DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

D TRANSMITTAL	ID: EBZN
SURVEY AGENCY	Facility ID: 00748

								-	
MEDICARE/MEDICAID PROVID	DER	3. NAME AND AD					4. TYPE OF ACT	ION: <u>7</u> (L8)	
NO.(L1) 245316		(L3) NEW RICH					1. Initial	2. Recertification	
2. STATE VENDOR OR MEDICAID (L2) 825340400	NO.	(L4) 312 NORTH (L5) NEW RICH		IKEEI	(L6) 5 0	6072	3. Termination 5. Validation	4. CHOW 6. Complaint	
5. EFFECTIVE DATE CHANGE OF	OWNEDSHID	7. PROVIDER/SU	<u> </u>	ODV	<u>02</u> (L7)		7. On-Site Visit	9. Other	
(L9)	OWNERSHII	01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA	8. Full Survey Af	ter Complaint	
	3/2016 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF				
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC		FISCAL YEAR ENI	DING DATE: (L35)	
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE		12/31		
11LTC PERIOD OF CERTIFICATIO	N	10.THE FACILITY	' IS CERTIFIED	AS:					
From (a):		X A. In Complia	nce With		And/Or Approve	ed Waivers Of	The Following Require	ments:	
To (b):		Program Re	equirements		2. Techn	ical Personnel	6. Scope of	Services Limit	
		Compliance			3. 24 Ho		7. Medical		
12.Total Facility Beds	50 (L18)	1. A	cceptable POC			RN (Rural SN	-		
13.Total Certified Beds	50 (L17)	B. Not in Comp	U		5. Life S	afety Code	9. Beds/Roo	om	
14. LTC CERTIFIED BED BREAKDO	NW/NI	Requirements	and/or Applied V	Waivers:	* Code: A	БЕТС	(L12)		
18 SNF 18/19 SNF	JWN 19 SNF	ICF	IID		1861 (e) (1) or 1		(L15)		
50	19 5141	ici	Ш		1801 (c) (1) 01 1	1801 (j) (1).	(213)		
(L37) (L38)	(L39)	(L42)	(L43)						
16. STATE SURVEY AGENCY REM	IARKS (IF APPLICA	BLE SHOW ETC CA	ANCELLATION I	DATE):					
17. SURVEYOR SIGNATURE		Date :			18. STATE SURV	EY AGENCY	APPROVAL	Date:	
Kathryn Serie, Unit	Supervisor	0	5/27/2016		Kamala Fisko De	owning Hea	Ith Program Repres	sentative 6/6/2016	
				(L19)		-		(1	L20)
PA	RT II - TO BE	COMPLETED I	BY HCFA RE	EGIONAL	OFFICE OR	SINGLE ST	TATE AGENCY		
19. DETERMINATION OF ELIGIBI	LITY		IPLIANCE WITH	H CIVIL			ncial Solvency (HCFA-2		
1. Facility is Eligible to l	Participate	RIGH	HTS ACT:			th of the Above	l Interest Disclosure Str :	nt (HCFA-1513)	
2. Facility is not Eligible	e (L21)								
	(L21)								
22. ORIGINAL DATE	23. LTC AGREEN	MENT 24	4. LTC AGREEN	MENT	26. TERMINATI	ION ACTION:		(L30)	
OF PARTICIPATION	BEGINNING	DATE	ENDING DA	ГЕ	VOLUNTARY	_00	INVOL	UNTARY	
06/01/1986					01-Merger, Closur			o Meet Health/Safety	
(L24)	(L41)		(L25)		02-Dissatisfaction			o Meet Agreement	
25. LTC EXTENSION DATE:	27. ALTERNATI				03-Risk of Involun 04-Other Reason fo	•	OTHER		
	A. Suspension	of Admissions:	(1.44)		04-Other Reason R	or withdrawar	07-Prov 00-Acti	ider Status Change	
(L27)	B. Rescind Su	spension Date:	(L44)				00-71011	ve	
		•	(L45)						
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS				
		03001							
	(L28)			(L31)					
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	DATE					
	(L32)			(L33)	DETERMINA	TION APPR	ROVAL		



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, Program Specialist

Licensing and Certification Program

Kumalu Fiske Downing

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112



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

New Richland Care Center May 27, 2016 Page 2

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, Program Specialist

Licensing and Certification Program

Kumalu Fiske Downing

Health Regulation Division

Minnesota Department of Health Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112

Fax: (651) 215-9697

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION			DATE OF REV	/ISIT
	A. Building B. Wing		Y2	5/23/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		•	
NEW RICHLAND CARE CENT	ER	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).

ITE Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4			DATE Y5
ID Prefix	F0225	Correction	ID Prefix F	0226	Correction	ID Prefix	F0309		Correction
Reg. #	483.13(c)(1)(ii)-(iii), (c)(2) Completed	Reg. #	33.13(c)	Completed	Reg. #	483.25		Completed
LSC		05/05/2016	LSC		05/05/2016	LSC			05/18/2016
ID Prefix	F0314	Correction	ID Prefix F	0322	Correction	ID Prefix	F0323		Correction
Reg. #	483.25(c)	Completed	Reg. #	33.25(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 F	0356	Correction	ID Prefix	F0441		Correction
Reg. #	483.25(n)	Completed	Reg. #	33.30(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			
REVIEWI STATE A		EWED BY ALS) KS/kfd	DATE 05/26/201		JRE OF SURVEYOR 03048			DATE 5/23	3/2016
REVIEWI CMS RO		EWED BY ALS)	DATE	TITLE				DATE	
FOLLOWUP TO SURVEY COMPLETED ON 3/31/2016				CORRECTED DEFICIENCIES (CMS-2567)				s 🗆 no	

Form CMS - 2567B (09/92) EF (11/06)

Page 1 of 1

EVENT ID:

EBZN12

Correction

Completed

ID Prefix

Reg. #

		POST-C	ERTI	FICATIO	ON RE	EVISIT F	REPOR	RT		
PROVID	ER / SUPPLIER / CL	IA / MULTIPLE CON	ISTRUCTIO	N					DATE OF RE	VISIT
IDENTIF 245316	ICATION NUMBER	A. Building 01 - B. Wing	MAIN BU	ILDING 01				Y2	5/4/2016	Y3
NAME O	F FACILITY				STREE	T ADDRESS, C	CITY, STATE	, ZIP CODE		
NEW R	ICHLAND CARE O	CENTER			312 N	ORTHEAST 1S	T STREET			
					NEW F	RICHLAND, MN	56072			
provisio		ch corrective action v identification prefix c								
ITE	EM	DATE	ITEN	I		DATE	ITEM		DA	TE
Y4	1	Y5	Y4			Y5	Y4		Υ	5
ID Prefix		Correction	ID Prefix			Correction	ID Prefix		Cor	rection
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101		Completed	Reg. #	NFPA 101	Cor	npleted
LSC	K0025	04/19/2016	LSC	K0069		04/19/2016	LSC	K0154	04/2	8/2016

Correction

Completed

ID Prefix

Reg. #

Correction

Completed

ID Prefix

Reg. #

NFPA 101

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: EBZN

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART I -	TO BE COMPI	LETED BY T	THE STAT	TE SURVEY	AGENCY		Facility ID: 00748
MEDICARE/MEDICAID PROV. NO.(L1) 245316 STATE VENDOR OR MEDICA: (L2) 825340400		3. NAME AND AI (L3) NEW RICH (L4) 312 NORTH (L5) NEW RICH	LAND CARE HEAST 1ST ST	CENTER	(L6)	56072	4. TYPE OF A 1. Initial 3. Termination 5. Validation	2. Recertification n 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE O (L9)	F OWNERSHIP	7. PROVIDER/SU 01 Hospital	JPPLIER CATEG	ORY 09 ESRD	<u>02</u> (L7) 13 PTIP	22 CLIA	7. On-Site Vis 8. Full Survey	it 9. Other After Complaint
6. DATE OF SURVEY 03/ 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	31/2016 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR E	ENDING DATE: (L35)
11LTC PERIOD OF CERTIFICATI From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds	50 (L18) 50 (L17)	Compliance1. A X B. Not in Con	equirements e Based On:	gram	2. Tech 3. 24 F 4. 7-Da 5. Life	nnical Personnel Iour RN ay RN (Rural SN Safety Code	7. Medic	of Services Limit al Director t Room Size
14. LTC CERTIFIED BED BREAKI	OWN	Requirements	and/or Applied	varvers.	* Code:	B*	(LIZ)	
18 SNF 18/19 SNI 50		ICF	IID		1861 (e) (1) or		(L15)	
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY RE	MARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION 1	DATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SUF	RVEY AGENCY	APPROVAL	Date:
Wendy Buckholz,	HFE NE II		04/26/2016	(L19)	K <u>amala Fiske-</u> l	Downing, Hea	lth Program Rep	resentative 05/20/2016 (L20)
P	ART II - TO BE	COMPLETED I	BY HCFA RE	EGIONAI	OFFICE OF	R SINGLE S	TATE AGENC	Y
DETERMINATION OF ELIGIBLE 1. Facility is Eligible to 2. Facility is not Eligible.	Participate		IPLIANCE WITH	ł CIVIL	2. (ncial Solvency (HCF/ Il Interest Disclosure :	
22. ORIGINAL DATE	23. LTC AGREEI	MENT 24	4. LTC AGREEN	MENT	26. TERMINA	TION ACTION:		(L30)
OF PARTICIPATION 06/01/1986	BEGINNING		ENDING DA		VOLUNTARY 01-Merger, Clos	_00		OLUNTARY ail to Meet Health/Safety
(L24)	(L41)		(L25)			on W/ Reimburse		ail to Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI A. Suspension	VE SANCTIONS n of Admissions:	(L44)		03-Risk of Involu 04-Other Reason	untary Termination for Withdrawal	OTH	rovider Status Change
(L27)	B. Rescind St	uspension Date:	(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/	/CARRIER NO.		30. REMARKS			-
		03001						
	(L28)	00001		(L31)				
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	DATE				
	(L32)			(L33)	DETERMIN	ATION APPF	ROVAL	



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

Kamala Fiske Downing

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112

Fax: (651) 215-9697

PRINTED: 04/26/2016 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER NEW RICHLAND CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFOCINCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING MFORMATICAL) F 000 INTITIAL 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 with the regulations has been attained in accordance with your enfication. F 225 483.13(c)(1)(ii)-(iii), (c)(2) - (4) SS=D 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 unfilress 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).		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		E SURVEY MPLETED
NEW RICHLAND CARE CENTER 312 NORTHEAST 1ST STREET NEW RICHLAND, MN 56072 NORTHEAST 1ST STEET NORTHEAST 1ST STREET NEW RICHLAND, MN 56072 NORTHEAST 1ST STEET NORTHEAST 1ST STEET NORTHEAST 1ST STEET NORTHEAST 1ST STREET NEW RICHLAND, MN 56072 NORTHEAST 1ST STREET NEW RICHLAND, MN 56072 NORTHEAST 1ST STREET NEW RICHLAND, MN 56072 NORTHEAST 1ST STREET NORTHEAST 1ST STREET NEW RICHLAND, MN 56072 NORTHEAST 1ST STREET NEW RIC			245316	B. WING _		03/	/31/2016
FRIEFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) FOOD 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 with the regulations has been attained in accordance with your verification. F 225 As 13(c)(1)(ii)-(ii), (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 or other facility staff to the State 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 throughers, including injuries of unknown source and misappropriation of the facility and to other officials in accordance with State law through established procedures (including to the			ER		312 NORTHEAST 1ST STREET		
The facilitys 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 225 483.13(c)(1)(ii)-(iii), (c)(2) - (4) SS=D 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 misapropriation 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	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLÉTION
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 225 483-13(c)(1)(ii)(iii), (c)(2) - (4) SS=D 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 misapropriation 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	F 000	INITIAL COMMENT	rs .	F 00	00		
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 225 SS=D NESTIGATE/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		as your allegation of Department's acception enrolled in ePOC, year the bottom of the form. Your electronic be used as verification	of compliance upon the otance. Because you are your signature is not required first page of the CMS-2567 ic submission of the POC will ion of compliance.				
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		on-site revisit of you validate that substa regulations has bee your verification. 483.13(c)(1)(ii)-(iii), INVESTIGATE/REF	ur facility may be conducted to ntial compliance with the en attained in accordance with (c)(2) - (4)	F 22	25		5/5/16
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		been found guilty of mistreating resident had a finding entered registry concerning of residents or misa and report any know court of law against indicate unfitness for other facility staff to	f abusing, neglecting, or ts by a court of law; or have ed into the State nurse aide abuse, neglect, mistreatment appropriation of their property; wledge it has of actions by a an employee, which would or service as a nurse aide or the State nurse aide registry				
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		involving mistreatm including injuries of misappropriation of immediately to the ato other officials in a through established State survey and control of the	ent, neglect, or abuse, unknown source and resident property are reported administrator of the facility and accordance with State law I procedures (including to the ertification agency).				

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

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.

