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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: IY0J

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00748

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245316**

2.STATE VENDOR OR MEDICAID NO.
(L2) **825340400**

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

4. TYPE OF ACTION: **7** (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/26/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **50** (L18)

13.Total Certified Beds **50** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

B. Not in Compliance with Program
Requirements and/or Applied Waivers:

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

* Code: A (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Date :
Sarah Strenke, HFE NE II — 06/16/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Shellae Dietrich, Certification Specialist — 07/25/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 07/28/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/19/2017
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245316 June 16, 2017

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 16, 2017 the above facility is certified for or recommended for:

50 Skilled Nursing Facility/Nursing Facility Beds

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

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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 16, 2017

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

RE: Project Number S5316026

Dear Mr. Alexander:

On April 17, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 6, 2017. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On May 26, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on May 8, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 6, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 16, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 6, 2017, effective May 16, 2017 and therefore remedies outlined in our letter to you dated April 17, 2017, will not be imposed.

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.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: IY0J

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00748

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2. STATE VENDOR OR MEDICAID NO. (L2) **825340400**

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(L3) **NEW RICHLAND CARE CENTER**
(L4) **312 NORTHEAST 1ST STREET**
(L5) **NEW RICHLAND, MN** (L6) **56072**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **04/06/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

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

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

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

17. SURVEYOR SIGNATURE Date :
Wendy Buckholz, HFE NE II 05/15/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 05/19/2017 (L20)

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

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

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3. Both of the Above :
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22. ORIGINAL DATE OF PARTICIPATION
06/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
April 17, 2017

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

RE: Project Number S5316026

Dear Mr. Alexander:

On April 6, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

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

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

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

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

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

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

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), 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
Email: Kathryn.serie@state.mn.us
Office: (507) 476-4233 Fax: (507) 537-7194

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 16, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that

substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by July 6, 2017 (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 October 6, 2017 (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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

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

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245316	A. BUILDING _____ B. WING _____	04/06/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC 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.	F 000		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the	F 157		5/16/17

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

Electronically Signed | 04/27/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245316	A. BUILDING _____ B. WING _____	04/06/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 1 resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure the resident representative was notified of a significant medication error for 1 of 5 (R59) residents reviewed for unnecessary medication. Findings include: R59 was admitted to the facility on 3/27/17, following a hospitalization for a cerebral vascular accident (CVA) and atrial fibrillation . R59 was receiving an anticoagulant medication to prevent blood clotting.	F 157	1. The family for resident (59) have been notified. 2. A review of other residents using anticoagulants found that no other residents have been affected by this practice. 3. The policy and procedure was reviewed and updated. All licensed staff will be re-educated on the notification process by May 16, 2017. This training will be completed by the Director of Nursing.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245316	A. BUILDING _____ B. WING _____	04/06/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 2 Review of the current physician order list dated 3/28/17, indicated R59 was to receive Coumadin 8 milligrams (mg) on 3/28/17, 3/29/17 and 3/30/17. Recheck INR (international ratio) on 3/31/17. Review of R59's medical record did not indicate an INR was drawn on 3/31/17, as ordered. And no further direction for the continued Coumadin use had been addressed. R59 had not received a Coumadin dose since 3/30/17. Review of a Physician fax notification dated 4/3/17, identified an INR result for R59 of 1.2 at 8:00 a.m. New physician orders were provided to give Coumadin 8 mg on 4/3/17, 4/4/17 and 4/5/17 and to recheck INR on 4/6/17. When interviewed on 4/4/17, at 1:52 p.m. registered nurse (RN)-A, indicated she had discovered the omission of R59's INR when conducting a chart review on 4/3/17. RN-A verified the DON and physician had been notified but denied notifying the family. RN-A confirmed the family should have been notified of the missed INR. When interviewed on 4/4/17, at 3:41 p.m. the DON verified the family was not notified and stated, "This is a significant error and I would expect the family to be notified". The facility's Physician/Family notification protocol, undated, directs notification to family and resident of significant change and to document.	F 157	4. All incidents, medication errors and significant changes will be reviewed weekly by the IDT team for the next 8 weeks and then monthly for the next 4 months to ensure families are notified as required and to ensure we are in compliance with policies and regulations. The results of these audits will be reviewed at the next 6 QAA meetings.	
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED	F 278		5/16/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245316	A. BUILDING _____ B. WING _____	04/06/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 3 (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to accurately code the Minimum Data Set (MDS) assessment for 1 of 1	F 278	1. The MDS assessment for Resident (43) will be modified by May 16, 2017 to show he does not use dentures.	

