DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
February 26, 2025

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

RE: CCN: 245316
Cycle Start Date: January 8, 2025

Dear Administrator:

On February 12, 2025, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 26, 2025

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

Re: Reinspection Results
Event ID: 498212

Dear Administrator:

On February 12, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on January 8, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

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January 27, 2025

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

RE: CCN: 245316
Cycle Start Date: January 8, 2025

Dear Administrator:

On January 8, 2025, a survey was completed at your facility by the Minnesota Department of Health 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable 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.

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.

The state agency may, in lieu of an onsite 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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);

- Civil money penalty (42 CFR 488.430 through 488.444).

- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by April 8, 2025 (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).

In addition, if substantial compliance with the regulations is not verified by July 8, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: **https://forms.web.health.state.mn.us/form/NHDisputeResolution**

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: **https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html**

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
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 01/08/2025

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 On 1/8/25, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed: H53164100C (MN00109588, MN000109575) with a deficiency cited at F684. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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 onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review the	F 684	Corrective action for affected residents:	2/7/25

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

Electronically Signed | 01/31/2025

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

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F 684	Continued From page 1 facility failed to comprehensively assess and monitor for signs/ symptoms of fluid overload and evaluate the effectiveness of physician prescribed treatments for 1 of 3 residents (R1) who had diagnosis of congestive heart failure. Findings include R1's face sheet dated 1/8/25, identified R1 had diagnosis that included chronic right heart failure. R1's comprehensive minimum data set (MDS) dated 10/23/24, identified R1 was cognitively intact. R1 had no rejection of cares, and had no shortness of breath. R1's care plan focus created 11/6/23, identified R1 had atrial fibrillation (a-fib), chronic right heart failure, and tachycardia. Interventions included providing a-fib medication as ordered, educate R1 on the importance of taking medications, and monitor/document/report to provider signs and symptoms of a-fib. The care plan did not address individualized interventions or goals for the management of fluid overload. R1's physician order dated 11/21/24, included daily weights to be checked in the morning, weight to be checked prior to meal intake. R1's weight monitoring record identified on 11/21/24, R1 weighed 187.5 pounds (lbs) R1's December 2024 treatment administration record (TAR) identified the aforementioned order to obtain weights. The TAR identified weights were not obtained according to physician order. Between 12/1/24 through 12/18/24 the TAR identified the following:	F 684	" Had a meeting with the resident on the importance of following physician-prescribed treatments, their goals of care, and how aggressive they want to be with their plan of care. Identifying other residents having the potential to be affected: " All residents with a Dx of CHF and/or heart failure have the potential to be affected by this practice. RN nurse manager/DON or designee audited all resident diagnosis and identified and implemented the following Measures put into place or systemic changes: " Daily CHF documentation for those with a diagnosis of CHF or heart failure placed in TAR for floor nurses to assess residents and notify physicians of changes in weight, SOB, lung sounds, edema, skin abnormalities (temp, color, texture), Pedal pulses (present), pain, and provider notification if needed. Upon admission and quarterly or sig change for everyone with a Dx of CHF or heart failure by 1/28/25. " RN nurse manager/DON or designee will put the CHF section in the care plan with physician-prescribed treatments by 2/5/25. Plan to monitor performance: " RN nurse manager/DON or designee will perform daily audits for all patients with CHF to ensure there is documentation and provider notification made if needed, due to change in condition or refusal of physician-prescribed treatments. Daily for	

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F 684	Continued From page 2 -No weights documented between 12/1/24 through 12/11/24 with charting codes of either '2'-indicating refusal or '8' indicating see nurses note. On 12/2/24 and 12/10/24 the boxes were left blank. -On 12/12/24: weight was 189.4 -On 12/13/24: weight was 189.4 -On 12/14/24: no weight was documented and indicated refused. -On 12/15/24: weigh was 189.4 -No weights were documented between 12/16/24 through 12/18/24 and indicated refused. In review of R1's record between 12/1/24 through 12/17/24 there was no indication the physician had been notified the ordered weights were not obtained. Additionally not evident R1 was monitored for signs/symptoms of fluid overload which would include edema monitoring. R1's physician visit note dated 12/18/24, identified an assessment of chronic right heart failure with an order for furosemide (diuretic medication) 10 milligrams (mg) three times a week. Weight most recently was 189.4 and stable. R1's December 2024 TAR identified daily weights were not obtained between 12/18/24 through 12/26/24; on 4 entries directed to see progress notes, 3 entries identified refused, one box was blank, and one box was marked not applicable. There was no indication the physician was notified R1 was refusing weights nor evident R1 was monitored for signs/symptoms of fluid overload. R1's December 2024 TAR identified on 12/27/24, R1 weighed 205 lbs.	F 684	1 week, then once weekly for 2 weeks, then once monthly for 6 months	

