on 3/29/16 at 7:30 p.m. indicated she was unsure of how long the resident had utilized the bed rail. The DON revealed she was unaware R31's rail	21665		

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	00748	A. BUILDING: _____ B. WING _____	03/31/2016

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21665	Continued From page 22 could pose any potential for entrapment. Interview with the administrator on 3/29/16 at 7:30 p.m. confirmed R1 and R31's bed cane rails had not been evaluated for safety related to the size of the opening. The administrator indicated he would be removing the rails at this time. During observation on 3/28/16, at 3:50 p.m. bilateral bed cane rails were observed on either side of R25's bed. The rails were observed to have a wide opening that measured 12 1/4 inches in length and 5 1/4 inches at the widest part (opening) of the rail. Review of R25's physical therapy note dated 2/8/16, identified the resident as utilizing a bed cane for assistance to safely roll from side to side in bed. The note did not include an assessment related to safety of the bed cane rail. Review of the current plan of care indicated R25 utilized a trapeze on bed and bed cane on both side of bed to reposition self. Further review of R25's medical record did not include any additional information related to the use of the residents bed rail nor an assessment related to the use of the bed rail. Review of incident reports for the past year did not reveal any injuries nor potential injuries related to the bed rails attached to R25's bed. When interviewed on 3/28/16, at 3:50 p.m. R25 indicated he utilized the beds rails for positioning/rolling from side to side in bed. When interviewed on 3/28/16, at 7:35 p.m. the director of nursing (DON) confirmed the bed rail measurements on R25's bed though indicated	21665		

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21665	Continued From page 23 she had not realized R25's bed rails could be a safety concern which included potential entrapment; R25's bed rails were subsequently removed from the bed. On 3/28/16, at approximately 7:45 p.m. when R25 learned of the safety concerns related to the bed cane rails, R25 confirmed he would be able to get his head through the opening in the bed cane rail. Interview with the DON on 3/30/16 at 9:59 a.m. indicated nursing does not assess the safety of bed cane rails, but thought the maintenance department did. Interview with the facility maintenance director on 3/30/16 at 10:00 a.m. indicated he had not been assessing bed cane rails for safety. SUGGESTED METHOD OF CORRECTION: The DON or designee could develop policies and procedures to ensure cane rails are assessed for safe use and side rails are maintained for safety. The DON or designee could educate all appropriate staff on these policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21665		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult	21980		5/18/16

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21980	Continued From page 24	21980		

has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless:

(1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or

(2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4).

(b) A person not required to report under the provisions of this section may voluntarily report as described above.

(c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point.

(d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.

(e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section

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21980	Continued From page 25 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to immediately report allegations of abuse to the administrator and designated State agency and thoroughly investigate the allegations for 2 of 5 resident reports (R27, R17) reviewed. Findings include: The facility failed to notify the administrator and State agency immediately and failed to thoroughly investigate an allegation of maltreatment/abuse for R27. Review of an incident report for R27, dated 9/18/15, revealed a nursing description: "CNA [nursing assistant] was assisting resident into shower in the [hallway] shower room. CNA came out and told RN [registered nurse] that resident had 2 skin tears on left upper arm above the elbow. 'They were there when we undressed her.' The skin tears are--lower 1.6 cm [centimeters] and 1 cm and the upper 2.3 x 1 cm and they are in the shape of triangles. Review of the resident description revealed 'All the bruising and these skin tears are from fingernails and people grabbing me hard.' Resident then grabber [sic] her left forearm enough to make indents in edema to show RN how she is grabbed." The incident report did not indicate a date and time the administrator was notified of the incident. Review of the incident report submitted to the	21980	corrected	