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		X3) DATE COMP	SURVEY LETED
		245316	B. WING _			03/3	1/2016
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, ST 312 NORTHEAST 1ST ST NEW RICHLAND, MN 5	REET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTI' CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD B ED TO THE APPROPRI FICIENCY)		(X5) COMPLETION DATE
F 225	violations are thoro prevent further pote investigation is in p The results of all in to the administrator representative and with State law (inclu- certification agency incident, and if the	ave evidence that all alleged ughly investigated, and must ential abuse while the rogress. vestigations must be reported	F 2	25			
	by: Based on interview facility failed to immabuse to the admin agency and thoroug for 2 of 5 resident refindings include: The facility failed to State agency immerinvestigate an alleg for R27. Review of an incide 9/18/15, revealed a [nursing assistant] shower in the [hallwout and told RN [rehad 2 skin tears on elbow. 'They were to the state of the state	v and document review, the nediately report allegations of istrator and designated State ghly investigate the allegations eports (R27, R17) reviewed. o notify the administrator and ediately and failed to thoroughly ration of maltreatment/abuse ent report for R27, dated a nursing description: "CNA was assisting resident into way] shower room. CNA came gistered nurse] that resident left upper arm above the there when we undressed her.'-lower 1.6 cm [centimeters]		1. R27 and R17 whosen negatively affer Employees were trapolicy and on the negative and Director of Nurand April 13. 2. A review of all a found that no other negatively affected 3. The Social Wo Nursing are now at all allegations of aboneeded after receivincident from the faimmediately report abuse. Investigation complete name of a the interview along	ected by this practained on our abust eed to immediate to the administration on March 15 allegations of abust residents have be by this practice. Orker and Director ble to do an initial buse from their howing the details of acility in order to all allegations of ons will now include staff, date and time	se ly sor si, 18 se een r of report me if the de the ne of	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION		E SURVEY PLETED
		245316	B. WING		03/:	31/2016
	PROVIDER OR SUPPLIER	ER	;	STREET ADDRESS, CITY, STATE, ZIP CODE B12 NORTHEAST 1ST STREET NEW RICHLAND, MN 56072		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 225	in the shape of trial description reveale skin tears are from grabbing me hard.' her left forearm endedma to show RN incident report did the administrator where the administrator reported to the Statinivestigative report 9/27/15, and accommented include the documents include the the administrator reported to the statinivestigative report 9/27/15, and accommented for resident interview are not documented for resident interviews documented regard treatment of them or residents on the unconcerns. On 3/31/16, at 9:19 services (DSS) and nursing assistants regarding the incide interviews. However, the complete names of interviews and full stresidents were interesidents were interesidents were interesidents were interesidents in experiencing similar administrator reported.	age 2 apper 2.3 x 1 cm and they are ngles. Review of the resident d'All the bruising and these fingernails and people Resident then grabber [sic] ough to make indents in I how she is grabbed." The not indicate a date and time ras notified of the incident. ent report submitted to the aled the allegation of ted by R27 on 9/18/15 was te agency on 9/21/15. The systematic properties from staff. Solete name of staff, date and not full statements of staff were rall interviews. No other were completed or ding their experiences of staff during cares to ascertain if the staff, date and not	F 225	staff. In addition, during the invest process, Social Services will inter other residents as needed to dete others have experienced similar treatment. 4. All incidents will be audited the business day to determine if policic followed and if further action need taken. The results of these audits discussed at the next 6 monthly 0 meeting.	e next y was ds to be s will be	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G			(X3) DATE SURVEY COMPLETED	
		245316	B. WING			03/3	31/2016	
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZI 312 NORTHEAST 1ST STREET NEW RICHLAND, MN 56072	P CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD HE APPROPI	BE	(X5) COMPLETION DATE	
F 225	the administrator control not notified of the interport of a potential exploitation a facility visitor, (V) An incident report of revealed V-A unexproom. R17 was hearnly room. Review progress notes, darevealed the facility nursing DON, adminformed on 8/25/1 allegations of finan V-A against R17. Vonfront R17 about altercation occurred not feel safe at the report submitted to 8/27/15 revealed the State agency of the allegations until 8/2 On 3/31/16, the DS the allegation and in and mistreatment in immediately reported. The Vulnerable Add Care Center, undata "We need to report [name of administration	ent on 9/21/15. The DSS and confirmed the State agency was incident until 9/21/15. In immediately notify the State ation and observation of an and mistreatment of R17 by A. Idated 8/25/15, revised 8/27/15 pectedly visited R17 in her ard yelling at V-A to "get out of of the incident report and ted 8/25/15 through 8/27/15 or (including the director of inistrator and DSS) were 6 by R17 and V-A about cial exploitation committed by A was at the facility to a these allegations and a verbal director. A review of the incident the State agency, dated the facility did not notify the exploitation and exploitation and exploitation and exploitation confirmed and exploitation and exploitation involving R17 was not exploitation for New Richland and the Reporting for New Richland and Reporting for New Richland and Reporting for New Richland and Reporting for New Richland	F 2	225				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG		E SURVEY PLETED
		245316	B. WING _		03/:	31/2016
	ROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 312 NORTHEAST 1ST STREET NEW RICHLAND, MN 56072		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	can assist you with Director of Nursing present in the buildi investigation as well involved, staff witned it on to someone else here at the time the to start the process to report this immediable, after the resid Department of Healto investigate and so by [name of administration policy further directed abuse, neglect, injuresident to resident abuse are promptly by facility managemincluded: "7. Interview Witness Interview Fromplete the intervistatements rather the statement. This given questions that may This should include incident and other sincident occurred." residents that the a	ident or RN on Duty or on call the process, if Administrator, or Social Services are not ng. You need to start the I, talk to the residents isses, etc. Please do not pass se coming on duty. If you were incident happened, you need incident in safe to the Minnesota of this in, which will be done strator, DON and DSS]." The red staff "All reports of resident ries of unknown source, abuse and resident to staff and thoroughly investigated tent." Steps of investigation ew the staff. Use the Incident form." and "You need to ewing and record their nan allowing them to write the resident you a chance to ask help determine the cause. The person who reported the staff working at the time the and "b. Interview other coused employee has termine if they have a employee."	F 22			5/5/16
SS=D	ABUSE/NEGLECT, The facility must de policies and proced mistreatment, negle	ETC POLICIES velop and implement written	1 22			5/5/10

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245316	B. WING		03/3	31/2016
	PROVIDER OR SUPPLIER	ER	3	STREET ADDRESS, CITY, STATE, ZIP CODE 812 NORTHEAST 1ST STREET NEW RICHLAND, MN 56072		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	Continued From pa	ge 5	F 226			
	by: Based on interview facility failed to imp immediate reporting administrator and Sinvestigating allega (R27, R17) reviewed Findings include: The Vulnerable Add Care Center, undat to report Vulnerable administrator] administrator] administrator] administrator] administrator or has it reported to Charge of The Rescan assist you with Director of Nursing present in the build investigation as we involved, staff witned it on to someone element at the time the to start the process to report this immediable, after the residue Department of Heat to investigate and so by [name of administrator] policy further direct abuse, neglect, injuresident to resident	ult Reporting for New Richland ed, directed staff: "We need e Adult incidents to [name of nistrator immediately and to		 R27 and R17 were not found to been negatively affected by this pray Employees were trained on our about policy and on the need to immediate report all incidents to the administration and Director of Nursing on March 1 and April 13. A review of all allegations of abound that no other residents have negatively affected by this practice. The Social Worker and Direct Nursing are now able to do an initial all allegations of abuse from their homeded after receiving the details of incident from the facility in order to immediately report all allegations of abuse. Investigations will now include complete name of staff, date and tifthe interview along with full statements. In addition, during the investignoses, Social Services will interview other residents as needed to determ others have experienced similar treatment. All incidents will be audited the business day to determine if policy followed and if further action needs taken. The results of these audits of discussed at the next 6 monthly QA meeting. 	use ely ator 5, 18 use been or of al report ome if f the feate of ents of gative ew mine if next was to be will be	

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED	
		245316	B. WING		03/	/31/2016
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP COI 312 NORTHEAST 1ST STREET NEW RICHLAND, MN 56072		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) COMPLETION DATE
F 226	by facility managerincluded: "7. Intervi Witness Interview F complete the interv statements rather the statement. This give questions that may This should include incident and other sincident occurred." residents that the aprovided care to de complaint about the The facility failed to State agency immerinvestigate an alleg R27. Review of an incide 9/18/15, revealed a [nursing assistant] is shower in the [hallwout and told RN [rehad 2 skin tears on elbow. 'They were to the skin tears are land 1 cm and the unin the shape of triar description revealers skin tears are from grabbing me hard.' her left forearm endedema to show RN incident report did rethe administrator were reversely shown of the incident report did reversely shown of the incident rep	nent." Steps of investigation ew the staff. Use the Incident form." and "You need to iewing and record their han allowing them to write the es you a chance to ask help determine the cause. the person who reported the staff working at the time the and "b. Interview other ccused employee has termine if they have a	F 2	226		

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED	
		245316	B. WING		03	/31/2016
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIF 312 NORTHEAST 1ST STREET NEW RICHLAND, MN 56072	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 226	mistreatment repor reported to the statinvestigative report 9/27/15, and accomdocuments include However, the comptime of interview and tocumented for resident interviews documented regard treatment of them or residents on the unconcerns. On 3/31/16 at 9:19 services (DSS) and nursing assistants aregarding the incide interviews. However complete name of sinterview and full stresidents were interexperiences of staff cares to ascertain in experiencing similar administrator report have been notified reviewed the incident the administrator control to the incident of the in	ted by R27 on 9/18/15 was e agency on 9/21/15. The submitted to the State on apanying investigative interviews from staff, date and ad full statements of staff were rall interviews. No other were completed or ding their experiences of staff during cares to ascertain if it were experiencing similar. a.m. the director of social administrator reported and nurses were interviewed ent. Notes were taken of the err, the notes did not include the staff, date and time of atements of staff. No other reviewed regarding their freatment of them during fresidents on the unit were r concerns. The DSS and ted the administrator may not until the interdisciplinary team and on 9/21/15. The DSS and confirmed the state agency was accident until 9/21/15. Immediately notify the state attion and observation of n and mistreatment of R17 by	F 2	226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245316	B. WING		03/31/2016	
	PROVIDER OR SUPPLIER	ER	3	STREET ADDRESS, CITY, STATE, ZIP CODE 112 NORTHEAST 1ST STREET NEW RICHLAND, MN 56072		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		
F 226 F 309 SS=D	my room" Review of progress notes, data revealed the facility nursing (DON, adminformed on 8/25/16 allegations of finance V-A against R17. V-confront R17 about altercation occurred not feel safe at the report submitted to revealed the facility of the 8/25/15 incide 8/27/15. On 3/31/16 the DSS the allegation and in and mistreatment in immediately reported.	of the incident report and ed 8/25/15 through 8/27/15 (including the director of inistrator and DSS) were 5 by R17 and V-A about cial exploitation committed by Awas at the facility to these allegations and a verbal d. R17 reported to staff she did facility. A review of the incident the state, dated 8/27/15 did not notify the state agency ent and allegations until	F 226		5/18/16	
	provide the necessary or maintain the high mental, and psycho	receive and the facility must ary care and services to attain nest practicable physical, social well-being, in e comprehensive assessment				
	by: Based on observat review, the facility for checks were compl	NT is not met as evidenced ion, interview and document ailed to ensure neurological eted after a fall with a possible 1 resident (R39) reviewed for		 Resident 39 was assessed and to have not suffered neurologically a result of this incident. No other residents were found to the suffered neurologically and the suffered neurologically are suffered neurologically as the suffered neurological neurologi	s a	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245316	B. WING		03/3	31/2016
	PROVIDER OR SUPPLIER	ER	3	STREET ADDRESS, CITY, STATE, ZIP CODE 112 NORTHEAST 1ST STREET NEW RICHLAND, MN 56072		.,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	diagnoses of heart disorder. R39's admission M 2/22/16 identified F assistance of two smobility. R39's Care Area As 3/6/16, indicated R impaired mobility, anot fallen recently, interventions shoul R39's care plan las R39 was at risk for safety needs, poor communication/corproblems and incorproblems and incorproble	lated 3/31/16 identified active failure and major depressive inimum Data Set (MDS), dated 39 required extensive taff for transfers and bed seessment (CAA) dated 39 had a risk of falls related to and her family stated she had The CAA indicated falls d be care planned. It revised 3/11/16, indicated falls r/t (related to) unaware of imprehension, gait/balance	F 309	been affected by this practice. 3. Nurses will be re-trained on the policy which involves possible hear by the DON on May 18th. All incide involving potential head injuries with neurological checks initiated by the charge nurse on duty at the time of incident in accordance with our pound and incidents involving possible hear injuries will be audited by the DON designee to ensure neurological chare performed per policy. 4. The DON or her designee will the result of these audits at the neurological chart in the policy.	d injury ents II have e f the licy. ad or her necks	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	NG		TE SURVEY MPLETED
		245316	B. WING		03	3/31/2016
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 312 NORTHEAST 1ST STREET NEW RICHLAND, MN 56072		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 309	to the mid-forehead from the nares at the incident report did repo	dide of the nose, an abrasion and had bright blood coming time of the incident. The not indicate whether	F3	09		
	R39 was resting in clipped to her shou	9/16, at 12:13 p.m. revealed bed with a magnetic alarm lder. A falls mat was noted on ed. R39 opened her eyes				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245316	B. WING _		03.	/31/2016	
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CO 312 NORTHEAST 1ST STREET NEW RICHLAND, MN 56072		0.1720.10	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 309	how she was feelin purple bruising alor and left eye, and a color. During interview on stated she thought checks conducted a flow sheet was in LPN-A located a newhich was dated 3/six entries; beginning and ending at 1:00 and times of the necorrespond with the at 2:12 a.m.). During interview on registered nurse (Finurse manager and 3/26/16 and that Ricident. RN-C revisheet and indicated neurological check timing of the incide the facility neurologishe would check the first half hour, then then hourly for 4 tin for 72 hours. Whe	age 11 at did not respond when asked g. R39 was noted to have ng the inside of the right eye swollen nose and was pale in a 3/29/16, at 3:37 p.m. LPN-A. there had been neurological for R39 after her fall, and that itiated to record the results. Eurological flowsheet for R39 (24/16 and included a total of ng at 3/24/16 at 11:00 p.m. p.m. on 3/27/16. The dates eurological checks did not et timing of R36's fall (3/26/16, at 12:30 p.m. RN)-C, indicated she was R39's d was aware of the fall dated as hit her head during the riewed R39's neurological flow d the dates and times of the s did not match up with the nt. When questioned about gical check policy, RN-C stated nem every 15 minutes for the every half hour four (4) times, nes and then every four hours n asked why there were no s recorded for 3/26/16, for R39	F 30	9			
	"That's a good que During interview on medical doctor (ME facility's medical dir	ntil 9:00 a.m., RN-C stated stion." n 3/30/16 1:53 p.m. R39's D)-A indicated he was also the rector and would have aff to follow their neurological					