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F 684	Continued From page 3 R1's progress notes dated 12/27/24, identified a significant weight gain noted of 17# in 2 weeks. R1 was weighed on both the wheelchair scale and mechanical lift scale for accuracy. Slight edema was noted to right outer shin but no edema on left shin. The progress note did not identify the extent of the edema. R1's physician order dated 12/27/24, included the order that directed nursing to monitor every shift for shortness of breath, edema, and blood pressure. Recheck weight on Monday 12/30/24 and update the physician. R1's progress notes dated 12/28/24, identified no edema, no SOB, lung sounds had left clear, right lower lobe crackles. R1's progress notes dated 12/29/24, identified no edema, no SOB, lung sounds left clear, right lower lobe crackles. Remained in bed all shift. R1's progress notes on 12/30/24, identified R1 denied SOB, slept with head of bed flat, lung sounds clear. R1's progress note did not include edema assessment per physician orders. R1's progress note dated 12/31/24 at 2:40 p.m., identified R1 was sent to the emergency department due to having SOB. During an interview on 1/8/24 at 7:34 a.m., nursing assistant (NA)-A stated R1 always refused to get out of bed. R1 would be adamant about not getting up so it was hard to get the weight on the scale. NA-A could not recall swelling on R1 but R1's feet were always sore. During an interview on 1/8/25 at 9:46 a.m., NA-B	F 684		

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F 684	Continued From page 4 stated R1 would refuse weights. NA-B stated R1 would occasionally allow staff to weigh her on the mechanical lift. During an interview on 1/8/24 at 7:45 a.m., licensed practical nurse (LPN)-A stated R1 refused a lot of cares. There was quite a gap of weights documented for R1. The weight should be obtained prior to eating and if staff could not get it, it would not be accurate after eating. LPN-A did not notify R1's physician of her refusals to obtain weights. During an interview on 1/8/25 at 9:53 a.m., LPN-B stated R1 refused weights a lot and residents have the right to refuse. LPN-B did not notify MD-A of weight refusals. During an interview on 1/8/25 at 12:46 p.m., registered nurse (RN)-A stated R1 had diagnoses of congestive heart failure and the care plan did not include goals/interventions for that diagnosis. During an interview on 1/8/25 at 11:55 a.m., nurse manager (NM)-A and Director of Nursing (DON) stated R1 had a lack of weights because she refused. NM-A stated the physician was not notified of R1's weight refusals from December 17-26, 2024. DON stated she would expect the notification, explanation of weight refusal in the resident progress notes, and dictation from provider. The facility did not have a protocol for when to notify the physician when prescribed weights were refused. DON stated edema would be monitored weekly with the skin checks unless ordered by a prescriber. NM-A explained if new edema was identified, she would review weights, SOB, any other symptoms and notify the provider of the change of condition. DON would expect the	F 684		

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F 684	Continued From page 5 care plan to direct monitoring for signs/symptoms of congestive heartfailure. During an interview on 1/8/25 at 9:07 a.m., MD-A was not aware of the weight refusals. MD-A would expect some sort of notification on refusal of prescribed orders. MD-A indicated nurses were responsible to assess and monitor for signs and symptoms of fluid overload and notify the physician of changes. Further felt the frequency of edema monitoring along with other symptoms would be determined by nursing assessment and judgement. No policy was provided.	F 684		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 27, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: 498211

Dear Administrator:

The above facility was surveyed on January 8, 2025 through January 8, 2025 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:

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 feel free to call me with any questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
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
	00748	A. BUILDING: _____ B. WING _____	C 01/08/2025

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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 1/8/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed: H53164100C (MN00109588, MN00109575) with a licensing order issued at (0830) 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/ib14_1.html> 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 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		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in	2 830		1/31/25

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	00748	A. BUILDING: _____ B. WING _____	C 01/08/2025

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2 830	Continued From page 2 the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to comprehensively assess and monitor for signs/ symptoms of fluid overload and evaluate the effectiveness of physician prescribed treatments for 1 of 3 residents (R1) who had diagnosis of congestive heart failure. Findings include R1's face sheet dated 1/8/25, identified R1 had diagnosis that included chronic right heart failure. R1's comprehensive minimum data set (MDS) dated 10/23/24, identified R1 was cognitively intact. R1 had no rejection of cares, and had no shortness of breath. R1's care plan focus created 11/6/23, identified R1 had atrial fibrillation (a-fib), chronic right heart failure, and tachycardia. Interventions included providing a-fib medication as ordered, educate R1 on the importance of taking medications, and monitor/document/report to provider signs and symptoms of a-fib. The care plan did not address individualized interventions or goals for the management of fluid overload.	2 830	Corrected	