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21980	Continued From page 26 State agency revealed the allegation of mistreatment reported by R27 on 9/18/15 was reported to the State agency on 9/21/15. The investigative report, submitted to the state on 9/27/15, and accompanying investigative documents include interviews from staff. However, the complete name of staff, date and time of interview and full statements of staff were not documented for all interviews. No other resident interviews were completed or documented regarding their experiences of staff treatment of them during cares to ascertain if residents on the unit were experiencing similar concerns. On 3/31/16, at 9:19 a.m. the director of social services (DSS) and administrator reported nursing assistants and nurses were interviewed regarding the incident. Notes were taken of the interviews. However, the notes did not include the complete names of staff, date and time of interview and full statements of staff. No other residents were interviewed regarding their experiences of staff treatment of them during cares to ascertain if residents on the unit were experiencing similar concerns. The DSS and administrator reported the administrator may not have been notified until the interdisciplinary team reviewed the incident on 9/21/15. The DSS and the administrator confirmed the State agency was not notified of the incident until 9/21/15. The facility failed to immediately notify the State agency of an allegation and observation of potential exploitation and mistreatment of R17 by a facility visitor, (V)-A. An incident report dated 8/25/15, revised 8/27/15 revealed V-A unexpectedly visited R17 in her room. R17 was heard yelling at V-A to "get out of	21980		

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21980	Continued From page 27 my room". Review of the incident report and progress notes, dated 8/25/15 through 8/27/15 revealed the facility (including the director of nursing DON, administrator and DSS) were informed on 8/25/16 by R17 and V-A about allegations of financial exploitation committed by V-A against R17. V-A was at the facility to confront R17 about these allegations and a verbal altercation occurred. R17 reported to staff she did not feel safe at the facility. A review of the incident report submitted to the State agency, dated 8/27/15 revealed the facility did not notify the State agency of the 8/25/15 incident and allegations until 8/27/15 (2 days later). On 3/31/16, the DSS and administrator confirmed the allegation and incident of potential exploitation and mistreatment involving R17 was not immediately reported to the State agency. The Vulnerable Adult Reporting for New Richland Care Center, undated, directed staff : "We need to report Vulnerable Adult incidents to [name of administrator] administrator immediately and to the Minnesota Department of Health electronically." and "Who ever starts the incident, or has it reported to them, should be the Nurse in Charge of The Resident or RN on Duty or on call can assist you with the process, if Administrator, Director of Nursing or Social Services are not present in the building. You need to start the investigation as well, talk to the residents involved, staff witnesses, etc. Please do not pass it on to someone else coming on duty. If you were here at the time the incident happened, you need to start the process. Please remember we have to report this immediately or as soon as were are able, after the resident is safe to the Minnesota Department of Health, and then we have 5 days to investigate and send this in, which will be done	21980		

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21980	Continued From page 28 by [name of administrator, DON and DSS]." The policy further directed staff "All reports of resident abuse, neglect, injuries of unknown source, resident to resident abuse and resident to staff abuse are promptly and thoroughly investigated by facility management." Steps of investigation included: "7. Interview the staff. Use the Incident Witness Interview Form." and "You need to complete the interviewing and record their statements rather than allowing them to write the statement. This gives you a chance to ask questions that may help determine the cause. This should include the person who reported the incident and other staff working at the time the incident occurred." and "b. Interview other residents that the accused employee has provided care to determine if they have a complaint about the employee." SUGGESTED METHOD FOR CORRECTION: The administrator or designee could audit, and provide education and training to all staff regarding reporting responsibilities and implementing the procedures of the Abuse Prevention Policy and Vulnerable adult(s). TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21980		
21995	MN St. Statute 626.557 Subd. 4a Reporting - Maltreatment of Vulnerable Adults Subd. 4a. Internal reporting of maltreatment. (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting	21995		5/18/16

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21995	Continued From page 29 requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to implement their policy related to immediate reporting allegations of abuse to the administrator and State agency and thoroughly investigating allegations for 2 of 5 resident reports (R27, R17) reviewed. Findings include: The Vulnerable Adult Reporting for New Richland Care Center, undated, directed staff : "We need to report Vulnerable Adult incidents to [name of administrator] administrator immediately and to the Minnesota Department of Health electronically." and "Who ever starts the incident, or has it reported to them, should be the Nurse in Charge of The Resident or RN on Duty or on call can assist you with the process, if Administrator, Director of Nursing or Social Services are not present in the building. You need to start the investigation as well, talk to the residents involved, staff witnesses, etc. Please do not pass it on to someone else coming on duty. If you were here at the time the incident happened, you need to start the process. Please remember we have to report this immediately or as soon as were are able, after the resident is safe to the Minnesota Department of Health, and then we have 5 days to investigate and send this in, which will be done by [name of administrator, DON and DSS]." The policy further directed staff "All reports of resident abuse, neglect, injuries of unknown source, resident to resident abuse and resident to staff	21995	corrected	