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F 278	Continued From page 4 resident (R43) reviewed for dental care. Findings include: The annual MDS assessment dated 3/14/17, identified that R43 was edentulous (lacking teeth). Review of R43's dental Care Area Assessment (CAA) dated 3/27/17, identified R43 as edentulous with a full set of dentures worn daily. It further directed staff to observe for sores or ill fitting dentures. Review of R43's most current oral assessment dated 3/14/17, identified the resident as having all natural teeth with no concerns/problems with his teeth. However R43's oral assessments dated 9/12/16 and 12/13/16 both identified R43 as edentulous with upper and lower dentures that fit well. During interview on 4/5/17, at 9:02 a.m. nursing assistant (NA)-A stated R43 had his own natural teeth. During interview on 4/5/17, at 9:24 a.m. NA-B further confirmed R43 had his natural teeth and did not wear a partial nor dentures. Interview and observation of R43 with the MDS coordinator on 4/5/17, at 1:43 p.m. confirmed the resident had his own teeth, with worn appearing lower front teeth as well as missing teeth of the upper oral cavity. The MDS coordinator verified the MDS, dental CAA as well as the 9/12/16 and 12/13/16 oral assessments had been inaccurate at the time of completion. During interview on 4/6/17, at 2:27 p.m. director of nursing (DON) stated her expectation is for the	F 278	2. A review of all residents shows that no other residents have been affected by this practice. 3. The Director of Nursing will re-educate all licensed staff on the need for accurate assessments by May 16, 2017. 4. All assessments will be reviewed for accuracy during the quarterly care conference meetings. The results of these reviews will be discussed at the next 6 QAA meetings.	

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F 278	Continued From page 5 MDS, CAA, and oral assessments to be accurate and reflective of the resident status.	F 278		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;	F 329		5/16/17

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F 329	Continued From page 6 (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to identify the parameters for use of an as needed (PRN) antipsychotic medication (risperidone) and an antidepressant medication (Trazodone), and failed to consistently document behaviors and non-pharmacological interventions attempted prior administration of the PRN's for 1 of 5 residents (R33) reviewed for unnecessary medications. Findings include: R33's diagnoses per the 3/28/17, physician orders included: dementia with behavioral disturbance, delusional disorders, depression, and anxiety. Review of the quarterly Minimum Data Set (MDS) assessment dated 1/24/17, identified that R33 had severe cognitive impairment and required extensive assistance with all activities of daily living (ADL's). The MDS further indicated R33 exhibited wandering 4-6 days but less than daily during the look back period; and physical/verbal behavior directed towards others and rejection of care 1-3 days during the look back period. R33's signed physician order dated 3/28/17, identified the following as needed (PRN) medication orders: risperidone 0.25 milligrams (mg) one tablet by mouth (po) every 4 hours PRN for agitation and Trazodone HCl 50 mg one tablet po every HS (bedtime) PRN - may repeat once	F 329	1. Clear parameters for use of the PRN psychotropic medications will be added to resident's care plan by May 16, 2017. 2. A review of all resident using PRN psychotropic medications did not show any other residents to have been affected by this practice. 3. All nursing staff will be re-educated regarding behaviors and non-pharmacological interventions as well as the need for accurate charting of intervention effectiveness prior to the use of PRN medications. This will be completed by May 16, 2017 by the Director of Nursing. 4. The use of PRN medication will be audited weekly by the Unit Nurse Manager for the next 8 weeks ands then monthly for the next 4 months. The results of these audits will be reviewed at the next 6 QAA meetings	

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F 329	Continued From page 7	F 329		

before 3 a.m. for dementia with behavioral disturbance. In addition, scheduled doses included: risperidone 0.25 mg po 2 x/day (bid) and Trazodone 25 mg po every HS for sleep.

R33's care plan last reviewed 2/13/17, included a focus of targeted mood/behavior as evidenced by diagnosis of dementia. Care plan identified behaviors including: (1) wandering throughout the building and in and out of staff areas and other resident rooms, sometimes taking their things; and (2) Moving back and forth in rock-n-go wheelchair, tending to sleep all day and then awake at night, and recent episodes of agitation towards others, running into them and other things. The care plan included several interventions to attempt to distract R33 when behaviors occurred. Interventions included: administer medications as ordered, report behavior and mood issues to the charge nurse and document as appropriate. The care plan did not include parameters related to the PRN administration of risperidone and/or the Trazodone.