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2 830	Continued From page 3 R1's physician order dated 11/21/24, included daily weights to be checked in the morning, weight to be checked prior to meal intake. R1's weight monitoring record identified on 11/21/24, R1 weighed 187.5 pounds (lbs) R1's December 2024 treatment administration record (TAR) identified the aforementioned order to obtain weights. The TAR identified weights were not obtained according to physician order. Between 12/1/24 through 12/18/24 the TAR identified the following: -No weights documented between 12/1/24 through 12/11/24 with charting codes of either '2'-indicating refusal or '8' indicating see nurses note. On 12/2/24 and 12/10/24 the boxes were left blank. -On 12/12/24: weight was 189.4 -On 12/13/24: weight was 189.4 -On 12/14/24: no weight was documented and indicated refused. -On 12/15/24: weigh was 189.4 -No weights were documented between 12/16/24 through 12/18/24 and indicated refused. In review of R1's record between 12/1/24 through 12/17/24 there was no indication the physician had been notified the ordered weights were not obtained. Additionally not evident R1 was monitored for signs/symptoms of fluid overload which would include edema monitoring. R1's physician visit note dated 12/18/24, identified an assessment of chronic right heart failure with an order for furosemide (diuretic medication) 10 milligrams (mg) three times a week. Weight most recently was 189.4 and stable. R1's December 2024 TAR identified daily weights	2 830		

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2 830	Continued From page 4 were not obtained between 12/18/24 through 12/26/24; on 4 entries directed to see progress notes, 3 entries identified refused, one box was blank, and one box was marked not applicable. There was no indication the physician was notified R1 was refusing weights nor evident R1 was monitored for signs/symptoms of fluid overload. R1's December 2024 TAR identified on 12/27/24, R1 weighed 205 lbs. R1's progress notes dated 12/27/24, identified a significant weight gain noted of 17# in 2 weeks. R1 was weighed on both the wheelchair scale and mechanical lift scale for accuracy. Slight edema was noted to right outer shin but no edema on left shin. The progress note did not identify the extent of the edema. R1's physician order dated 12/27/24, included the order that directed nursing to monitor every shift for shortness of breath, edema, and blood pressure. Recheck weight on Monday 12/30/24 and update the physician. R1's progress notes dated 12/28/24, identified no edema, no SOB, lung sounds had left clear, right lower lobe crackles. R1's progress notes dated 12/29/24, identified no edema, no SOB, lung sounds left clear, right lower lobe crackles. Remained in bed all shift. R1's progress notes on 12/30/24, identified R1 denied SOB, slept with head of bed flat, lung sounds clear. R1's progress note did not include edema assessment per physician orders. R1's progress note dated 12/31/24 at 2:40 p.m.,	2 830		

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2 830	Continued From page 5 identified R1 was sent to the emergency department due to having SOB. During an interview on 1/8/24 at 7:34 a.m., nursing assistant (NA)-A stated R1 always refused to get out of bed. R1 would be adamant about not getting up so it was hard to get the weight on the scale. NA-A could not recall swelling on R1 but R1's feet were always sore. During an interview on 1/8/25 at 9:46 a.m., NA-B stated R1 would refuse weights. NA-B stated R1 would occasionally allow staff to weigh her on the mechanical lift. During an interview on 1/8/24 at 7:45 a.m., licensed practical nurse (LPN)-A stated R1 refused a lot of cares. There was quite a gap of weights documented for R1. The weight should be obtained prior to eating and if staff could not get it, it would not be accurate after eating. LPN-A did not notify R1's physician of her refusals to obtain weights. During an interview on 1/8/25 at 9:53 a.m., LPN-B stated R1 refused weights a lot and residents have the right to refuse. LPN-B did not notify MD-A of weight refusals. During an interview on 1/8/25 at 12:46 p.m., registered nurse (RN)-A stated R1 had diagnoses of congestive heart failure and the care plan did not include goals/interventions for that diagnosis. During an interview on 1/8/25 at 11:55 a.m., nurse manager (NM)-A and Director of Nursing (DON) stated R1 had a lack of weights because she refused. NM-A stated the physician was not notified of R1's weight refusals from December 17-26, 2024. DON stated she would expect the	2 830		

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2 830	Continued From page 6 notification, explanation of weight refusal in the resident progress notes, and dictation from provider. The facility did not have a protocol for when to notify the physician when prescribed weights were refused. DON stated edema would be monitored weekly with the skin checks unless ordered by a prescriber. NM-A explained if new edema was identified, she would review weights, SOB, any other symptoms and notify the provider of the change of condition. DON would expect the care plan to direct monitoring for signs/symptoms of congestive heartfailure. During an interview on 1/8/25 at 9:07 a.m., MD-A was not aware of the weight refusals. MD-A would expect some sort of notification on refusal of prescribed orders. MD-A indicated nurses were responsible to assess and monitor for signs and symptoms of fluid overload and notify the physician of changes. Further felt the frequency of edema monitoring along with other symptoms would be determined by nursing assessment and judgement. No policy was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents with impaired skin integrity, to assure they are receiving ongoing monitoring and assessment of the skin along with the necessary treatment/services to promote improvement. The director of nursing or designee, could conduct random audits of the delivery of care; review nursing assessments; to ensure appropriate care and services are implemented and reduce the risk of edema not being cared for properly. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		

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