DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 5, 2021

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

RE: CCN: 245316
Cycle Start Date: January 4, 2021

Dear Administrator:

On January 26, 2021, we notified you a remedy was imposed. On March 31, 2021 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of March 31, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective February 25, 2021 be discontinued as of March 31, 2021. (42 CFR 488.417 (b))

However, as we notified you in our letter of January 26, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from February 25, 2021. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 3, 2021

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

RE: CCN: 245316
Cycle Start Date: January 4, 2021

Dear Administrator:

On January 26, 2021, we informed you of imposed enforcement remedies.

On February 10, 2021, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the survey findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective February 25, 2021, will remain in effect.

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective February 25, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 25, 2021.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

As we notified you in our letter of January 26, 2021, 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 February 25, 2021.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt

of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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).

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:

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division 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 ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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

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

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 July 4, 2021 (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.

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.

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:

Tamika.Brown@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 Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION/ INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:
https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

Feel free to contact me if you have questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245316	A. BUILDING _____ B. WING _____	C 02/10/2021

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

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F 000	INITIAL COMMENTS On 2/9/21 and 2/10/21, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found NOT to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H#5316032C (MN69715) with a deficiency cited at F686. The following complaints were found to be UNSUBSTANTIATED: H#5316029C (MN6085), (MN59785) H#5316030C (MN60600) H#5316031C (MN60760) H#5316033C (MN69739) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. .	F 000		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers.	F 686		3/25/21

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

Electronically Signed | 03/16/2021

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F 686	Continued From page 1 Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess, monitor and implement pressure relieving interventions for 1 of 2 residents (R1) reviewed who were at risk for pressure ulcer development. Findings include: R1's diagnoses as listed on progress notes printed on 2/9/21, indicated pneumonia due to coronavirus, diabetes, difficulty walking, muscle weakness and mild intellectual disability. Diagnoses did not include pressure injuries or ulcers to feet. R1's admission Minimum Data Set (MDS) assessment dated 1/12/21, indicated R1 had severe cognitive impairment, adequate hearing and vision, unclear speech, was usually understood and could usually understand. R1 required extensive assistance of one or two staff for bed mobility, transfers, dressing, toileting and locomotion; and did not walk. The MDS indicated R1 had pressure ulcers; two which were unstageable (Slough and/or eschar: Known but	F 686	Plan of Correction F686 Other Residents with Potential to be Affected: While all residents have the potential to be affected by this alleged deficient practice, no negative outcomes were identified other than that of R1. R1 no longer resides at our facility and discharged on 02/04/2021. Systemic Changes to Ensure Compliance: Facility promoted a Registered Nurse to become wound care certified, with a course completion date of 02/19/2020. Wound Care Nurse will re-assess all residents for pressure injury risk using the Braden Scale, those residents identified as high risk will be referred to the IDT for further review and if applicable interventions will be put in place to prevent or treat pressure injuries and other skin integrity issues. Additionally, those high-risk residents will be seen weekly by the wound care nurse to identify	

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F 686	Continued From page 2 not stageable due to coverage of wound by slough and/or eschar) pressure injuries presenting as deep tissue injury (Purple or maroon area of discolored intact skin due to damage of underlying soft tissue) and one present upon admission. R1's current physician orders dated 2/9/21, included vinegar and water foot soaks daily in the evening, which were started on 1/9/21, and a nutritional supplement that was started on 1/20/21. R1's scale for predicting pressure sore risk dated 1/12/2021, indicated R1 had a low risk, with a score of 15. R1's care plan printed on 2/9/21, indicated R1 was at risk for skin impairment due to immobility following hospitalization for Covid19. Interventions included alternating air mattress, bed cradle, heel protectors, and weekly skin assessments. Staff were to inform nurse of any skin impairments observed while providing care. Staff were to identify and document potential causative factors to skin breakdown and eliminate or resolve them. The care plan did not include repositioning as an intervention. In addition, R1's care plan indicated R1 was diabetic and staff were to inspect his feet daily for open areas, sores, pressure areas, blisters, edema or redness. R1's progress note from date of admission on 1/6/21, indicated: R1 had a small purple blister on his left great toe. A nursing home rounding worksheet dated 1/7/21,indicated "small purple blister left great	F 686	any areas of pressure before breakdown occurs. Care Plans and Kardex will be reviewed and updated to reflect recommendations of the Wound Care Nurse and wound consultant and risk level determined by the Braden Scale. All residents will have a new Braden Scale assessment completed on them by 03/19/2021. All residents will have quarterly Braden Scale assessments. The facility treatment guidelines for wound care as well as skin related policies have been reviewed and updated. They were reviewed to ensure inclusion of the following: Prevention (turning and repositioning), weekly skin checks, weekly wound detailed assessments. Staff have been reeducated on the following: Nurses: Facility treatment guidelines for wound care, the necessary components of all physician orders, inclusive of wound treatments, wound staging and proper treatment and prevention strategies (provided by consultant), Nurses and CNA's: Individualized resident centered turning and repositioning program;, internal weekly skin checks. Weekly audits of skin checks will be completed by the Wound Care Nurse for 5 random residents weekly x4 and then weekly until 100% compliance is sustained for 3 weeks. Facility has purchased new training mannequins (Seymore Butts, Wilma Wound Foot, Foot molds) to be used for Nursing Department wide training and in-service. We have also contracted with Jeri Lundgren of Senior Providers	