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		245316	B. WING			03/3	31/2016
	PROVIDER OR SUPPLIER	ER		3	TREET ADDRESS, CITY, STATE, ZIP CODE 12 NORTHEAST 1ST STREET IEW RICHLAND, MN 56072		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	especially if the fall suspected head injunction on indicated she was of 3/26/16. When ask after the fall, RN-D neurological flow shought she was consider the recorded them neurological checks keep doing them if During further interest. During further interest. During further interest. During further interest. PN-D provided the policy and confirme subsequent neurological checks keep doing them if During further interest. PN-D wouldn't have want what are you going hospital?" During interview on director of nursing in should have conducted in accordance with head of the neurological checks was a concern possibility these neinitiated after the firindicated that after would have expected.	after an unwitnessed fall, resulted in a bloody nose or ury. 3/31/16, at 6:19 a.m. RN-D on duty when R39 fell on ked about neurological checks stated she had started a neet and verified that the sheet dated 3/24/16 was the R39. RN-D stated she onfused as to the times when and there was a policy for s, but stated they didn't have to	F3	809			

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 312 NORTHEAST 1ST STREET NEW RICHLAND, MN 56072 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)			245316	B. WING		03/3	31/2016
			ER		312 NORTHEAST 1ST STREET		
	PREFIX	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE	(X5) COMPLETION DATE
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 34 MR 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 314	F 314	The facility policy e revised 12/2/04 ind possible head injurithe resident hit their falls. Every (Q) 15 4. Q hour (HR) x 4 Vital signs need to each neuro assess showing signs of between the facility who enters the facility f	ntitled Neuro Assessment, last icated to do neuro check on les: any falls where you know it head or any unwitnessed minutes x 4. Q 30 minutes x 2. Q 2 HR x 4. Q 4 HR x 2. It only be done on the first set of ment, unless the resident is eing unstable. IENT/SVCS TO IRESSURE SORES INTERSORES INTERSO		1. Clarified doctor s order for residuith the appropriate nursing staff arensured all orders are followed as vectors: 2. A review of all other doctor orders allowed us to verify and correct as all orders to ensure they are followed written. 3. The nursing staff will be re-education on the need to	nd written. s needed ed as	5/18/16

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 312 NORTHEAST 1ST STREET NEW RICHLAND, MN 56072			
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F 314	(MDS) assessment required extensive bed mobility, transf Interview for Menta had a score of 3, in impairment. The a R35 had an unheal measuring 1.0 cent wide (W) x 0.4 cm Review of the care RN Reviewing ulce ordered. Review of the prog 23:36 (11:36 p.m.) order to wound on Review of the faxed included: Cleanse protocol, pat dry - a collagen, apply thin with foam dressing and PRN (as needed Review of the elect revealed the follow order: "Order date Everyday Cleanse Pat dry. Apply skin and let it dry. Apply bed. Cover with fo WOUND CARE" A start date of 11/25/ order had been imporder was unchanged.	quarterly Minimum Data Set to dated 2/9/16, indicated R35 assistance of two staff with er and toilet use. The Brief I Status (BIMS) indicated R35 dicating severe cognitive ssessment further identified ed stage 3 pressure ulcer (PU) timeters (cm) long (L) x 0.2 cm deep (D). plan dated 2/8/16 included: r weekly. Wound care as ress note dated 3/9/16, at indicated: "New treatment buttock see physician orders." d physician order dated 3/9/16 wound on buttock per apply skin prep, pack with layer of silver hydrogel, cover. Dressing change twice daily	F 314	transcription. The DON or design audit 1 resident per week during rounds who has a pressure ulce ensure current treatment is per lorders, that appropriate interven in place to prevent development pressure sores and to promote have audits will be reviewed at 6 monthly QAIP meetings. 4. The results of these audits will reviewed at the next 6 QAIP meensure treatments are as writter and within policy and guidelines.	wound r to MD tions are of future nealing. the next Il be etings to n by MD		

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245316	B. WING		03/:	31/2016
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 312 NORTHEAST 1ST STREET NEW RICHLAND, MN 56072		
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F 314	day. The current of with collagen. During observation registered nurse (RR35's coccyx PU. saline; the wound not (W) x 0.6 cm (D). It the surrounding ski applied a thin layer wound and covered was not observed to collagen. When interviewed or RN-B revealed she treatment to R35's resident had recent the 200 hall. RN-B RN-C prior to perfor 3/30/16 as RN-C wround with collage direction. RN-B correction. RN-B corr	on 3/31/16, at 8:37 a.m. (N)-B performed a treatment to RN-B cleansed the wound with neasured 1.0 cm (L) x 0.4 cm RN-B then applied skin prep to n, allowed the skin to dry, then of silver hydrogel to the d with a foam dressing. RN-B to pack the wound with neasured 1.0 cm (L) x 0.4 cm RN-B then applied skin prep to n, allowed the skin to dry, then of silver hydrogel to the d with a foam dressing. RN-B to pack the wound with neasured 1.2:00 p.m. had only performed the PU one other time as the sty moved from the 100 hall to indicated consulting with rming R35's PU treatment on as the nurse manager on the far with R35's PU treatment. The packed R35's coccyx n on 3/30/16 per RN-C's nfirmed she did not pack collagen during the observation reviewed R35's treatment of include instructions for the d with collagen. RN-B physician order dated 3/9/16 order indicated to pack the n. RN-B stated being unsure were packing R35's coccyx agen when performing the	F 314			
		on 3/31/16, at 12:07 p.m. the (DON) confirmed R35's 3/9/16				

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		245316	B. WING		03/	/31/2016
	PROVIDER OR SUPPLIER CHLAND CARE CENT	ER		STREET ADDRESS, CITY, STATE, ZIP COE 312 NORTHEAST 1ST STREET NEW RICHLAND, MN 56072		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 314	incorrectly. DON further stated being unsure packing the wound performing the treat confirmed the inacciproblem. During intentered the office a transcribed the new electronic record intranscription. When interviewed to confirmed she had PU when he resident earlier in the week. That time was not be confirmed that the fincreased from oncother treatment characteristics. When interviewed to confirmed that the fincreased from oncother treatment characteristics. When interviewed to DON stated the proof new orders was the order was correfurther stated that if the order made characteristics.	ment order was transcribed of the stated knowledge that cking R35's PU coccyx wound performing the treatment and measurements. DON to the floor nurses were with collagen when to the transcription was a terview with the DON, RN-B and stated RN-C had initially order on 3/9/16 and the dicated RN-A had edited the dicated RN-A had edited the dicated RN-A further requency of the treatment had the to twice daily otherwise not anges had been ordered. In 3/31/16, at 12:31 p.m. the cedure related to transcription to have a second nurse verify anges to the order, the order to be verified by another nurse. The en R35's 3/9/16 PU treatment the en R35's 3/9/16 PU treatment the en R35's 3/9/16 PU treatment and there was no the en R35's PU are included to pack the n and there was no	F3	14		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245316	B. WING _		03/	31/2016	
	PROVIDER OR SUPPLIER CHLAND CARE CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 312 NORTHEAST 1ST STREET NEW RICHLAND, MN 56072			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 322 F 322 SS=D	Based on the compresident, the facility (1) A resident who lalone or with assist tube unless the residemonstrates that unavoidable; and (2) A resident who is gastrostomy tube resident.	REATMENT/SERVICES - a SKILLS brehensive assessment of a rmust ensure that has been able to eat enough ance is not fed by naso gastric ident's clinical condition use of a naso gastric tube was s fed by a naso-gastric or eceives the appropriate	F 32			5/18/16	
	pneumonia, diarrhe metabolic abnorma ulcers and to restor skills.	ices to prevent aspiration ea, vomiting, dehydration, lities, and nasal-pharyngeal re, if possible, normal eating NT is not met as evidenced					
	Based on observative review the facility factorized placement infusing medication had placement of a Findings include: During observation on 3/31/16, at 10:30 had set up R23's medication and set up R23's medication of the factorized placement of the facility of the factorized placement of the factorized placement of the facility of the facilit	tion, interview and document ailed to ensure nursing staff to fa nasogastric tube prior to for 1 of 1 resident (R23) who nasogastric tube. of a medication administration 0 a.m. registered nurse (RN)-A redications as ordered. RN-A d medications into a 60 cubic		1. The nurse has been re-train 7th concerning the proper place naso-gastric tube. All nurses we re-educated on the placement naso-gastric tube on May 18th. 2. Since our state review reside had her naso-gastric tube remote other residents in our facility cuuses a naso-gastric tube.	ement of a vill be of a ent 23 has byed. No		

-	F DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DENTIFICATION NUMBER: (X4) MULTIPLE CONSTRUCTION (X3) A. BUILDING			X3) DATE SURVEY COMPLETED		
		245316	B. WING		03/3	31/2016
NAME OF PROVIDER OR SUPPLIER NEW RICHLAND CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 312 NORTHEAST 1ST STREET NEW RICHLAND, MN 56072		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 322	medication through was not observed to nasogastric tube properties when interviewed as the checks tube planark located on the the black mark located on the place as she observed the length of tube from the length of tube from did she check plistening. Interview with the did 3/31/16, at 2:00 p.m. checked placement medications by medications by medicated on the tube DON explained that included initial mean tube was placed. A facility Nasogastrundated, identified the administration of placement of the tufeedings/medication of air and listening to check for stomace length of the tubing length with the reconstruction. Do not profeeding/medications placement or if tubi changed.	yringe and infused the R23's nasogastric tube. RN-A or check placement of R23's ior to infusing the medications. At this time, RN-A indicated accement by visualizing a black of tube. RN-A further included if its like it is located in the same wed the prior day, she confirms firmed she had not measured from the black line to the nose placement by aspiration and/or irrector of nursing (DON) on in. indicated RN-A should have to prior to the infusion of the asuring from the black mark to the resident's nose. The talk R23's medical record surements taken after the included of medications; check be before beginning the ins by inserting a small amount with a stethoscope or aspirate the contents. Measure the from the nose and compare orded length following initial occeed with its if you cannot confirming measurement has	F 322	3. Will ensure all nursing staff who to use naso-gastric tube, will have skills verified by the DON or her debefore being allowed to use the tul Nurses will read and sign a copy opolicy regarding naso-gastric tube prior to admitting a resident who utube. 4. When we have a resident who is a naso-gastric tube, The DON or designee will audit the staff and refor proper use and placement of tweekly for 4 weeks or until the tub removed. The results of these audie reviewed at the next QAIP meets.	their esignee be. f the use se this s using sident abe e is dits will	
F 323 SS=D	483.25(h) FREE OF HAZARDS/SUPER		F 320	3		4/1/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 323	environment remains as is possible; and	ge 19 sure that the resident as as free of accident hazards each resident receives on and assistance devices to	F 323			
	by: Based on observar review the facility far use of a product cat for 3 of 4 residents these rails. Findings include: During observation again at 7:15 p.m. and the inner right so observed to have a 12 1/4 inches in ler widest part (opening in the shape of a cat confirmed by licens 7:15 p.m. and she was wide enough for head/neck. There we the rail opening. The bed cane man available guidance including: "There is associated with bed.	tion, interview and document alled to determine whether the lled, bed cane rails, were safe (R1, R25 & R31) who utilized on 3/28/16, at 6:30 p.m. and a bed cane rail was observed de of R1's bed. This rail was wide opening that measured agth and 5 1/4 inches at the g) of the rail. The bed rail was ane. Measurements were ed practical nurse (LPN)-A at confirmed R1's bed cane rail or potential entrapment of the was no fabric material covering ufacturer, Stander, also made to prevent entrapment a risk of entrapment a risk of entrapment drail products. Stander Inc. is ning users of potential		1. All resident who utilize grab bars had them replaced with new ones to meet current safety specifications. 2. No other residents have been for have been affected by this practice. 3. All grab bars have been replaced new ones that meet current safety specifications and the old ones have removed from the building to preve reoccurrence of this incident. All residents who need grab bars will be assessed our Rehab Department for use before having them installed. Maintenance will verify on an annual that the current grab bars in use more current safety requirements and specifications. 4. Maintenance will verify on an annual basis that the current grab bars in use more current safety requirements and specifications. The results of these checks will be reviewed at the follows Safety Meeting.	hat und to . d with we been int a pe or safe al basis eets nual use and	

