Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
August 6, 2025

Administrator

New Richland Care Center
312 NORTHEAST 1ST STREET
NEW RICHLAND, MN 56072

RE: CCN: 245316
Cycle Start Date: June 5, 2025

Dear Administrator:

On August 1, 2025, the Minnesota Departments 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

August 6, 2025

Administrator
New Richland Care Center

312 NORTHEAST 1ST STREET
NEW RICHLAND, MN 56072

Re: Reinspection Results
Event ID: XVT812

Dear Administrator:

On August 1, 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 June 5, 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

Electronically delivered
June 30, 2025

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

RE: CCN: 245316
Cycle Start Date: June 5, 2025

Dear Administrator:

On June 5, 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:

Nicole Dahl, RN, Regional Operations Supervisor
Marshall District Office
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102 Marshall, Minnesota 56258-2504
Email: Nicole.Dahl@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

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 September 5, 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 December 5, 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 06/05/2025

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 6/02/25 through 6/05/25, 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 H53165607C (MN113293) with a deficiency cited at F684. H53166208C (MN113459) was also investigated, however no deficiencies were cited. 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:	F 684		8/1/25

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

Electronically Signed | 07/10/2025

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 Based on observation, interview, and document review, the facility failed to provide physician ordered dressing changes and assess wounds during those dressing changes, monitor for signs and symptoms of a worsening known infection, notify the physician of a change of condition and the need to acquire antibiotics from the E-Kit, acquire needed dressing change supplies, follow professional standards of practice by dating wound dressings and educate staff on identifying early signs and symptoms of sepsis (life-threatening infection) for 3 of 3 resident (R1, R2, and R3) reviewed. Findings include: Review of the current, National Library of Medicine, Sepsis: Early recognition and Optimized Treatment article, located at https://pmc.ncbi.nlm.nih.gov/articles/PMC6304323/, identified sepsis is a life-threatening condition caused by infection and represents a substantial global health burden. Systemic inflammatory response syndrome (SIRS) criteria is defined as having a patient with a suspicious or known infection with additional 2 criteria, such as a temperature above 100.4 or below 96.8 degrees Fahrenheit (F), a heart rate over 90 beats per minute (bpm) or a respiratory rate over 20 breaths per minute (bpm). A systolic blood pressure equal to or under 100 millimeters of mercury (mm/hg), respirations equal to or over 22 bpm, and altered mental status are indications of "being likely to be septic". Clinical evidence indicates that patients with acute deterioration or sepsis manifest clinical signs or symptoms several hours before the condition worsens. Review of the current, National Library of	F 684	Plan of Correction for F684 Quality of Care Facility: New Richland Care Center Survey Dates: 6/02/25 6/05/25 Tag Number: F684 Date of Completion: 08/01/2025 1. Corrective Action for Affected Residents: Resident R1 experienced a significant change in condition and was transferred to a higher level of care due to worsening infection. A facility-level investigation determined neglect had occurred related to missed dressing changes, failure to assess wounds as ordered, and lack of timely provider notification. LPN-A was immediately removed from the schedule and placed on a "do not return" list. All documentation related to the event was reviewed and submitted per regulatory requirements. 2. Identification of Other Residents at Risk: The facility determined the event was isolated to R1. No additional residents were identified as affected. Therefore, this section is not applicable. 3. Systemic Changes: An in-service training was completed on 7/7/25 for nursing staff. The training covered Change in Condition, Sepsis Awareness, and Risk Management and included educational slides and a follow-up quiz to verify comprehension. The training materials are being uploaded into Relias to ensure that current staff who missed the in-person session and new hires can be assigned this education as part of orientation and competency	