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F 686	Continued From page 3 toe" in small print by staff for the provider to take note of when she saw R1 on 1/8/21. A progress note by nurse practitioner (NP)-B dated 1/8/21, indicated she examined R1 via real-time audio/video technology. Listed under review of systems for skin was: denies bruising, bleeding, rashes, or changes in moles. Listed under physical exam for skin was: warm, pink and dry. No rashes, excoriations (scratches), open areas. There was no mention of purple blister to left great toe. A progress note dated 1/12/21, at 1:42 p.m. completed by RN-B indicated R1 had a light purple area on the back of his right heel measuring 2 centimeters (cm) x 3 cm. R1 also had a scab on his outer left foot measuring 0.5 cm in diameter. R1 continued to have a purplish-blue area on the tip of his left great toe. R1's comprehensive skin assessment dated 1/12/21, at 9:21 p.m. completed by RN-B indicated R1 had right heel pressure injury measuring 2 cm x 3 cm, and a left toe pressure injury measuring 0.3 cm x 0.3 cm. No mention of the scab on outer left foot. Air mattress and foot cradle were applied to bed. Rooke boots (special boots to protect the foot from pressure) to left lower extremity. A progress note dated 1/18/21, at 6:48 p.m. by a licensed practical nurse (LPN) indicated: the wound nurse assessed R1's feet and there were black areas on heels and a black spot on left great toe. A progress note dated 1/23/21, at 7:21 p.m. by a LPN indicated: the blister on the tip of R1's left	F 686	Resources for facility wide wound education and implementation of new wound care policies and procedures. Nurses will be reeducated on the utilization and completion of the Braden Scale to identify the risk level for skin breakdown of residents and implementing and care planning appropriate interventions to prevent pressure injuries / skin breakdown. Nursing Unit Managers have been reeducated on the requirement and need to promptly report changes in skin condition to the resident's provider. We will also reeducate CNA's on their role in alleviating and preventing pressure injuries, notifying nurses of changes to a resident's skin condition, and the availability of the interventions located on the care plan or Kardex. Nursing Unit Managers will audit 5 employees from the nursing department per week for 3 weeks to confirm that they are aware of and can locate interventions on the Kardex or Care Plan. Audits will be brought to the QAPI Team for review. The QAPI Team will decide if the audits need to continue. System Maintenance: The Wound Care Nurse or DON will conduct Skin Wound Audits on all current pressure injuries 1x and all new pressure injuries ongoing for 3 months to improve identification of new pressure injuries and to prevent worsening of existing pressure injuries. All findings of concern will be immediately addressed and reported to the QAPI committee for further review and consideration of additional corrective	