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F 323	well as methods to versions of this guiwww.stander.com. Entrapment is a sit become caught by other body parts in bed rail or bedside shows 2 bed rail properties of illustration purporties. To HENTRAPMENT? The Administration (FD) Workgroup (HBSW following guidelines a zones. ZONE 1 - Wispace between the present a risk of he recommended spart quarters of an inchiproducts have inclusive around part, or all, helps reduce the rischould never be us securely attached. The removed to clean it review of R1's phy 9/30/15, identified to the time of the current was able to position the use of the bed secured.	prevent entrapment. Updated de are located at WHAT IS ENTRAPMENT? uation where an individual can their head, neck, chest or the tight spaces around the mobility aid. The below picture oducts being used on a bed oses. ARE THERE ANY HELP PREVENT he U.S. Food and Drug A) and the Hospital Bed Safety (1) have established the sto help prevent entrapment. The categorized by seven (1) THIN THE RAIL Any open perimeters of the rail can ead entrapment. The FDA ce is less than four and three 4-3/4"). Some Stander uded a fabric material cover of the bed rail. This cover sk of entrapment. The product sed when the cover is not The cover should only be the resident utilized a bed cane for assistance when oped. The progress note did not be bed cane rail had been (y).	F 323	3			

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F 323	include a determinal had been deemed Review of incident include any injuries the bed rail for R1. When interviewed indicated she utilize and for sitting up in Interview with the c3/29/16, at 7:30 p.r rail on her bed since DON revealed she be a safety concernent rapment. R1's bed rail was o3/28/16, at 7:40 p.r bar that was within zones/openings for Interview with the Econfirmed nursing of bed cane rails, it department made to Interview with the m3/30/16, at 10:00 a any determination autilized on resident During observation bed cane rail was of the bed. The rail was opening which mea	ation as to whether the bed rail safe for R1's use. I reports for the past year did or potential injuries related to on 3/28/16, at 7:15 p.m. R1 ed the bed rail for positioning bed. Ilirector of nursing (DON) on in. indicated R1 has had a bed se admission on 6/17/14. The was unaware R1's rail could in that included potential bserved to be removed on in. and replaced with a grab the recommended safety potential entrapment. DON on 3/30/16, at 9:59 a.m. does not assess for the safety out thought the maintenance	F 32	23			

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F 323	wide enough for pohead/neck. Fabric opening of the rail. Review of R31's ph 2/23/16, identified to cane for assistance progress note did nassessment related rail. Review of R31's many additional information the residents bed considered rail. Review of incident year, did not include injuries related to the Interview with the day 3/29/16 at 7:30 p.m. how long the resident The DON revealed could pose any potential pose any pote	A also confirmed the rail was tential entrapment of the material was not covering the sysical therapy (PT) note dated he resident utilized the bed with repositioning in bed. The tot include a safety of the use of the bed cane edical record did not include mation related to the use of ane rail nor the safety of the reports for R31 in the last e any injuries or potential	F 32	23		
	side of R25's bed. have a wide opening	The rails were observed to g that measured 12 1/4 inches inches at the widest part				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245316	B. WING		03/	31/2016	
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 312 NORTHEAST 1ST STREET NEW RICHLAND, MN 56072	, 33,	• · · · • · · · ·	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 323	2/8/16, identified the cane for assistance in bed. The note directed to safety of the currentilized a trapeze of side of bed to repose R25's medical reconsiderational information residents bed rail in the use of the bed of the week of the w	I. Inysical therapy note dated the resident as utilizing a bed to safely roll from side to side do not include an assessment the bed cane rail. In the plan of care indicated R25 in bed and bed cane on both sition self. Further review of ord did not include any on related to the use of the or an assessment related to rail. In the plan of care indicated R25 in bed and bed cane on both sition self. Further review of ord did not include any on related to the use of the or an assessment related to rail. In the plan of care indicated to R25 is bed. In 3/28/16, at 3:50 p.m. R25 in the beds rails for rom side to side in bed. In 3/28/16, at 7:35 p.m. the (DON) confirmed the bed rail R25 is bed though indicated in R25 is bed rails could be a chincluded potential bed rails were subsequently	F 323	3			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
		245316	B. WING		03	/31/2016	
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP COD 312 NORTHEAST 1ST STREET NEW RICHLAND, MN 56072	E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 323	department did. Interview with the fa 3/30/16 at 10:00 a.r assessing bed cane	thought the maintenance acility maintenance director on m. indicated he had not been e rails for safety.	F 3.				
F 334 SS=D	IMMUNIZATIONS The facility must de that ensure that (i) Before offering the each resident, or the representative receivenefits and potent immunization; (ii) Each resident is immunization October annually, unless the contraindicated or traindicated or	offered an influenza oer 1 through March 31 e immunization is medically he resident has already been his time period; the resident's legal the opportunity to refuse medical record includes indicates, at a minimum, the ent or resident's legal provided education regarding tential side effects of influenza ent either received the tion or did not receive the tion due to medical	F 3	34		5/18/16	

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		245316	B. WING		03/31/201	16
	PROVIDER OR SUPPLIER	ER	;	STREET ADDRESS, CITY, STATE, ZIP CODE 312 NORTHEAST 1ST STREET NEW RICHLAND, MN 56072		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPL	5) LETION TE
F 334	legal representative the benefits and poimmunization; (ii) Each resident is immunization, unless medically contrained already been immu (iii) The resident or representative has immunization; and (iv) The resident's redocumentation that following: (A) That the resident representative was the benefits and popneumococcal immunication or (v) As an alternative and practitioner reconstruction or the pneumococcal immunication, unless following the immunization, unless immunization;	ne pneumococcal a resident, or the resident's a receives education regarding tential side effects of the offered a pneumococcal as the immunization is icated or the resident has nized; the resident's legal the opportunity to refuse medical record includes indicated, at a minimum, the ent or resident's legal provided education regarding tential side effects of funization; and ent either received the funization or did not receive immunization due to medical refusal. a, based on an assessment formmendation, a second funization may be given after 5 first pneumococcal as medically contraindicated or resident's legal representative	F 334			
	by: Based on interview failed to provide do	NT is not met as evidenced and record review, the facility cumentation that e offered and/or administered		1. Residents R4, R39 and R47 hav discharged.	e been	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,		E CONSTRUCTION		SURVEY PLETED
		245316	B. WING		····	03/3	31/2016
	PROVIDER OR SUPPLIER	ER		3	TREET ADDRESS, CITY, STATE, ZIP CODE 12 NORTHEAST 1ST STREET IEW RICHLAND, MN 56072		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 334	for 3 of 5 residents the sample. This praffect all newly adm Findings include: R4 was admitted or immunization flows R4 and/or a representative in the risks and beneficiated and been offered at R47 was admitted or record lacked any documentation record lacked any expression and benefits for the representative in the representative in and benefits for the CON 3/31/16, at 9:30 (DON) verified sheevidence that reside and/or that the re	(R4, R39, R47) reviewed in actice had the potential to nitted residents. In 11/5/15; the medical record heet failed to identify whether entative had been notified of its for the pneumococcal R4 had been offered the In 2/22/16; the medical record ntation of the immunization nization record and lacked ococcal or influenza vaccines and/or administered. In 10/15/15 and the medical evidence the influenza vaccine and/or offered. The did did not include any evidence ed the vaccine and/or whether had been notified of the risks vaccine. In many the director of nursing was unable to produce any ents received the vaccines dents or representative were bout the risks and benefits of DON confirmed each resident ne influenza and	F3	34	 No other residents were found to been affected by this practice. The DON or her designee will at new admissions to ensure our polic concerning immunization/vaccines followed as written. The results of audits will be reviewed at the next 6 meeting. The results of these audits will be reviewed at the next 6 QAIP meeting action will be taken as needed to excompliance. 	idit all cy is these 6 QAIP e ngs and	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION NG	` '	(X3) DATE SURVEY COMPLETED	
		245316	B. WING		03/	/31/2016	
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 312 NORTHEAST 1ST STREET NEW RICHLAND, MN 56072			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 356 SS=C	workers and all per receive annual influidentified it was the encourage all staff annual flu shot in a complications as a The procedure for the following: 1. On admission, the discuss with the far previous vaccinationed educational informational advantages and discustional informational information and the educational information in the education of the education of the education of the education in their assistant DNS with the information in their assistant DNS with the education of the medication of the daily basis: The facility must per a daily basis: The total number by the following cations are sufficient to the total number by the following cations are s	sommended all healthcare sons over the age of 50 to lenza vaccines. The policy policy of the facility to and residents to receive an effort to minimize the result of contracting influenza. The policy identified the he nurse manager would mily and/or the resident in history and provide ation that included the sadvantages of vaccines. The receive the vaccination or enial. In will be placed in the chart in on. If family do not know if they vaccination the nurse manager ill attempt to find the past medical history, administration of the vaccine record including the name of on, time and date given, nurses on the face sheet. In NURSE STAFFING opens the following information on set the following information on set the following information on set the following information on the same set the same se	F 3			4/1/16	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245316	B. WING			03/3	31/2016
	PROVIDER OR SUPPLIER	ER		31	REET ADDRESS, CITY, STATE, ZIP CODE 2 NORTHEAST 1ST STREET EW RICHLAND, MN 56072		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 356	vocational nurses (- Certified nurses on Resident census.) The facility must pospecified above on of each shift. Data on Clear and readable on a prominent play residents and visitor. The facility must, up make nurse staffing for review at a cost standard. The facility must make nurse staffing data for an required by State later. This REQUIREMENT by: Based on observative the facility facurrent census inform hours worked on the This had the potent residing at the facility facuring observations 3/30/16 the facility in have the correct date.	nift: rses. tical nurses or licensed as defined under State law). e aides. est the nurse staffing data a daily basis at the beginning must be posted as follows: le format. acce readily accessible to	F3	356	1. The posting of nursing hours had been changed to meet state standaged. 2. No residents were found to have negatively affected by this practice. 3. The scheduler has printed a coppregulation for posting nursing hours will follow the directions as written. 4. The format used for posting hours be audited weekly for the next 16 wand the results of these audits will be and the results of these audits will be a serviced.	been y of the and rs will veeks	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION		E SURVEY PLETED
		245316	B. WING		03/	31/2016
	PROVIDER OR SUPPLIER	ER	3	STREET ADDRESS, CITY, STATE, ZIP CODE 812 NORTHEAST 1ST STREET NEW RICHLAND, MN 56072		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 356	nurse (LPN) and nu Inaccurate posting hours worked are li Census posted/actu-3/28/16- 48/47 Nursing hours post-3/28/16- NA: 48 hrs-3/29/16- NA: 36 hr-2/30/16- RN: 32 hr Hours of shift poste-3/28/16-RN: 6:00 ap.m. LPN: 2:00 p.m3/19/16-RN: 6:00 ap.m. LPN: 2:00 p.m8:00 p.m. NA: 2:00 p.m3/30/16- RN: 6:00 p.m. LPN: 2:00 p.m10 p.m10 p.m10 p.m10 p.m. LPN: 2:00 p.m10 p.m	urse (RN), licensed practical ursing assistance (NA). of the census and nursing sted below: ual census: ed vs. actual hours worked: s vs. 32 hrs s vs. 28 hrs s vs. 24 hrs ed vs. actual hours a.m2:30 p.m. vs. 8:00-4:30 p.m10:30 p.m. vs. 2:00 p.m10:30 p.m. vs. 2:00 p.m10:30 p.m. vs. 2:00 p.m10:30 p.m. vs. 2:00 p.m10:30 p.m. vs. 4:00 p.ma.m2:30 p.m. vs. 8:00-4:30 p.m. vs. 8:00-4:30 p.m. vs. 4:00 p.ma.m2:30 p.m. vs. 4:00 p.ma.m2:30 p.m. vs. 4:00 p.ma.m2:30 p.m. vs. 4:00 p.m.	F 356	reviewed at the next 4 QA meeting ensure compliance.	s to	
F 441 SS=D	483.65 INFECTION SPREAD, LINENS	I CONTROL, PREVENT	F 441			5/18/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245316	B. WING		03/	31/2016	
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CODI 312 NORTHEAST 1ST STREET NEW RICHLAND, MN 56072		J. 172010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 441	Infection Control Pr safe, sanitary and of to help prevent the of disease and infection Control The facility must est Program under white (1) Investigates, control in the facility; (2) Decides what pushould be applied to (3) Maintains a reconstruction actions related to in (b) Preventing Spreadisolate the resident (2) The facility must communicable disection direct contact direct contact will treat (3) The facility must hands after each din hand washing is incomprofessional practical (c) Linens Personnel must has transport linens so infection.	stablish and maintain an rogram designed to provide a comfortable environment and development and transmission ction. If Program stablish an Infection Control ch it - introls, and prevents infections rocedures, such as isolation, or an individual resident; and ord of incidents and corrective infections. If and of Infection in the facility must infection, the facility must infection, the facility must infection in Control Program resident needs isolation to infection, the facility must interest in the disease. It requires the disease infected skin lesions with residents or their food, if the facility is ansmit the disease. It requires the facility must interest resident contact for which dicated by accepted in the spread of infection in the spread	F 44				
	This REQUIREMEN	NT is not met as evidenced					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	,		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		245316	B. WING			03/3	31/2016
	PROVIDER OR SUPPLIER	ER		3	TREET ADDRESS, CITY, STATE, ZIP CODE 12 NORTHEAST 1ST STREET IEW RICHLAND, MN 56072		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	review the facility far hygiene during a wiresidents (R35) reviewed in Findings include: During observation 8:37 a.m. registered provide treatment to Nursing assistant (I room to assist with treatment. After Noonto his right side, brought a plastic coto R35's bedside. If RN-B verbalized the movement "smearif would need to clear RN-B picked up the utilized while assist wiped the fecal sme RN-B then proceed treatment/dressing and perform the treatment/dressing and perform the treatment gloves are providing treatment. When interviewed of confirmed she show cleansing the fecal prior to the PU wou stated she realized the clean treatment.	tion, interview, and document ailed to ensure proper hand ound treatment for 1 of 3 iewed for pressure ulcers. of wound cares on 3/31/16, at d nurse (RN)-B was noted to to R35's coccyx pressure ulcer. NA)-B was also present in the turning R35 during the A-B assisted with turning R35 RN-B donned gloves and ontainer with dressing supplies Prior to starting the treatment eresident had some boweling" on his buttocks that she hase prior to the PU treatment. As soiled washcloth NA-B had aing R35 with peri care, and earing from R35's buttocks. Ited to obtain R35's wound supplies from the plastic bin atment/dressing change with ands used to cleanse the ttocks. RN-B failed to remove and apply new gloves prior to and redressing the wound. on 3/31/16, at 9:30 a.m. RN-B alld have changed gloves after smearing from the skin and and treatment. RN-B further after she retreived items from a basket with the same soiled should have removed and	F 4	.41	1. The nurse in questions was re-tron the proper use of PPE vie on line training March 31st. The resident vnegatively affected by this practice. 2. No other residents were affected practice. 3. All nurses will be re-trained on prhand hygiene and the use of PPE of 18th by the DON or her designee. use and hand-washing will be audit weekly during wound rounds by the or her designee. 4. The results of these audits will be reviewed at the next 4 QAIP meeting action taken as needed to ensure compliance with our hand hygiene and PPE policies.	e was not I by this roper on May PPE ed e DON e	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		(X3) DATE COM	E SURVEY PLETED
		245316	B. WING			03/3	31/2016
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 312 NORTHEAST 1ST STREET NEW RICHLAND, MN 56072			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE
F 441	DON confirmed RN gloves and perform washing the resider performing the PU to Review of the Infect Precaution policy daperform hand hygie from a contaminate site during patient of indicated after removith non-antimicrob	on 3/31/16, at 11:27 a.m. the l-B should have changed ed hand hygiene after nt' buttocks and prior to treatment. tion Control Standard ated 2010, indicated to ne if hands will be moving d body site to a clean body eare. The policy further oving gloves to wash hands and water if contact with	F 4	41			