Review of the electronic administration record (eMAR) revealed R33 was administered PRN risperidone 7 times from 1/23/17 - 3/8/17 and PRN Trazodone 3 times from 1/16/17 - 2/11/17. Further review of R33's eMAR and electronic record indicated documentation related to R33's behavior exhibited and staff interventions attempted prior to administration of prn risperidone were only documented 2 out of 7 times, and prior to administration of prn Trazodone 1 out of 3 times.

Review R33's medication review report by the pharmacist dated 7/6/16, indicated: ATTN

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F 329	Continued From page 8 NURSING--MEDICATION MONITORING: Resident is receiving frequent doses of Trazodone, mostly for sleep or restlessness. Risperdal PRN used x 1 on 7/5/16 for restlessness/anxious. Documentation of non-pharmacological interventions attempted prior to PRN agent use are mostly lacking. Risperdal PRN may only be utilized for behavior which present a risk to self or others, with use for restlessness/anxious being too generalized to determine if use is appropriate or not. RECOMMENDATION: Please re-educate staff on the need to document specific target behaviors observed, non-pharmacological interventions attempted and the success/failure of these interventions prior to use of any PRN agent, and ensure the dose-response follow-up. When interviewed on 4/5/17, at 12:43 p.m. licensed practical nurse (LPN)-A stated staff would attempt to distract R33 before giving prn risperidone or Trazodone. LPN-A confirmed there were no clear parameters outlined on the eMAR indicating when to give the prn risperidone or Trazodone though stated this may be identified in R33's care plan. LPN-A further stated if a prn psychotropic medication is administered, staff are trained to chart behaviors exhibited and interventions attempted prior to administering the medication. When interviewed on 4/06/17, at 10:24 a.m. LPN-C stated she would only give the prn risperidone to R33 if all attempts at redirection had failed. LPN-C further stated she would probably only give the prn Trazodone to R33 if she wasn't sleeping and it was the middle of the night. LPN-C confirmed there were no clear parameters on when to give the prn risperidone	F 329		

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F 329	Continued From page 9 or Trazodone. LPN-C further confirmed resident's behaviors and nonpharmacological interventions attempted prior to administration of a prn psychotropic medication were supposed to be charted in the electronic record. When interviewed on 4/6/17, at 12:27 p.m. registered nurse (RN)-B stated the expectation was for staff to chart resident behavior and interventions attempted prior to administration of a psychotropic prn medication. RN-B further stated education had been provided to staff but documentation was still lacking. RN-B also verified there were no parameters related to (r/t) use for R33's prn risperidone and Trazodone. When interviewed on 4/6/17, at 1:24 p.m. the director of nursing (DON) indicated (r/t antipsychotic prn use), would expect to give if there were psychotic symptoms displayed and would also expect documentation of the behaviors displayed and interventions attempted prior to administration of the prn antipsychotic medication. DON further stated r/t R33's prn Trazodone, would want to see at least 4-6 hours in between the scheduled dose and administration of the prn. DON stated would also expect documentation to reflect behavior exhibited and interventions attempted prior to administration of the prn Trazodone.	F 329		
F 333 SS=D	483.45(f)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS 483.45(f) Medication Errors. The facility must ensure that its- (f)(2) Residents are free of any significant	F 333		5/16/17

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F 333	Continued From page 10 medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure the laboratory test ordered by the physician to titrate a therapeutic dose of anticoagulant medication (warfarin) was completed for 1 of 1 (R59) resident reviewed who had a significant medication error reported and experienced a delay in the administration of the medication. Findings include: R59 was admitted on 3/27/17, following a hospitalization for a cerebral vascular accident (CVA-stroke) and atrial fibrillation (irregular heart beat). R59's dismissal summary from the hospital dated 3/27/17, identified the following INR's (international ratio) laboratory test results documented in relationship to the dosage of warfarin (Coumadin) administered: 3/27/17=INR 1.4; warfarin 6 milligrams (mg); 3/26/17=INR 1.3; warfarin 6 mg ; 3/25/17= INR 1.3; warfarin 5 mg; 3/24/17=INR 1.2; warfarin 5 mg. The medication was indicated for diagnosis of chronic atrial fibrillation and the INR goal was identified to be titrated between (2-3). Review of the current physician order list dated 3/28/17, indicated R59 was to receive Coumadin 8 milligrams (mg) on 3/28/17, 3/29/17 and 3/30/17; a recheck of INR level was scheduled for 3/31/17 (Friday). Review of R59's medical record did not indicate an INR was drawn on 3/31/17, as ordered and	F 333	1. Resident (R59) did not experience an adverse event due to this error. His medication regimen is up to date. 2. No other residents were found to have been affected by this practice. 3. The policy and procedure was reviewed and updated. All licensed staff will be re-educated on the medication transcription policy by May 16, 2017. The training will be completed by the Director of Nursing. 4. Audits will be conducted by Unit Nurse Managers to ensure proper transcription for the next 8 weeks then monthly for the next 4 months. The results of these audits will be reviewed at the next 6 QAA meetings.	