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F 686	Continued From page 4 great toe had gotten more fluid filled, and his left heel had a large dark ulcer-looking area as well. R1's right heel had beginning stages of an ulcer too. Fax prepared for NP for further direction. A progress note dated 1/25/21, at 9:59 a.m. written by RN-A indicated the following: #1 - unstageable pressure injury to right posterior heel, measuring 3 x 2.5 x 0.2 cm; dry eschar (a collection of dead tissue); no drainage, no pain. #2 - lateral left heel, deep tissue injury measuring 3 x 1.5 cm dark purple; no drainage, no pain. #3 - tip of left great toe deep tissue injury measuring 3 x 1.5 cm dark purple, no drainage, no pain. The note further indicated: continue to use heel protectors, foot cradle and betadine (an antiseptic) paint to dry these areas up. Keep feet warm and elevated as tolerated. Continue to monitor. A progress note dated 2/1/21, at 9:52 a.m. written by RN-A indicated the following: #1 - unstageable pressure injury to right posterior heel, measuring 3 x 2.5 x 0.2 cm; most of it dry eschar; some drainage to distal part of wound; no pain. #2 - lateral left heel, deep tissue injury measuring 3 x 1.5 cm dark purple; no drainage, no pain. #3 - tip of left great toe deep tissue injury measuring 3 x 1.5 cm dark purple, no drainage, no pain. A progress note dated 2/1/21, at 8:42 p.m. written by a LPN indicated: R1's left heel had three to four open areas with some drainage. Note also indicated the AM nurse reported she had addressed this with the facility wound nurse that morning.	F 686	measures. The D.O.N. and/or designee are responsible for these corrective actions.	

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F 686	Continued From page 5	F 686		

A progress note dated 2/2/21, at 9:36 a.m. completed by a LPN indicated: R1's right heel was draining. A message was sent to NP-B requesting evaluation at wound clinic. At 12:47 p.m., orders were received for wound clinic consult and an appointment was scheduled for 2/10/21.

A progress note dated 2/4/21, at 8:27 a.m. indicated R1's county case worker called and requested R1's heels be evaluated by a doctor and was informed R1 was due to be seen on rounds the next day by NP-B.

A progress note dated 2/4/21, at 1:01 p.m. indicated R1 had a coughing spell when eating. A concern of aspiration pneumonia was reported to NP-B who gave orders to transport R1 to the hospital by ambulance.

During a telephone interview on 2/9/21, at 12:17 p.m. social services (SS)-C stated R1 developed sores on his heels after being admitted to the facility on 1/6/21. SS-C stated they were told at R1's care conference on 1/20/21, that R1 had some sores on his feet related to Covid19. When the SS-C expressed concern to the facility about R1's heels, SS-C stated they were slow to respond; slow to get the nurse practitioner involved and slow to get a referral to a wound specialist. SS-C stated R1 was sent to the hospital for a choking episode on 2/4/21, where he was admitted and remained hospitalized.

During an interview on 2/10/21, at 10:43 a.m. RN-A stated she had only been in the role of wound care nurse for a week; the prior wound care nurse no longer worked at the facility. RN-A

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F 686	Continued From page 6	F 686		

stated she is not able to fill in the gaps regarding the development and progression of wounds to R1's heels. RN-A stated residents were supposed to have weekly skin checks with their bath but was not able to locate R1's weekly skin check documentation. RN-A stated only the designated wound care nurse monitors, measures and documents pressure injuries.

During an interview on 2/10/21, at 2:25 p.m. RN-A stated the first time the right heel and left foot wounds were identified was in a progress note on 1/12/21, and acknowledged there was no documentation by a provider indicating awareness of the heel wounds.

During an interview on 2/9/21, at 2:50 p.m. the director of nursing (DON) stated he was not familiar with R1's pressure ulcers, other than hearing of skin concerns at interdisciplinary team meetings. The DON was unaware that R1's pressure wounds had not been monitored, measured and documented on a weekly basis but expected that to occur. The DON admitted the previous wound care nurse "let some things slip as she transitioned out the door." The DON was not aware the nursing staff did not notify the provider of the development of pressure ulcers to heels on 1/12/21, and worsening of the wound on the left great toe. The DON stated he would expect staff to notified the facility nurse practitioner when changes like this occurred. The DON provided documentation that a provider acknowledged R1's pressure injuries on 1/19/21; a week after pressure injuries were first identified by staff.
Documentation was as follows:

R1's admission history and physical (H & P)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 7	F 686		

examination dated 1/19/21, indicated medical doctor (MD)-D conducted a real-time audio/video consult with R1.
The H & P indicated: nursing is concerned about bilateral deep tissue injuries to his heels as well as his left great toe; they are using Rooke boots for this. Diagnosis indicated:
--pressure induced deep tissue damage of left heel
--pressure induced deep tissue damage of right heel
--pressure induced deep tissue damage of left great toe

The DON further stated on 2/9/21 at 2:50 p.m., the interventions such as an air mattress, Rooke boots, off-loading, and repositioning would be used to prevent further deterioration; adding the Braden skin assessment, resident comorbidities, nutritional status and mobility would determine a residents need for repositioning. When informed R1 did not have repositioning as an intervention on his care plan, the DON stated he didn't know why that was. The DON stated he would expect interventions such as repositioning to prevent further deterioration of a pressure wound.