F5316025

PRINTED: 04/27/2016 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 245316 B. WING 03/30/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 312 NORTHEAST 1ST STREET **NEW RICHLAND CARE CENTER NEW RICHLAND, MN 56072** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 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

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

TITLE

A 10 E 10 0 4 6

(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.

Facility ID: 00748

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION ING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		245316	B. WING		03/	/30/2016	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 312 NORTHEAST 1ST STREET NEW RICHLAND, MN 56072			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORREC' X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
K 000	DEFICIENCY MUSTOLLOWING INFO 1. A description of to correct the deficition of the constructed of the constructed in 197 Type II(111) constructed to the determined to be a Because the originare of the same ty construction type at the facility was sure the facility was sure the constructed for an otification. The facility has a consult of the consus of 47 at the correct the determined to the consultation.	state.mn.us and in@state.mn.us PRRECTION FOR EACH ST INCLUDE ALL OF THE ORMATION: what has been, or will be, done	K				

PRINTED: 04/27/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		ECONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVE COMPLETED	
		245316	B. WING			03/3	0/2016
	PROVIDER OR SUPPLIER	ER		31	REET ADDRESS, CITY, STATE, ZIP CODE 2 NORTHEAST 1ST STREET EW RICHLAND, MN 56072		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
	Continued From pa	_		000			4/19/16
SS=F	Smoke barriers shalleast a one half hor constructed in accordance with N Sections 19.1.1.4 a emergency, this deaffect the safety of visitors. FINDINGS INCLUID During the facility the AM and 11:30 PM revealed: 1: Penetration in strong barriers shall be recorded by room 20 walls.	all be constructed to provide at ur fire resistance rating and ordance with 8.3. Smoke ermitted to terminate at an ws shall be protected by reservations and interview, the properly construct and 2.2-hour fire separation, in FPA 101 (2000), Chapter 19, and 19.1.2.1. In a fire efficient practice could adversely (50) residents, staff and DE: our between the hours of 09:30 on 03/30/2016, observation moke barrier above ceiling 02 had wires running through		069	1. Maintenance Supervisor has fill penetrations in the smoke barrier value fire rated caulk on April 19, 201. 2. The completion date is April 19, 3. Maintenance or his designee will follow-up on all construction and installation of cables, pipes and will ensure the integrity of smoke barrimaintained.	led the with a 6. 2016.	4/19/16
K 069 SS=E	Cooking facilities a with 9.2.3. 19.3. This STANDARD Based on docume interview, the facili extinguishing systems accordance with 2 19.3.5 and 9.7 and	are protected in accordance 2.6, NFPA 96 is not met as evidenced by: entation review and staff ty's kitchen cooking hood fire em was not arranged in 000 NFPA 101 - Sections 1998 NFPA 96 section ient practice could affect 47	K	003	The hood fire suppression syst been inspected in February of 201 set up to be inspected on a Bi-Anr basis with Summit Companies out Rochester. The completion date is April 19,	6 and is nual of	

Facility ID: 00748

FORM CMS-2567(02-99) Previous Versions Obsolete

CLIVIER	12 LOV MEDICAVE	& MEDICAID SERVICES			O O	VID NO.	0930-038
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION D1 - MAIN BUILDING 01		SURVEY PLETED
		245316	B. WING			03/3	30/2016
	PROVIDER OR SUPPLIER	ER		31	TREET ADDRESS, CITY, STATE, ZIP CODE 12 NORTHEAST 1ST STREET EW RICHLAND, MN 56072		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETIC DATE
K 069	Continued From pa	age 3	K 0	69			
	This deficient pract of Facility Maintena	ice was confirmed by Director ance at the time of discovery.			3. Maintenance Supervisor has conwith Summit Companies out of Rocto inspect the kitchen hood fire suppression system Bi-annually an monitor the inspection quarterly to they being performed as required by Safety regulations.	chester d will ensure	
K 154 SS=D	Where a required a out of service for meriod, the authorit and the building is watch system is prunprotected by the system has been retained. This STANDARD K-154: Where a resystem is out of sea 24-hour period, the approved fire watch parties left unprote sprinkler system has 9.7.6.1 On facility tour betwon 03/30/2016, observiewed revealed plan for the out of sprinkler system. This deficient practical and the sprinkler system.	automatic sprinkler system is nore than 4 hours in a 24-hour y having jurisdiction is notified, evacuated or an approved fire ovided for all parties left shutdown until the sprinkler eturned to service. 9.7.6.1 is not met as evidenced by: equired automatic sprinkler rvice for more than 4 hours in the authority having jurisdiction building is evacuated or an h system is provided for all cted by the shutdown until the as been returned to service. Ween 09:30 AM and 12:30 PM servation and documentation that there was not a single service plan for the fire	K 1	54	 Our disaster plan will be update new standards by April 28, 2016 wl include the information for the sprir system. Completion date is April 28, 2010 Maintenance Supervisor will revilife safety policies on an annual to they are current with the latest chain 	nich will nkler 6. iew all ensure	4/28/16
K 155	discovery. NFPA 101 LIFE SA	ce Director at the time of AFETY CODE STANDARD fire alarm system is out of	K 1	155			4/28/16

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION 01 - Main Building 01	(X3) DATE SURVEY COMPLETED	
		245316	B. WING		03/3	0/2016
NAME OF PROVIDER OR SUPPLIER NEW RICHLAND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 312 NORTHEAST 1ST STREET NEW RICHLAND, MN 56072				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
K 155	the authority having building is evacuate provided for all par shutdown until the returned to service This STANDARD K-155: Where a reof service for more period, the authorit and the building is watch is provided for the shutdown unbeen returned to see On facility tour betwon 03/30/2016, observiewed revealed plan for the out of system.	an 4 hours in a 24-hour period, g jurisdiction is notified, and the ed or an approved fire watch is ties left unprotected by the fire alarm system has been . 9.6.1.8 is not met as evidenced by: equired fire alarm system is out than 4 hours in a 24-hour y having jurisdiction is notified, evacuated or an approved fire for all parties left unprotected it in the fire alarm system has	K 155	1. Our disaster plan will be update new standards by April 28, 2016 w include the information for the Fire system. 2. Completion date is April 28, 201 3. Maintenance Supervisor will rev life safety policies on an annual ba ensure they are current with the larchanges.	hich will Alarm 6. iew all sis to	



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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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.

New Richland Care Center April 15, 2016 Page 2

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

Kumala Fiske Downing

Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112

Fax: (651) 215-9697

PRINTED: 04/26/2016 FORM APPROVED

03/31/2016

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING: _____

(X3) DATE SURVEY COMPLETED

B. WING _

00748

NAME OF PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	
NEW RIC	CHLAND CARE CENTER	312 NOR' NEW RICI			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENC (EACH DEFICIENCY MUST BE PRECEDED E REGULATORY OR LSC IDENTIFYING INFORM	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments		2 000		
	*****ATTENTION*****				
	NH LICENSING CORRECTION OF	RDER			
	In accordance with Minnesota Statute, 144A.10, this correction order has been pursuant to a survey. If, upon reinsperfound that the deficiency or deficiencies herein are not corrected, a fine for each not corrected shall be assessed in account a schedule of fines promulgated to the Minnesota Department of Health.	en issued ction, it is es cited ch violation cordance			
	Determination of whether a violation has corrected requires compliance with all requirements of the rule provided at the number and MN Rule number indicate. When a rule contains several items, factorial comply with any of the items will be collack of compliance. Lack of compliance re-inspection with any item of multi-paresult in the assessment of a fine ever that was violated during the initial inspectorized.	e tag d below. tilure to nsidered ce upon rt rule will n if the item			
	You may request a hearing on any ass that may result from non-compliance v orders provided that a written request the Department within 15 days of rece notice of assessment for non-complian	vith these is made to ipt of a			
	INITIAL COMMENTS: You have agreed to participate in the ereceipt of State licensure orders consist the Minnesota Department of Health Informational Bulletin 14-01, available http://www.health.state.mn.us/divs/fpc.obul.htm The State licensing orders a delineated on the attached Minnesota	stent with at /profinfo/inf			

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

Electronically Signed

04/25/16

(X6) DATE

EBZN11

PRINTED: 05/24/2016 FORM APPROVED

(X6) DATE

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00748	B. WING		03/3	1/2016
	PROVIDER OR SUPPLIER	FR 312 NOR	DRESS, CITY, S THEAST 1ST HLAND, MN		•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surve found that the defic herein are not corrected shall	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health.				
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been compliance with all rule provided at the tag alle number indicated below. It is several items, failure to the items will be considered Lack of compliance upon my item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result from orders provided tha the Department with	hearing on any assessments non-compliance with these tawritten request is made to nin 15 days of receipt of a nt for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.si	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/infe licensing orders are				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

04/25/16 **Electronically Signed**

STATE FORM 6899 EBZN11 If continuation sheet 1 of 33

TITLE

PRINTED: 05/24/2016 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00748	B. WING		03/	31/2016
	PROVIDER OR SUPPLIER	FR 312 NOR	DRESS, CITY, S THEAST 1ST HLAND, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
2 000	Department of Hearyou electronically, is necessary for Starenter the word "correct. You must then State licensure procompletion date, the corrected prior to electronic Department on March 28th, 29 surveyors of this Deabove provider and orders are issued. electronic plan of correviewed these ord they will be complemented by will be complemented to Minnesota Departmented they will be complemented to Minnesota Departmented they will be complemented to Minnesota Departmented they will be complemented to Minnesota Departmented to Minneso	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health. Ith, 30th and 31st 2016, epartment's staff, visited the the following correction Please indicate in your orrection that you have ers, and identify the date when ted. Inent of Health is documenting Correction Orders using ag numbers have been sota state statutes/rules for umber appears in the far left or Prefix Tag." The state compliance is listed in the ent of Deficiencies" column to Comply" portion of the nis column also includes the n violation of the state statute, "This Rule is not met as wing the surveyors findings Method of Correction and crection. ARD THE HEADING OF THE WHICH STATES,	2 000			
	"PROVIDER'S PLA	N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY.				