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F 684	Continued From page 2 Medicine, Understanding Post-Sepsis Syndrome: How Can Clinicians Help article, located at https://pmc.ncbi.nlm.nih.gov/articles/PMC10546999, identified sepsis is a global health challenge, with over 49 million cases annually. Recent medical advancements have increased in-hospital survival rates to approximately 80%, but the escalating incidence of sepsis, owing to an ageing population, rise in chronic diseases, and antibiotic resistance, have also increased the number of sepsis survivors. Subsequently, there is a growing prevalence of "post-sepsis syndrome" (PSS). This syndrome includes long-term physical, medical, cognitive, and psychological issues after recovering from sepsis. Around 75% of sepsis survivors develop at least one new medical, psychological, or cognitive diagnosis after hospital discharge. Only half of the sepsis survivors (both ICU and non-ICU) achieve complete or near-complete recovery within two years after hospital discharge. On the other hand, one in six patients experiences persistent impairments. As such, sepsis survivors are at risk for re-hospitalization, recurrent infections and chronic illness and have a shorter life expectancy, and lower quality of life. sepsis survivors have a significantly increased risk of cardiac events up to 5 years after the sepsis episode. Early administration of appropriate antibiotics remains the cornerstone of bacterial sepsis treatment and is essential for infection control, particularly if administered in the critical early hours. R1 Review of 5/21/25 at 10:19 a.m., report to the State Agency (SA) identified LPN-A neglected to complete wound care per orders. Review of the 5/23/25 at 2:31 p.m. 5-day investigation report	F 684	reviews. A master list of all clinical staff was compiled to track completion of this education and to ensure 100% compliance. On 7/1/25, a Medline representative evaluated and reorganized the central supply room to ensure timely access to wound care supplies, including availability during weekends and after-hours. Nurse Practitioner Alanna Valadez to be consulted for recommendations regarding wound care standing orders and preferred dressing products. She will also advise on best practices for monitoring infections associated with chronic wounds. Dr. Wilcox, the facility Medical Director, is reviewing all current standing orders for wound care to ensure alignment with current clinical standards. Nurses were instructed on the proper protocol for using the emergency medication kit (E-Kit), including obtaining physician authorization to initiate antibiotics in a timely manner if pharmacy delivery would be delayed. All dressing changes are now required to be dated and initialed by the staff member completing them. Compliance with this practice is being monitored through ongoing direct observation and routine audits. 4. Monitoring: The Director of Nursing or designee is completing wound care audits five times per week for two weeks, followed by three times per week for an additional two weeks. Each audit verifies that wound care has been completed as ordered, that assessments are thorough and up to date, that physicians are notified appropriately,	

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F 684	Continued From page 3 identified R1 was interviewed. R1 stated she had not refused wound care. The nurse had told her that she did not have enough supplies. The investigation found Facility nursing staff counted dressing supplies and there were enough supplies to complete the dressing change until follow-up appointment the following day. R1's dressing was changed on 5/19/2025, she did not have the dressing changed on 5/20/2025, went to the wound clinic on 5/21/2025, when she returned, wound clinic had outlined the redness on her leg. During the night, the redness grew outside of the lines and pain increased, went into the ER for further evaluation. The facility found evidence of neglect when R1 verified that she did not refuse the treatment, and there were adequate supplies. LPN-A was immediately put on the "do not return list, and supervisor was notified". There was no documentation to show the facility had notified the Minnesota Board of Nursing of their findings. R1's 5/01/25, admission assessment Minimum Data Set (MDS) identified R1 was cognitively intact. R1 had a history of chronic venous hypertension [CVH] (damaged valves in legs causing high blood pressure in the veins) of her bilateral lower extremities, severe sepsis with septic shock (life-threatening infection that leads to low blood pressure and organ failure that requires immediate medical intervention) and a non-pressure chronic ulcer of her right foot. R1 was dependent on staff for toileting, dressing, and transfers. R1 had 7 venous and arterial ulcers upon admission. R1 was not noted to have any behaviors. R1's undated, current care plan identified R1 was at risk for pressure injury related to chronic	F 684	and that the Braden Scale is completed and current. Audit results will be brought to QAPI meetings for review and action planning as needed. Staff who fail to meet documentation or treatment expectations will be re-educated immediately, and progressive discipline will be implemented as necessary. 5. Completion Date: 08/01/2025 This Plan of Correction addresses the deficient practice cited under F684 and outlines steps taken to correct the issue, prevent recurrence, and monitor for continued compliance. Documentation and supporting materials are available for review upon request.	

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F 684	Continued From page 4 venous ulcerations, inflammation, history of cellulitis, soft tissue infection and chronic lower extremity edema. Interventions was for facility staff to identify/document potential factors related to skin breakdown, monitor/documents location, size and treatment of wound, report abnormal failure to heal, signs and symptoms of infection to physician and wound nurse, inform charge nurse of skin impairments when providing R1's care, wound treatments to be completed as prescribed by the physician, and apply Vani cream to good skin, Aquacel AG to wounds, and change the dressing daily. R1's 5/1/25 at 8:44 a.m., admission progress note related to the wound clinic's assessment and orders identified: 1) The 1st wound had an irregular shape and was located at the pretibial (inner lower leg next to the tibial bone) area. The wound measured 7.0 centimeters (cm) in length, 6 cm in width, and 0.2 cm in depth. Clinic staff noted there was no tunneling, no undermining, the wound bed had granulation (new tissue) with no odor, but had large serosanguinous (bloody clear) drainage and had redness. 2) The 2nd wound was a venous (originating from vein) ulcer non-staged wound. The wound measured 3 cm length, 8.5 cm in width, and 0.1 cm in depth, with no tunneling or undermining. Clinic staff noted there was granulation and exposed tissue, but no odor, and there was a large amount of serosanguinous drainage. 3) The 3rd wound was a left lateral venous non-staged venous ulcer. The wound measured 4 cm in length, 6 cm in width, and 0.1 cm in depth. Clinic staff noted there was no tunneling, no undermining, had granulation with tissue exposed, no odor, a moderate amount of	F 684		