Facility policy titled Prevention of Pressure Injuries, with revised dated of April 2020, indicated:
--The purpose was to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors.
--Inspect skin on a daily basis when performing or assisting with personal cares. Identify signs of developing pressure injuries.
--Reposition as indicated in care plan. Reposition all residents with or without risk of pressure injuries on an individualized schedule. Choose

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	245316	A. BUILDING _____ B. WING _____	C 02/10/2021

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frequency based on resident risk factors and current clinical practice guidelines.
--Review and select medical devices with consideration of the ability to minimize tissue damage, including size, shape, it's application and ability to secure device.
Monitor regularly for comfort and signs of pressure-related injury.
--Evaluate, report and document potential changes in the skin.

Facility policy titled Pressure Ulcer/Skin Breakdown - Clinical Protocol with revised dated of April 2010, indicated:
--The nursing staff and practitioner will assess and document an individual's significant risk factors for developing pressure ulcers.
--The nurse shall describe and document the following: Full assessment of pressure sore, including location, stage, length, width and depth; presence of exudate or necrotic tissue.
--The physician will assist the staff to identify the type (arterial or stasis ulcer) and characteristics (presence of necrotic tissue, status of would bed) of an ulcer.
--The physician will order pertinent wound treatments, including pressure reduction surfaces, wound cleansing and debridement approaches, dressings and application of topical agents.

Facility policy titled Pressure Injuries Overview, with revised date of March 2020, included: Definitions and clinical features of pressure injuries. Defined avoidable and unavoidable pressure injuries.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 3, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: W4X611

Dear Administrator:

The above facility was surveyed on February 9, 2021 through February 10, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please 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.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 2/9/21 and 2/10/21, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H#5316032C (MN69715)with a licensing order issued at MN Rule 4658.0525 Subd. 3. The following complaints were found to be UNSUBSTANTIATED: H#5316029C (MN6085), (MN59785) H#5316030C (MN60600) H#5316031C (MN60760) H#5316033C (MN69739) Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 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. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box	2 000		

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2 000	Continued From page 2 available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document	2 900	Corrected	3/16/21

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2 900	Continued From page 3 review, the facility failed to assess, monitor and implement pressure relieving interventions for 1 of 2 residents (R1) reviewed who were at risk for pressure ulcer development. Findings include: R1's diagnoses as listed on progress notes printed on 2/9/21, indicated pneumonia due to coronavirus, diabetes, difficulty walking, muscle weakness and mild intellectual disability. Diagnoses did not include pressure injuries or ulcers to feet. R1's admission Minimum Data Set (MDS) assessment dated 1/12/21, indicated R1 had severe cognitive impairment, adequate hearing and vision, unclear speech, was usually understood and could usually understand. R1 required extensive assistance of one or two staff for bed mobility, transfers, dressing, toileting and locomotion; and did not walk. The MDS indicated R1 had pressure ulcers; two which were unstageable (Slough and/or eschar: Known but not stageable due to coverage of wound by slough and/or eschar) pressure injuries presenting as deep tissue injury (Purple or maroon area of discolored intact skin due to damage of underlying soft tissue) and one present upon admission. R1's current physician orders dated 2/9/21, included vinegar and water foot soaks daily in the evening, which were started on 1/9/21, and a nutritional supplement that was started on 1/20/21. R1's scale for predicting pressure sore risk dated 1/12/2021, indicated R1 had a low risk, with a score of 15.	2 900		