Minnesota Department of Health

STATE FORM 6899 EBZN11 If continuation sheet 2 of 33

-	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00748	B. WING		03/31/2016	
	PROVIDER OR SUPPLIER	FR 312 NOR	DRESS, CITY, S THEAST 1S HLAND, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 000	THIS WILL APPEA THERE IS NO REC	ge 2 R ON EACH PAGE. QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E 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.		2 830			5/18/16
	by: Based on observati review, the facility for checks were compl head injury for 1 of accidents with falls. Findings include: R39's face sheet, d diagnoses of heart disorder.	ent is not met as evidenced on, interview and document ailed to ensure neurological eted after a fall with a possible 1 resident (R39) reviewed for ated 3/31/16 identified active failure and major depressive inimum Data Set (MDS), dated		corrected		

6899

Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00748	B. WING		03/3	31/2016
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		
NEW RIC	CHLAND CARE CENT	FR	HLAND, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 3	2 830			
		39 required extensive taff for transfers and bed				
	3/6/16, indicated R3 impaired mobility, a	ssessment (CAA) dated 39 had a risk of falls related to nd her family stated she had The CAA indicated falls d 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.					
	2:12 a.m. indicated	ress notes, dated 3/26/16 at R39 was found laying on the d, on her left side. An				

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00748	B. WING		03/3	31/2016
	PROVIDER OR SUPPLIER	FR 312 NOR	DRESS, CITY, S THEAST 1ST HLAND, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	abrasion was noted the nares present. the incident regardito her primary doct any neurological chime of the incident RN-D. A follow up nursing a.m. indicated R39' reactive and she has extremities. No fur neurological checks overnight shift. A subsequent nursi 3/26/16 at 1:13 p.m on the bridge of her received Tylenol 10 Neurological check normal limits at this progress note was indicated R39's neu (good). No further recorded. Observation on 3/2 R39 was resting in clipped to her shou either side of her be when spoken to, bu how she was feelin purple bruising alor	I on the forehead with blood at R39's family was notified of ng the fall and a fax was sent or. The note did not indicate ecks were done on R39 at the the note was recorded by noted, dated 3/16/16 at 3:36 spupils were normal and ad normal movement in her ther notes regarding R39's were recorded for the notes regarding R39's were recorded for the notes from the fall, and no milligrams for discomfort. were noted to be within time. A secondary nursing recorded at 9:30 p.m. and urological checks were go neurological checks were go neurological checks were noted to heck were noted to he with a magnetic alarm lider. A falls mat was noted on ed. R39 opened her eyes at did not respond when asked g. R39 was noted to have not the inside of the right eye swollen nose and was pale in	2 830			
	stated she thought checks conducted	3/29/16, at 3:37 p.m. LPN-A. there had been neurological for R39 after her fall, and that itiated to record the results.				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00748	B. WING		03/3	31/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
NEW RIC	CHLAND CARE CENT	FR	THEAST 1ST HLAND, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	LPN-A located a newhich was dated 3/six entries; beginning and ending at 1:00 and times of the necorrespond with the at 2:12 a.m.). During interview on registered nurse (Rouse manager and 3/26/16 and that Raincident. RN-C revisheet and indicated neurological checks timing of the incident the facility neurological checks the first half hour, then then hourly for 4 times for 72 hours. When neurological checks on the flowsheet un "That's a good quested facility's medical direxpected facility states the fall suspected head injury policy are specially if the	surological flowsheet for R39 24/16 and included a total of ag at 3/24/16 at 11:00 p.m. p.m. on 3/27/16. The dates urological checks did not a timing of R36's fall (3/26/16, 3/30/16, at 12:30 p.m. N)-C, indicated she was R39's I was aware of the fall dated By hit her head during the liewed R39's neurological flow I the dates and times of the se did not match up with the att. When questioned about ical check policy, RN-C stated em every 15 minutes for the every half hour four (4) times, hes and then every four hours a sked why there were no a recorded for 3/26/16, for R39 attil 9:00 a.m., RN-C stated estion." 3/30/16 1:53 p.m. R39's and the ector and would have aft to follow their neurological after an unwitnessed fall, resulted in a bloody nose or				

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					TE SURVEY MPLETED	
		00748	B. WING		03/3	31/2016
	PROVIDER OR SUPPLIER	STER 312 NORT	ORESS, CITY, S THEAST 1ST HLAND, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 830	thought she was co she recorded them neurological checks keep doing them if a During further internance. RN-D provided the policy and confirme subsequent neurological flowsh were stable. RN-D wouldn't have wants what are you going hospital?" During interview on director of nursing (should have conduce R39 in accordance confirmed the neurofile did not reflect the accordance with hee this was a concern. possibility these neurolitiated after the fir indicated that after would have expected neurological flowsh per facility policy. The facility policy eneroised 12/2/04 indipossible head injurithe resident hit their falls. Every (Q) 15 4. Q hour (HR) x 4 Vital signs need to each neuro assess showing signs of be	infused as to the times when and there was a policy for so, but stated they didn't have to they were stable. View on 3/31/16, at 7:05 a.m. facility's neurological check of that she didn't continue with origical checks if the initial ones further stated "I knew they ged to do much for her anyway, to do? Send her to the 3/31/16, at 8:18 a.m. the DON stated that RN-D cred neurological checks on with the facility policy and pological check flowsheet on the expectations and reiterated When asked if there was a surological checks were st fall on 3/23/16, the DON R39's fall on 3/26/16 she ged staff to start a new geet and follow the schedule Intitled Neuro Assessment, last icated to do neuro check on es: any falls where you know in head or any unwitnessed minutes x 4. Q 30 minutes x 2. Q 2 HR x 4. Q 4 HR x 2. Tonly be done on the first set of ment, unless the resident is	2 830			

Minnesota Department of Health STATE FORM

ORM EBZN11 If continuation sheet 7 of 33

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00748	B. WING		03/3	31/2016
	PROVIDER OR SUPPLIER	FR 312 NOR	DRESS, CITY, S THEAST 1S' HLAND, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	The Director of Nur develop, review, an procedures to ensu conditions are condincluding neurologic as directed. The Directed and procedures. The designee could devensure ongoing cor TIME PERIOD FOR (21) days.	sing or designee could d/or revise policies and re assessment of resident lucted, and that interventions cal checks, are implemented rector of Nursing or designee opropriate staff to the policies are Director of Nursing or relop monitoring systems to impliance. R CORRECTION: Twenty-one	2 830			E/40/40
2 900	Subp. 3. Pressure comprehensive res of nursing services development of a nursing services development of a nursing services development of a nursing services that: A. a resident who without pressure sores unlessure sores un lessure so	ent is not met as evidenced	2 900			5/18/16
	Based on observati	on, interview, and document illed to follow the physician		corrected		

Minnesota Department of Health

STATE FORM 6899 EBZN11 If continuation sheet 8 of 33

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY IPLETED	
		00748	B. WING		03/3	31/2016
	PROVIDER OR SUPPLIER	FR 312 NOR	DRESS, CITY, S THEAST 1ST HLAND, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 900	prescribed order re pressure ulcer for 1 for pressure ulcers. Findings include: R35 was admitted of including senile degichronic kidney dise face sheet. R35's most recent of (MDS) assessment required extensive bed mobility, transfollater for Mental had a score of 3, in impairment. The assessment wide (W) x 0.4 cm of the care RN Review of the care RN Reviewing ulcerordered. Review of the program for the wound on the faxed included: Cleanse protocol, pat dry - a collagen, apply thin with foam dressing and PRN (as needed Review of the elect revealed the following the surface of the elect revealed the following the elect reverse of the elect revealed the following the elect reverse of the elect r	lated to the treatment of a of 3 residents (R35) reviewed on 5/20/15. with diagnoses generation of the brain and ase per the admission record quarterly Minimum Data Set dated 2/9/16, indicated R35 assistance of two staff with er and toilet use. The Brief I Status (BIMS) indicated R35 dicating severe cognitive seessment further identified ed stage 3 pressure ulcer (PU) imeters (cm) long (L) x 0.2 cm deep (D). plan dated 2/8/16 included: r weekly. Wound care as ress note dated 3/9/16, at indicated: "New treatment outtock see physician orders." d physician order dated 3/9/16 wound on buttock per ipply skin prep, pack with layer of silver hydrogel, cover. Dressing change twice daily	2 900			

Minnesota Department of Health

STATE FORM 6899 EBZN11 If continuation sheet 9 of 33

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			71. BOILBING.			
		00748	B. WING		03/3	1/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
NEW RICHLAND CARE CENTER			THEAST 1ST HLAND, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900	Everyday Cleanse Pat dry. Apply skin and let it dry. Apply bed. Cover with fo WOUND CARE" A start date of 11/25/ order had been imporder was unchang care treatment order the frequency which day. The current of with collagen. During observation registered nurse (FR35's coccyx PU. saline; the wound registered nurse (FR35's coccyx PU. saline; the wound registered nurse (FR35's resident had rever was not observed to collagen. When interviewed to RN-B revealed she treatment to R35's resident had recent the 200 hall. RN-B RN-C prior to perfor 3/30/16 as RN-C wrong and famil RN-B stated she had wound with collaged direction. RN-B co R35's wound with con 3/31/16 as had record which did not wound to be packet.	wound per facility protocol. In prep to the surrounding skin by silver hydrogel to the wound am. Dressing change daily. Although the order indicated a 15, the eTAR reflected the olemented starting 3/9/16. The gled from the previous wound er (dated 11/25/15) other than the changed from daily to twice a reder did not include to pack. On 3/31/16, at 8:37 a.m. RN)-B performed a treatment to RN-B cleansed the wound with measured 1.0 cm (L) x 0.4 cm RN-B then applied skin prep to in, allowed the skin to dry, then of silver hydrogel to the did with a foam dressing. RN-B to pack the wound with On 3/31/16, at 12:00 p.m. In had only performed the PU one other time as the tly moved from the 100 hall to be indicated consulting with perming R35's PU treatment on the star with R35's PU treatment. The packed R35's coccyx on on 3/30/16 per RN-C's of include instructions for the did with collagen. RN-B physician order dated 3/9/16				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00748	B. WING		03/3	31/2016
	PROVIDER OR SUPPLIER	312 NOR	DRESS, CITY, S	STATE, ZIP CODE		
NEW KI	NEW RICHLAND CARE CENTER NEW RIC			56072		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 900	ра		2 900			
	wound with collage whether the nurses	order indicated to pack the n. RN-B stated being unsure were packing R35's coccyx agen when performing the				
	director of nursing (pressure ulcer treat incorrectly. DON fursive RN-C had been page with collagen when weekly and obtaining stated being unsure packing the wound performing the treat confirmed the inacconfirmed the office at transcribed the new	on 3/31/16, at 12:07 p.m. the (DON) confirmed R35's 3/9/16 ment order was transcribed urther stated knowledge that oking R35's PU coccyx wound performing the treatment of measurements. DON if the floor nurses were with collagen when the transcription was a terview with the DON, RN-B and stated RN-C had initially order on 3/9/16 and the dicated RN-A had edited the				
	confirmed she had PU when he resided stated the resident earlier in the week. that time was not be confirmed that the fincreased from once	on 3/31/16, at 12:11 p.m. RN-A performed treatments to R35's d on the 100 hall, though had moved to the 200 hall RN-A stated the wound at eing packed. RN-A further requency of the treatment had e to twice daily otherwise no anges had been ordered.				
	DON stated the pro of new orders was t the order was corre further stated that if the order made cha	on 3/31/16, at 12:31 p.m. the ocedure related to transcription to have a second nurse verify oct once transcribed. DON the second nurse verifying anges to the order, the order of the verified by another nurse.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
00748		B. WING		03/3	03/31/2016	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
NEW RIC	CHLAND CARE CENT	FR	THEAST 1ST HLAND, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900	order had been edit another nurse. DO treatment should ha wound with collager documentation to result of the director of nurse policies and proced provided pressure ut to the resident's indidirector of nursing crisk for pressure ulthe necessary treat ulcers from develop pressure ulcers. The in-service all appropressure ulcer internursing could condidelivery of care to eservices were implested.	en R35's 3/9/16 PU treatment ted it had not been verified by N further confirmed R35's PU ave included to pack the n and there was no effect otherwise. CHOD OF CORRECTION: sing could review and revise ures to ensure the facility ulcer interventions according ividualized needs. The could review all residents at cers to assure they received ment to prevent pressure bing and to promote healing of e director of nursing could oriate staff on appropriate ventions. The director of uct random audits of the ensure appropriate care and	2 900			
2 930	MN Rule 4658.0525 Nasogastric, Gastro	5 Subp. 7 B. Rehab - ostomy tubes	2 930			5/18/16
	and feeding syringes. Based o	ric tubes, gastrostomy tubes, n the comprehensive resident sing home must ensure that:				
	gastrostomy tube o appropriate treatme aspiration pneumor	who is fed by a nasogastric or reeding syringe receives the ent and services to prevent nia, diarrhea, vomiting, olic abnormalities, and				