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F 333	Continued From page 11	F 333		

subsequently, no further physician orders were followed up by staff related to the continued administration of warfarin (Coumadin) and the appropriate dose. R59 had not received a Coumadin dose since 3/30/17 since the laboratory results (INR) were not completed and not available for evaluation.

Review of a Physician fax notification dated 4/3/17, identified an INR result of 1.2 at 8:00 a.m. New physician orders instructed staff to administer warfarin (Coumadin) 8 mg on 4/3/17, 4/4/17 and 4/5/17 and to recheck INR on 4/6/17.

When interviewed on 4/4/17, at 1:52 p.m. registered nurse (RN)-A, indicated she had discovered the omission of R59's INR laboratory test orders while conducting a chart review on 4/3/17. RN-A indicated she filed a medication error report. RN-A confirmed R59's INR should have been added to the calendar for draw on 3/31/17, but it had not been entered. RN-A verified the DON and physician had been notified of the omission.

When interviewed on 4/4/17, at 3:41 p.m. the director of nursing (DON) verified the omission of the blood level monitoring (INR) so that R59's warfarin dosage could be determined. The DON indicated that when physician ordered lab tests and/or appointments are received, they are entered into the calendar located at the nurses desk. These orders are noted by the charge nurse and a recheck by the night nurse is completed to verify they were processed correctly. After the nurse processes the order it is faxed to the pharmacy for updates.

Review of a physician progress note dated

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	245316	A. BUILDING _____ B. WING _____	04/06/2017

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F 333	Continued From page 12 4/6/17, identified the identified/missed INR lab results for R59. The physician indicated R59's INR was still sub-therapeutic at 1.4 (goal 2-3) on 3/27/17. Orders were sent to the facility to increase the dose on 3/31/17, 4/1/17 and 4/2/17 but these doses had not been administered. R59's INR level on 4/3/17, remained low at 1.2. The warfarin was then restarted after review of the INR. The Lab Order Policy & Procedure specified during transcription of lab order, the charge nurse will make a notation on the desk calendar regarding resident name/date due/ type of lab. Lab orders are not to be entered into PCC (electronic medical record).	F 333		

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	245316	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/06/2017**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, New Richland Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/27/2017

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

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. New Richland Care Center is a 1-story building with no basement. The building was constructed at 2 different times. The original building was constructed in 1975 and was determined to be of Type II(111) construction. In 1992, addition was constructed to the lower North Wing that was determined to be of Type II(111) construction. Because the original building and the 1 addition are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinkled. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that are monitored for automatic fire department notification. The facility has a capacity of 50 beds and had a census of 44 at the time of the survey.	K 000		

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 920 SS=E	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is not met as evidenced by: Based on observation and interview, the Facility failed to comply with 10.2.4 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5.This deficient practice could affect 20 of the 44 residents. Electrical Equipment - Power Cords and	K 920	1. The extension cord has been removed from the resident's room. 2. The Maintenance Supervisor has inspected each room on April 19, 2017 to ensure no other extension cords are in use.	4/19/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245316	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/06/2017**

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K 920	Continued From page 3 Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 FINDINGS INCLUDE: On facility tour between 10:00 AM and 2:00 PM on 04/06/2017, observation during the inspection revealed an extension cord being used used as a source of fixed wiring in Resident Room #212. This deficient practice was verified by the Facility Maintenance Director.	K 920	3. The Maintenance Supervisor will do monthly check of each room to ensure extension cords are not in use and that we are in compliance with all life safety policies and regulations. 4. These inspections will be reviewed at the monthly safety meetings.	