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2 900	Continued From page 4 R1's care plan printed on 2/9/21, indicated R1 was at risk for skin impairment due to immobility following hospitalization for Covid19. Interventions included alternating air mattress, bed cradle, heel protectors, and weekly skin assessments. Staff were to inform nurse of any skin impairments observed while providing care. Staff were to identify and document potential causative factors to skin breakdown and eliminate or resolve them. The care plan did not include repositioning as an intervention. In addition, R1's care plan indicated R1 was diabetic and staff were to inspect his feet daily for open areas, sores, pressure areas, blisters, edema or redness. R1's progress note from date of admission on 1/6/21, indicated: R1 had a small purple blister on his left great toe. A nursing home rounding worksheet dated 1/7/21,indicated "small purple blister left great toe" in small print by staff for the provider to take note of when she saw R1 on 1/8/21. A progress note by nurse practitioner (NP)-B dated 1/8/21, indicated she examined R1 via real-time audio/video technology. Listed under review of systems for skin was: denies bruising, bleeding, rashes, or changes in moles. Listed under physical exam for skin was: warm, pink and dry. No rashes, excoriations (scratches), open areas. There was no mention of purple blister to left great toe. A progress note dated 1/12/21, at 1:42 p.m. completed by RN-B indicated R1 had a light purple area on the back of his right heel measuring 2 centimeters (cm) x 3 cm. R1 also	2 900		

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2 900	Continued From page 5 had a scab on his outer left foot measuring 0.5 cm in diameter. R1 continued to have a purplish-blue area on the tip of his left great toe. R1's comprehensive skin assessment dated 1/12/21, at 9:21 p.m. completed by RN-B indicated R1 had right heel pressure injury measuring 2 cm x 3 cm, and a left toe pressure injury measuring 0.3 cm x 0.3 cm. No mention of the scab on outer left foot. Air mattress and foot cradle were applied to bed. Rooke boots (special boots to protect the foot from pressure) to left lower extremity. A progress note dated 1/18/21, at 6:48 p.m. by a licensed practical nurse (LPN) indicated: the wound nurse assessed R1's feet and there were black areas on heels and a black spot on left great toe. A progress note dated 1/23/21, at 7:21 p.m. by a LPN indicated: the blister on the tip of R1's left great toe had gotten more fluid filled, and his left heel had a large dark ulcer-looking area as well. R1's right heel had beginning stages of an ulcer too. Fax prepared for NP for further direction. A progress note dated 1/25/21, at 9:59 a.m. written by RN-A indicated the following: #1 - unstageable pressure injury to right posterior heel, measuring 3 x 2.5 x 0.2 cm; dry eschar (a collection of dead tissue); no drainage, no pain. #2 - lateral left heel, deep tissue injury measuring 3 x 1.5 cm dark purple; no drainage, no pain. #3 - tip of left great toe deep tissue injury measuring 3 x 1.5 cm dark purple, no drainage, no pain. The note further indicated: continue to use heel protectors, foot cradle and betadine (an antiseptic) paint to dry these areas up. Keep feet	2 900		

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2 900	Continued From page 6 warm and elevated as tolerated. Continue to monitor. A progress note dated 2/1/21, at 9:52 a.m. written by RN-A indicated the following: #1 - unstageable pressure injury to right posterior heel, measuring 3 x 2.5 x 0.2 cm; most of it dry eschar; some drainage to distal part of wound; no pain. #2 - lateral left heel, deep tissue injury measuring 3 x 1.5 cm dark purple; no drainage, no pain. #3 - tip of left great toe deep tissue injury measuring 3 x 1.5 cm dark purple, no drainage, no pain. A progress note dated 2/1/21, at 8:42 p.m. written by a LPN indicated: R1's left heel had three to four open areas with some drainage. Note also indicated the AM nurse reported she had addressed this with the facility wound nurse that morning. A progress note dated 2/2/21, at 9:36 a.m. completed by a LPN indicated: R1's right heel was draining. A message was sent to NP-B requesting evaluation at wound clinic. At 12:47 p.m., orders were received for wound clinic consult and an appointment was scheduled for 2/10/21. A progress note dated 2/4/21, at 8:27 a.m. indicated R1's county case worker called and requested R1's heels be evaluated by a doctor and was informed R1 was due to be seen on rounds the next day by NP-B. A progress note dated 2/4/21, at 1:01 p.m. indicated R1 had a coughing spell when eating. A concern of aspiration pneumonia was reported to NP-B who gave orders to transport R1 to the	2 900		