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AND DIAN OF CODDECTION INDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00748	B. WING		03/3	1/2016
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 03/3	71/2010
NEW RIC	CHLAND CARE CENT	SER 312 NOR	THEAST 1ST	T STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 930		lcers and to restore, if	2 930			
	by: Based on observat review the facility fa checked placemen	ent is not met as evidenced ion, interview and document ailed to ensure nursing staff t of a nasogastric tube prior to a for 1 of 1 resident (R23) who a nasogastric tube.		corrected		
	on 3/31/16, at 10:3 had set up R23's m poured the prepare centimeters (CC) s medication through was not observed to nasogastric tube power with the place as she obserpatency. RN-A conthe length of tube fixed to the second to t	of a medication administration 0 a.m. registered nurse (RN)-A nedications as ordered. RN-A and medications into a 60 cubic yringe and infused the R23's nasogastric tube. RN-A to check placement of R23's rior to infusing the medications. At this time, RN-A indicated acement by visualizing a black to tube. RN-A further included if as like it is located in the same are the prior day, she confirms of the black line to the nose blacement by aspiration and/or				
	3/31/16, at 2:00 p.r checked placemen medications by me located on the tube	director of nursing (DON) on m. indicated RN-A should have t prior to the infusion of the asuring from the black mark to the resident's nose. The t R23's medical record				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00748	B. WING		03/3	1/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD		STATE, ZIP CODE	1 00/0	.,
NEW RIC	CHLAND CARE CENT	FR	THEAST 1S ⁻ HLAND, MN			
(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 SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 930	included initial meatube was placed. A facility Nasogastrundated, identified the administration oplacement of the tufeedings/medication of air and listening to check for stomaclength of the tubing length with the recoinsertion. Do not prefeeding/medications placement or if tubic changed.	surements taken after the ic tube feeding policy, a procedure which included of medications; check be before beginning the as by inserting a small amount with a stethoscope or aspirate ch contents. Measure the from the nose and compare orded length following initial	2 930			
	The director of nursipolicies and proced provided appropriat director of nursing of to provide appropriate director of nursing of compliance.	sing could review and revise lures to ensure nursing the nasogastric tube care. The could inservice licensed staff ate nasogastric care. The				
21375	Program Subpart 1. Infection home must establist control program destantary environments		21375			5/18/16
	THIS WIN DEQUIREME	ent is not met as evidenced				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00748	B. WING		03/3	1/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
NEW RICHLAND CARE CENTER			THEAST 1S [.] HLAND, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21375	by: Based on observation review the facility fare hygiene during a wing residents (R35) review Findings include: During observation 8:37 a.m. registered provide treatment to Nursing assistant (I room to assist with treatment. After Noonto his right side, brought a plastic coto R35's bedside. If RN-B verbalized the movement "smearif would need to clear RN-B picked up the utilized while assist wiped the fecal sme RN-B then proceed treatment/dressing and perform the treatment/dressing and perform the treatment gloves are providing treatment. When interviewed of confirmed she show cleansing the fecal prior to the PU wou stated she realized the clean treatment.	ion, interview, and document ailed to ensure proper hand ound treatment for 1 of 3 riewed for pressure ulcers. of wound cares on 3/31/16, at d nurse (RN)-B was noted to a R35's coccyx pressure ulcer. NA)-B was also present in the turning R35 during the A-B assisted with turning R35 RN-B donned gloves and ontainer with dressing supplies Prior to starting the treatment re resident had some boweling" on his buttocks that she hase prior to the PU treatment. It is soiled washcloth NA-B had ing R35 with peri care, and rearing from R35's buttocks. It is led to obtain R35's wound supplies from the plastic bin reatment/dressing change with ands used to cleanse the ttocks. RN-B failed to remove and apply new gloves prior to and redressing the wound. on 3/31/16, at 9:30 a.m. RN-B all have changed gloves after smearing from the skin and and treatment. RN-B further after she retreived items from the basket with the same soiled should have removed and	21375	corrected		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
00748		B. WING		03/3	03/31/2016	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
NEW RIC	CHLAND CARE CENT	FR	THEAST 1S ⁻ HLAND, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21375	When interviewed of DON confirmed RN gloves and perform washing the resider performing the PU in Review of the Infect Precaution policy disperform hand hygie from a contaminate site during patient of indicated after remove with non-antimicrobial soap a spores is likely to he SUGGESTED MET. The director of nursuand revise the polici infection control conwound care, and promembers. A monited developed to ensur directed and report assurance committed.	on 3/31/16, at 11:27 a.m. the last should have changed ed hand hygiene after not buttocks and prior to treatment. Ition Control Standard atted 2010, indicated to the if hands will be moving at body site to a clean body sare. The policy further bying gloves to wash hands bial soap and water or with and water if contact with ave occurred. IHOD OF CORRECTION: sing or designee would review by and procedures related to incerns while performing ovide education to staff oring system could be e staff are providing cares as the results to the quality	21375			
21426	MN St. Statute 144. Prevention And Cor	A.04 Subd. 3 Tuberculosis ntrol	21426			5/18/16
	maintain a compreh infection control pro current tuberculosis issued by the Unite Control and Preven	e provider must establish and nensive tuberculosis ogram according to the most infection control guidelines d States Centers for Disease tion (CDC), Division of lation, as published in CDC's				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	00748		B. WING		03/31/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
NEW RIC	NEW RICHLAND CARE CENTER 312 NOR NEW RIC			「STREET 56072		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE
21426	Morbidity and Morta This program must infection control pla unpaid employees, residents, and volue Health shall provide regarding implement (b) Written compliate be maintained by the	ality Weekly Report (MMWR). include a tuberculosis in that covers all paid and contractors, students, inteers. The Department of e technical assistance intation of the guidelines.	21426			
	by: Based on interview facility failed to ens residents (R4, R39, tuberculin skin test addition, the facility (DA-A, LPN-A, and conducted. Findings include: R4 was admitted to the medical record receiving a 1st or 2 immunization record the test being admit the director of nursi	and document review, the ure 4 of 5 newly admitted, R47 and R57) had a two step (TST) administered. In failed to ensure 3 of 5 staff NA-A) had a two step TST		corrected		
	R39 was admitted ther immunization re	to the facility on 2/22/16 and ecord along with medical evidence of a two-step TST				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED	
		00748	B. WING		03/:	31/2016
	PROVIDER OR SUPPLIER	FR 312 NOR	DRESS, CITY, S THEAST 1ST HLAND, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
21426	being conducted. R47 was admitted to during review of implementation the revidence that the Tevidence of the first standard to the tevidence of the residence of the information recorded the first standard the tevidence of the information recorded the facility policity of the tevidence of the second-step had not facility's parameters further did not have on file and had to reach the tevidence of the second-step one of the on 1/11/16. The per evidence of the second-step of the secondence of the second the se	to the facility on 10/15/15 and munizations and TST medical record lacked any ST had occurred. To the facility on 2/2/16 and the nunization sheet identified R57 ep of the two-step TST on vidence of the 2nd TST being Ta.m. the DNS was given the ent's whose evidence of TST at 10:30 a.m. the resident ds were returned with no ormation required. The DNS no further evidence to sidents had received TST's y. Thurse (LPN)-B was hired on diministered the first step of the 19/16 but failed to have the p with the two-step. LPN-B's coked documentation of the was verified by the DNS the ot been administered within the state on policy. The facility executed the information from the entire the enti				

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	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE S D PLAN OF CORRECTION IDENTIFICATION NUMBER: A PUBLICATION OF COMPLETE CONSTRUCTION (X3) DATE S					
THE TENIN	OF CONTRECTION	IDENTIFICATION NOMBER.	A. BUILDING:		OOW	LLILD
		00748	B. WING		03/3	31/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
NEW RIC	CHLAND CARE CENT	FR	THEAST 1S ⁻ HLAND, MN			
040.15	CUIMMA DV CTA		1		ON!	0/5
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21426	Continued From pa	ge 18	21426			
21665	on 12/17/15 and he she had received th TST on 12/17/15. Nacked evidence of being completed. It second step had be SUGGESTED MET The administrator, review and revise p surveillance. The anursing, could mon to ensure ongoing of TIME PERIOD FOR (21) days.	THOD FOR CORRECTION: director of nursing, could solicies and procedures for TB dministrator, director of itor resident and TB screening	21665			5/18/16
21003	A nursing home must functional, comfortate environment, allowing personal belonging. This MN Requirements: Based on observation review the facility facuse of a product care.	ust provide a safe, clean, able, and homelike physical ing the resident to use is to the extent possible. ent is not met as evidenced ion, interview and document alled to determine whether the illed, bed cane rails, were safe (R1, R25 & R31) who utilized	21000	corrected		3/16/10
	Findings include:					
		on 3/28/16, at 6:30 p.m. and				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		00748	B. WING		03/3	31/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
NEW RICH	HLAND CARE CENT	FR	THEAST 1ST HLAND, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
	observed to have a 12 1/4 inches in len widest part (opening in the shape of a cat confirmed by licens 7:15 p.m. and she was wide enough for head/neck. There withe rail opening. The bed cane many available guidance including: "There is associated with bed committed to informentrapment condition well as methods to versions of this guid www.stander.com. Entrapment is a situst become caught by other body parts in bed rail or bedside shows 2 bed rail profor illustration purpor GUIDELINES TO HENTRAPMENT? TI Administration (FD/Workgroup (HBSW following guidelines a zones. ZONE 1 - We space between the present a risk of he recommended space quarters of an inch products have inclusive around part, or all, or	de of R1's bed. This rail was wide opening that measured 19th and 5 1/4 inches at the 19th of the rail. The bed rail was ane. Measurements were 19th ed practical nurse (LPN)-A at confirmed R1's bed cane rail or potential entrapment of the was no fabric material covering 19th of the was no fabric material was prevent entrapment. Updated 19th of the was no fabric material covering 19th of the was no fabric material was no fabric ma	21665			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00748	B. WING		03/3	1/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
NEW RIC	CHLAND CARE CENT	FR	THEAST 1ST HLAND, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21665	should never be us securely attached. removed to clean it Review of R1's phy 9/30/15, identified t (a type of bed rail) if transferring out of be include whether the assessed for safety. Review of the curre was able to position the use of the bed of Further review of Rinclude a determinate had been deemed seen deemed seen include any injuries the bed rail for R1. When interviewed of indicated she utilized and for sitting up in Interview with the dia/29/16, at 7:30 p.n rail on her bed sinc DON revealed she be a safety concernentrapment. R1's bed rail was of 3/28/16, at 7:40 p.n bar that was within	ed when the cover is not The cover should only be ." sical therapy note dated he resident utilized a bed cane for assistance when bed. The progress note did not a bed cane rail had been of the cane rail had been of the cane rail had been of the cane rail. I'S medical record did not ation as to whether the bed rail safe for R1's use. reports for the past year did or potential injuries related to the bed rail for positioning and the safe for positioning the cover of the past year did the bed rail for positioning the cover of the positioning the cover of the past year did the bed rail for positioning	21665			
	Interview with the D	OON on 3/30/16, at 9:59 a.m.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00748	B. WING		03/3	31/2016
NAME OF PROVIDER OR SUPPLIER NEW RICHLAND CARE CENT	FR 312 NOR	DRESS, CITY, STATEMENT TO THE AST 1ST HLAND, MN !	STREET		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
of bed cane rails, bedepartment made to the later with the magnetic state of the part of t	does not assess for the safety out thought the maintenance he determination. naintenance director on .m. indicated he had not made about whether bed cane rails beds were safe for use. on 3/28/16, at 7:20 p.m., a observed on R31's left side of as observed to have a wide assured 12 1/4 inches in length the widest part (opening) of ents were confirmed by LPN-A also confirmed the rail was tential entrapment of the material was not covering the existent utilized the bed with repositioning in bed. The not include a safety of the use of the bed cane edical record did not include mation related to the use of ane rail nor the safety of the reports for R31 in the last e any injuries or potential				

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NAME OF PROVIDER OR SUPPLIER NEW RICHLAND CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 12 NORTHEAST 1ST STREET NEW RICHLAND, MN 56072 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CONTINUED FROM PROVIDER'S PLAN OF CORRECTION (AS) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE) DATE 21665 Continued From page 22 could pose any potential for entrapment. Interview with the administrator on 3/29/16 at 7:30	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	
NEW RICHLAND CARE CENTER 312 NORTHEAST 1ST STREET NEW RICHLAND, MN 56072 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) 21665 Continued From page 22 could pose any potential for entrapment.	00748	
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRÉFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DATE DATE DATE DATE DEFICIENCY) Continued From page 22 could pose any potential for entrapment.	II AND CARE CENTER 312 NO	
could pose any potential for entrapment.	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX
p.m. confirmed R1 and R31's bed cane ralls 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	could pose any potential for entrapment. Interview with the administrator on 3/29/16 at 7:3 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. collateral 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 inche 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 ndicated he utilized the beds rails for positioning/rolling from side to side in bed.	21665