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21995	Continued From page 30	21995		

abuse are promptly and thoroughly investigated by facility management." Steps of investigation included: "7. Interview the staff. Use the Incident Witness Interview Form." and "You need to complete the interviewing and record their statements rather than allowing them to write the statement. This gives you a chance to ask questions that may help determine the cause. This should include the person who reported the incident and other staff working at the time the incident occurred." and "b. Interview other residents that the accused employee has provided care to determine if they have a complaint about the employee."

The facility failed to notify the administrator and State agency immediately and thoroughly investigate an allegation of physical abuse for R27.

Review of an incident report for R27, dated 9/18/15, revealed a nursing description: "CNA [nursing assistant] was assisting resident into shower in the [hallway] shower room. CNA came out and told RN [registered nurse] that resident had 2 skin tears on left upper arm above the elbow. 'They were there when we undressed her.' The skin tears are Lower 1.6 cm [centimeters] and 1 cm and the upper 2.3 x 1 cm and they are in the shape of triangles." Review of the resident description revealed "'All the bruising and these skin tears are from fingernails and people grabbing me hard.' Resident then grabber [sic] her left forearm enough to make indents in edema to show RN how she is grabbed." The incident report did not indicate a date and time the administrator was notified of the incident.

Review of the incident report submitted to the State agency revealed the allegation of

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21995	Continued From page 31	21995		

mistreatment reported by R27 on 9/18/15 was reported to the state agency on 9/21/15. The investigative report, submitted to the State on 9/27/15, and accompanying investigative documents include interviews from staff. However, the complete name of staff, date and time of interview and full statements of staff were not documented for all interviews. No other resident interviews were completed or documented regarding their experiences of staff treatment of them during cares to ascertain if residents on the unit were experiencing similar concerns.

On 3/31/16 at 9:19 a.m. the director of social services (DSS) and administrator reported nursing assistants and nurses were interviewed regarding the incident. Notes were taken of the interviews. However, the notes did not include the complete name of staff, date and time of interview and full statements of staff. No other residents were interviewed regarding their experiences of staff treatment of them during cares to ascertain if residents on the unit were experiencing similar concerns. The DSS and administrator reported the administrator may not have been notified until the interdisciplinary team reviewed the incident on 9/21/15. The DSS and the administrator confirmed the state agency was not notified of the incident until 9/21/15.

The facility failed to immediately notify the state agency of an allegation and observation of potential exploitation and mistreatment of R17 by a facility visitor, (V)-A.

An incident report, dated 8/25, revised 8/27/15 revealed V-A unexpectedly visited R17 in her room. R17 was heard yelling at V-A to "'get out of my room'" Review of the incident report and

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21995	Continued From page 32 progress notes, dated 8/25/15 through 8/27/15 revealed the facility (including the director of nursing (DON, administrator and DSS) were informed on 8/25/16 by R17 and V-A about allegations of financial exploitation committed by V-A against R17. V-A was at the facility to confront R17 about these allegations and a verbal altercation occurred. R17 reported to staff she did not feel safe at the facility. A review of the incident report submitted to the state, dated 8/27/15 revealed the facility did not notify the state agency of the 8/25/15 incident and allegations until 8/27/15. On 3/31/16 the DSS and administrator confirmed the allegation and incident of potential exploitation and mistreatment involving R17 was not immediately reported to the State agency. SUGGESTED METHOD OF CORRECTION: The administrator or designee could audit, and provide education and training to all staff regarding reporting responsibilities and implementing the procedures of the Abuse Prevention Policy and Vulnerable adult(s). TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21995		