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2 900	Continued From page 7 hospital by ambulance. During a telephone interview on 2/9/21, at 12:17 p.m. social services (SS)-C stated R1 developed sores on his heels after being admitted to the facility on 1/6/21. SS-C stated they were told at R1's care conference on 1/20/21, that R1 had some sores on his feet related to Covid19. When the SS-C expressed concern to the facility about R1's heels, SS-C stated they were slow to respond; slow to get the nurse practitioner involved and slow to get a referral to a wound specialist. SS-C stated R1 was sent to the hospital for a choking episode on 2/4/21, where he was admitted and remained hospitalized. During an interview on 2/10/21, at 10:43 a.m. RN-A stated she had only been in the role of wound care nurse for a week; the prior wound care nurse no longer worked at the facility. RN-A stated she is not able to fill in the gaps regarding the development and progression of wounds to R1's heels. RN-A stated residents were supposed to have weekly skin checks with their bath but was not able to locate R1's weekly skin check documentation. RN-A stated only the designated wound care nurse monitors, measures and documents pressure injuries. During an interview on 2/10/21, at 2:25 p.m. RN-A stated the first time the right heel and left foot wounds were identified was in a progress note on 1/12/21, and acknowledged there was no documentation by a provider indicating awareness of the heel wounds. During an interview on 2/9/21, at 2:50 p.m. the director of nursing (DON) stated he was not familiar with R1's pressure ulcers, other than hearing of skin concerns at interdisciplinary team	2 900		

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2 900	Continued From page 8	2 900		

meetings. The DON was unaware that R1's pressure wounds had not been monitored, measured and documented on a weekly basis but expected that to occur. The DON admitted the previous wound care nurse "let some things slip as she transitioned out the door." The DON was not aware the nursing staff did not notify the provider of the development of pressure ulcers to heels on 1/12/21, and worsening of the wound on the left great toe. The DON stated he would expect staff to notified the facility nurse practitioner when changes like this occurred. The DON provided documentation that a provider acknowledged R1's pressure injuries on 1/19/21; a week after pressure injuries were first identified by staff.
Documentation was as follows:

R1's admission history and physical (H & P) examination dated 1/19/21, indicated medical doctor (MD)-D conducted a real-time audio/video consult with R1.
The H & P indicated: nursing is concerned about bilateral deep tissue injuries to his heels as well as his left great toe; they are using Rooke boots for this. Diagnosis indicated:
--pressure induced deep tissue damage of left heel
--pressure induced deep tissue damage of right heel
--pressure induced deep tissue damage of left great toe

The DON further stated on 2/9/21 at 2:50 p.m., the interventions such as an air mattress, Rooke boots, off-loading, and repositioning would be used to prevent further deterioration; adding the Braden skin assessment, resident comorbidities, nutritional status and mobility would determine a residents need for repositioning. When informed

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2 900	Continued From page 9 R1 did not have repositioning as an intervention on his care plan, the DON stated he didn't know why that was. The DON stated he would expect interventions such as repositioning to prevent further deterioration of a pressure wound. Facility policy titled Prevention of Pressure Injuries, with revised dated of April 2020, indicated: --The purpose was to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors. --Inspect skin on a daily basis when performing or assisting with personal cares. Identify signs of developing pressure injuries. --Reposition as indicated in care plan. Reposition all residents with or without risk of pressure injuries on an individualized schedule. Choose frequency based on resident risk factors and current clinical practice guidelines. --Review and select medical devices with consideration of the ability to minimize tissue damage, including size, shape, it's application and ability to secure device. Monitor regularly for comfort and signs of pressure-related injury. --Evaluate, report and document potential changes in the skin. Facility policy titled Pressure Ulcer/Skin Breakdown - Clinical Protocol with revised dated of April 2010, indicated: --The nursing staff and practitioner will assess and document an individual's significant risk factors for developing pressure ulcers. --The nurse shall describe and document the following: Full assessment of pressure sore, including location, stage, length, width and depth; presence of exudate or necrotic tissue. --The physician will assist the staff to identify the	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00748	A. BUILDING: _____ B. WING _____	C 02/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 900	Continued From page 10 type (arterial or stasis ulcer) and characteristics (presence of necrotic tissue, status of would bed) of an ulcer. --The physician will order pertinent wound treatments, including pressure reduction surfaces, wound cleansing and debridement approaches, dressings and application of topical agents. Facility policy titled Pressure Injuries Overview, with revised date of March 2020, included: Definitions and clinical features of pressure injuries. Defined avoidable and unavoidable pressure injuries. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure care and services are provided to prevent worsening or development of pressure ulcers. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance and report results of monitoring to the facility Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		