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00748	B. WING		03/3	31/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
NEW RIC	CHLAND CARE CENT	FR	THEAST 1ST HLAND, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21665	she had not realized safety concern whice entrapment; R25's removed from the bound of the safet cane rails, R25 conhis head through the lindicated nursing down of the safet cane rails, but department did. Interview with the Dindicated nursing down of the safet cane rails, but side cane side cane side cane side cane side cane side cane side use and side rather the DON or design appropriate staff on procedures.	d R25's bed rails could be a ch included potential bed rails were subsequently bed. Toximately 7:45 p.m. when R25 by concerns related to the bed firmed he would be able to get e opening in the bed cane rail. TON on 3/30/16 at 9:59 a.m. bes not assess the safety of thought the maintenance director on m. indicated he had not been e rails for safety. THOD OF CORRECTION: The ould develop policies and re cane rails are assessed for ails are maintained for safety. The could educate all these policies and ON or designee could develop	21665			
21980	Maltreatment of Vul Subd. 3. Timing of	f report. (a) A mandated	21980			5/18/16
	vulnerable adult is t	eason to believe that a peing or has been maltreated, dge that a vulnerable adult				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00748	B. WING		03/3	1/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
NEW RIG	CHLAND CARE CENT	FR .	THEAST 1ST HLAND, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21980	has sustained a phyreasonably explained information to the condividual is a vulned the individual is addreporter is not require maltreatment of the to admission, unless (1) the individual was another facility; or (2) the reporter kethat the individual is in section 626.5572 (b) A person not provisions of this sas described above (c) Nothing in this known or suspected knows or has reason been made to the condition (d) Nothing in this reporter from also reason to believe the 626.5572, subdivisi (5), occurred must be subdivision. If the retime believes that a agency will determine the criteria under set 17, paragraph (c), of facility may provided directly to the lead at the condition of the lead at the condition of the lead at the condition of the lead at the criteria under set 17, paragraph (c), of facility may provided directly to the lead at the criteria under set 17.	ysical injury which is not ed shall immediately report the ommon entry point. If an rable adult solely because nitted to a facility, a mandated ired to report suspected individual that occurred prior s: as admitted to the facility from the reporter has reason to ble adult was maltreated in the nows or has reason to believe a vulnerable adult as defined a vulnerable adult as defined a subdivision 21, clause (4). The required to report under the ection may voluntarily report as section requires a report of a maltreatment, if the reporter on to know that a report has	21980			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00748			03/3	31/2016
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, § THEAST 1S	STATE, ZIP CODE T STREET		
NEW RIC	CHLAND CARE CENT	FR	HLAND, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21980	Continued From pa	ige 25	21980			
	(5). The lead ager	ion 17, paragraph (c), clause ncy shall consider this naking an initial disposition of abdivision 9c.				
	by: Based on interview facility failed to immabuse to the adminagency and thorough	ent is not met as evidenced and document review, the nediately report allegations of histrator and designated State ghly investigate the allegations reports (R27, R17) reviewed.		corrected		
	Findings include:					
	State agency imme	o notify the administrator and ediately and failed to thoroughly gation of maltreatment/abuse				
	9/18/15, revealed a [nursing assistant] with shower in the [hallwout and told RN [rephad 2 skin tears on elbow. 'They were to the skin tears are and 1 cm and the upin the shape of triar description revealed skin tears are from grabbing me hard.' her left forearm endedema to show RN incident report did ruthe administrator with shower in the shape of triar description revealed skin tears are from grabbing me hard.'	ent report for R27, dated a nursing description: "CNA was assisting resident into way] shower room. CNA came gistered nurse] that resident a left upper arm above the there when we undressed her.' lower 1.6 cm [centimeters] upper 2.3 x 1 cm and they are ngles. Review of the resident d'All the bruising and these fingernails and people Resident then grabber [sic] ough to make indents in I how she is grabbed." The not indicate a date and time was notified of the incident.				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00748	B. WING		02/2	1/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	03/3	1/2010
	CHLAND CARE CENT	FR 312 NOR	THEAST 1S	STREET		
		NEW RICH	HLAND, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21980	mistreatment report reported to the Stati investigative report. 9/27/15, and accomdocuments include However, the comptime of interview and not documented for resident interviews documented regard treatment of them or residents on the unconcerns. On 3/31/16, at 9:19 services (DSS) and nursing assistants a regarding the incide interviews. Howeve complete names of interview and full st residents were interview and full st residents were interviewed the incide the administrator report have been notified to reviewed the incide the administrator control notified of the interview of an allegate potential exploitation a facility visitor, (V). An incident report	led the allegation of ted by R27 on 9/18/15 was a gency on 9/21/15. The submitted to the state on apanying investigative interviews from staff. Interviews from staff, date and ad full statements of staff were rall interviews. No other were completed or ling their experiences of staff during cares to ascertain if it were experiencing similar. a.m. the director of social administrator reported and nurses were interviewed ent. Notes were taken of the staff, date and time of atements of staff. No other reviewed regarding their freatment of them during fresidents on the unit were reconcerns. The DSS and ted the administrator may not until the interdisciplinary team not on 9/21/15. The DSS and onfirmed the State agency was accident until 9/21/15. immediately notify the State attion and observation of n and mistreatment of R17 by	21980			
	room. R17 was hea	ard yelling at V-A to "get out of				

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
		00748	B. WING		03/3	1/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS CITY S	STATE, ZIP CODE		
		312 NOR	THEAST 1ST	<i>'</i>		
NEW RI	CHLAND CARE CENT	FR	HLAND, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTIES OF T	D BE	(X5) COMPLETE DATE
21980	my room". Review progress notes, dat revealed the facility nursing DON, admi informed on 8/25/10 allegations of finance V-A against R17. V confront R17 about altercation occurred not feel safe at the report submitted to 8/27/15 revealed the State agency of the allegations until 8/2 On 3/31/16, the DS the allegation and in and mistreatment in immediately reported. The Vulnerable Adu Care Center, undat "We need to report [name of administration and to the Minneso electronically." and or has it reported to Charge of The Rescan assist you with Director of Nursing present in the build investigation as we involved, staff with it on to someone el here at the time the to start the process to report this immediable, after the residuence of the residuence of the residuence and the residuence of the resi	of the incident report and ed 8/25/15 through 8/27/15 (including the director of nistrator and DSS) were 6 by R17 and V-A about cial exploitation committed by A was at the facility to these allegations and a verbald. R17 reported to staff she did facility. A review of the incident the State agency, dated e facility did not notify the 8/25/15 incident and 7/15 (2 days later). S and administrator confirmed neident of potential exploitation avolving R17 was not ed to the State agency.	21980			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00748	B. WING		03/3	1/2016	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
NEW RIC	CHLAND CARE CENT	-R	THEAST 1ST ILAND, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21980	by [name of administrator of provide education are garding reporting implementing the prevention Policy at TIME PERIOD FOR	strator, DON and DSS]." The ed staff "All reports of resident ries of unknown source, abuse and resident to staff and thoroughly investigated nent." Steps of investigation ew the staff. Use the Incident form." and "You need to ewing and record their nan allowing them to write the es you a chance to ask help determine the cause. The person who reported the staff working at the time the eard "b. Interview other ccused employee has termine if they have a employee." CHOD FOR CORRECTION: r designee could audit, and and training to all staff	21980				
21995	MN St. Statute 626. Maltreatment of Vul	557 Subd. 4a Reporting - nerable Adults	21995			5/18/16	
	(a) Each facility sha ongoing written pro applicable licensing of suspected maltre facility has an interr	reporting of maltreatment. all establish and enforce an ocedure in compliance with rules to ensure that all cases eatment are reported. If a neal reporting procedure, a may meet the reporting					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				3) DATE SURVEY COMPLETED	
		00748	B. WING		03/3	1/2016	
NAME OF		CTDEET AD		STATE ZID CODE	1 00.0		
NAIVIE OF	PROVIDER OR SUPPLIER		THEAST 1S	STATE, ZIP CODE			
NEW RIC	CHLAND CARE CENT	FR .	HLAND, MN				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	COMPLETE DATE	
21995	Continued From pa	ge 29	21995				
	internally. However	s section by reporting r, the facility remains aplying with the immediate ents of this section.					
	by: Based on interview facility failed to implimmediate reporting administrator and S	and document review, the lement their policy related to g allegations of abuse to the state agency and thoroughly tions for 2 of 5 resident reports d.		corrected			
	Findings include:						
	Care Center, undatto report Vulnerable administrator] admithe Minnesota Departure electronically." and or has it reported to Charge of The Resican assist you with Director of Nursing present in the buildinvestigation as welinvolved, staff witnes it on to someone elemere at the time the to start the process to report this immediable, after the resid Department of Heatto investigate and significant of the policy further directed abuse, neglect, injurial or had investigate and significant control of the policy further directed abuse, neglect, injurial or had investigate and significant control of the policy further directed abuse, neglect, injurial or had investigate and significant control of the policy further directed abuse, neglect, injurial or had in the policy further directed abuse, neglect, injurial or had in the policy further directed abuse.	alt Reporting for New Richland ed, directed staff: "We need a Adult incidents to [name of nistrator immediately and to artment of Health "Who ever starts the incident, them, should be the Nurse in ident or RN on Duty or on call the process, if Administrator, or Social Services are noting. You need to start the II, talk to the residents asses, etc. Please do not pass se coming on duty. If you were incident happened, you need. Please remember we have diately or as soon as were are ent is safe to the Minnesota lith, and then we have 5 days end this in, which will be done strator, DON and DSS]." The ed staff "All reports of resident ries of unknown source, abuse and resident to staff					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00748	B. WING		03/3	1/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, §	STATE, ZIP CODE		
NEW RIC	CHLAND CARE CENT	FR	THEAST 1ST			
(X4) ID	SLIMMARY STA	ATEMENT OF DEFICIENCIES	HLAND, MN	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	COMPLETE DATE
21995	Continued From pa	ıge 30	21995			
	by facility managen included: "7. Intervi Witness Interview F complete the interv statements rather t statement. This giv questions that may This should include incident and other sincident occurred." residents that the a provided care to de complaint about the The facility failed to State agency imme	y and thoroughly investigated ment." Steps of investigation liew the staff. Use the Incident Form." and "You need to viewing and record their than allowing them to write the res you a chance to ask of help determine the cause. It is the person who reported the staff working at the time the and "b. Interview other accused employee has betermine if they have a re employee."				
	9/18/15, revealed a [nursing assistant] shower in the [hallwout and told RN [rehad 2 skin tears on elbow. 'They were to the skin tears are and 1 cm and the unin the shape of triar description revealeskin tears are from grabbing me hard.' her left forearm endedema to show RN incident report did rethe administrator were shown to the shape of the shape of triar description reveales skin tears are from grabbing me hard.'	ent report for R27, dated a nursing description: "CNA was assisting resident into way] shower room. CNA came gistered nurse] that resident a left upper arm above the there when we undressed her.' Lower 1.6 cm [centimeters] upper 2.3 x 1 cm and they are ngles." Review of the resident de "All the bruising and these fingernails and people Resident then grabber [sic] ough to make indents in I how she is grabbed." The not indicate a date and time was notified of the incident.				

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State agency revealed the allegation of

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00748	B. WING		03/3	1/2016	
NAME OF I	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
NEW RICHLAND CARE CENTER 312 NORT NEW RICH							
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21995	mistreatment repor reported to the stat investigative report 9/27/15, and accomdocuments include However, the comptime of interview arnot documented for resident interviews documented regard treatment of them or residents on the unconcerns. On 3/31/16 at 9:19 services (DSS) and nursing assistants aregarding the incide interviews. However complete name of sinterview and full stresidents were interexperiences of staff cares to ascertain it experiencing similar administrator reportance been notified reviewed the incidente administrator control in the incidente administrator report and incidente administrator report and incidente administrator report and incidente administrator report	ted by R27 on 9/18/15 was e agency on 9/21/15. The submitted to the State on apanying investigative interviews from staff. Olete name of staff, date and ad full statements of staff were rall interviews. No other were completed or ding their experiences of staff during cares to ascertain if it were experiencing similar. a.m. the director of social dadministrator reported and nurses were interviewed ent. Notes were taken of the er, the notes did not include the staff, date and time of attements of staff. No other reviewed regarding their freatment of them during fresidents on the unit were ar concerns. The DSS and ted the administrator may not until the interdisciplinary team ent on 9/21/15. The DSS and onfirmed the state agency was neident until 9/21/15.	21995				
	room. R17 was hea	ard yelling at V-A to "get out of of the incident report and					

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00748	B. WING		03/3	1/2016	
	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 312 NORTHEAST 1ST STREET						
NEW RICHLAND CARE CENTER NEW RICHLAND, MN 56072							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
21995	progress notes, dat revealed the facility nursing (DON, adminformed on 8/25/16 allegations of finance V-A against R17. Veconfront R17 about altercation occurred not feel safe at the report submitted to revealed the facility of the 8/25/15 incide 8/27/15. On 3/31/16 the DSS the allegation and in and mistreatment in immediately reported SUGGESTED MET The administrator oprovide education a regarding reporting implementing the prevention Policy a	ed 8/25/15 through 8/27/15 (including the director of inistrator and DSS) were by R17 and V-A about call exploitation committed by A was at the facility to these allegations and a verbald. R17 reported to staff she did facility. A review of the incident the state, dated 8/27/15 did not notify the state agency ent and allegations until S and administrator confirmed incident of potential exploitation and to the State agency. CHOD OF CORRECTION: or designee could audit, and and training to all staff	21995				