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F 684	Continued From page 5 serosanguinous drainage, redness, maceration (when skin is in contact with moisture for too long) and was denuded (loss of epidermis caused by prolonged moisture and friction). Facility staff were ordered to use acetic acid (vinegar), Aquacel AG (anti-microbial silver impregnated dressing) as the primary dressing with an ABD pad (large gauze pad), Artiflex (soft foam dressing used as a wrap), a Rosidal dressing (soft compression bandage). In addition as a secondary dressing, staff were to use Lopress (elastic compression dressing) and ensure dressings were changed daily and as needed (PRN) for all wounds. R1's, May 2025 Treatment Administration Record (TAR) identified facility nurses was to complete skin/wound note on dressing changes daily. R1's medical record identified R1 had lacked skin/wound assessments and treatments on the following dates: 5/5/25, 5/12/25, 5/15/25, 5/16/25, 5/20/25 and 5/21/25. R1's wound assessments identified they were only done weekly on 5/8/25 and 5/14/25. Assessments were as follows: 1) 5/8/25: R1's right pretibial right leg venous ulcer was measured and assessed. It was noted to be 7.0 centimeters (cm) in length, 7.0 cm in width, and 0.2 cm in depth. Wound description included: wound had full thickness, copious serous drainage, maceration (wrinkled skin) and no odor. 2) 5/14/25, R1's right pretibial lateral venous ulcer was measured and assessed. Wound measurement was 7.0 cm X 9.0 cm X 0.2 cm depth (increase in size). Wound description included: wound bed had full thickness, granulation, copious serosanguineous drainage,	F 684		

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F 684	Continued From page 6 maceration and no odor. There was no indication R1's physician was notified of the increase in size. There were no assessments conducted daily with dressing changes to identify if the wound had improved, worsened or stayed the same. Additionally, neither of R1's 2 other wounds were assessed during these weekly assessments. Further review of R1's progress notes identified on: 1) 5/18/25 at 4:43 p.m., R1 voiced concerns with staff of a shortage of absorbent pads for R1's dressing changes. The facility staff was to leave a message for supplies to be ordered with management and R1 was informed that the absorbent pads were on backorder. 2) 5/19/25 at 3:59 p.m., skin/wound note identified R1 had purulent (pus-like) drainage and a slight odor to R1's bilateral lower extremity (BLE). R1's right lower extremity appeared macerated (moisture related skin damage) and had 25% slough (layer of dead tissue) present. There was no indication staff had notified R1's physician of the changes in wound characteristics. 3) Later that day on 5/19/25 at 4:32 p.m., physical therapy (PT)-A noted R1 had increased drainage from her wound and bandage of the right lower leg. R1 had left PT prior to end of therapy in order for nursing staff to change R1's dressing. There was no indication staff had notified R1's physician of these additional changes in wound characteristics. 4) 5/20/25 at 1:57 p.m., PT noted R1 had "refused wound care" related to supplies. Staff also noted the facility "lacked supplies" to be able to change R1's wound dressings. R1 also had severe pain that morning and was found "yelling	F 684		

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F 684	Continued From page 7 for help". There was no indication R1's physician or the wound clinic had been notified of the increased pain or lack of being able to perform the dressing change. 5) 5/20/25 at 22:43 p.m., R1's had no pain and BLE wounds was not assessed. 6) 5/21/25 at 11:19 a.m., R1 had left for her wound care appointment. Facility nurse was made aware that R1's right knee, above the dressing was warm to touch and pink. R1's knee was not assessed by nursing staff before R1 had left the facility. 7) 5/21/25 at 4:44 p.m., PT note R1 had significant drainage from right lower extremity and had refused for facility staff to complete dressing change prior to scheduled wound clinic visit. 8) 5/21/25 at 10:01 p.m., R1 arrived back to the facility at 5:30 p.m. R1's legs were wrapped, and the redness was outline with a sharpie. R1 had concerns with the infection of her legs. The medical record lacked evidence that a physical baseline assessment had been completed 4 hours after R1 had arrived back to the facility from the wound clinic. 9) 5/21/25 at 9:57 p.m., vitals were 124/60 millimeters of mercury (mm/hg) blood pressure, a temperature of 99.1 degrees Fahrenheit (F), and respirations at 20 breaths per minute (bpm). 10) 5/22/25 at 2:44 a.m., progress note identified R1 complained of pain, had received oxycodone, reported chills, had a declining temperature of 98.6 degrees F, felt ill and had requested to be send to the ED. No other vital signs were assessed to identify sepsis criteria by assessing R1's oxygen saturation, respiratory rate, heart rate, blood pressure, or assessment of her mental status were obtained. R1's 5/22/25, local hospital admission summary	F 684		

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F 684	Continued From page 8 identified R1 had a history of chronic lower extremity edema (swelling) with chronic ulcerations since July of 2024 receiving long-term chronic wound care. She recently was admitted to a regional hospital from 04/17 /25 to 04/24/25 for care after fall and found to be in septic shock suspected from soft skin and tissue infection with acute kidney injury (AKI), severe metabolic acidosis (serious condition when pH level in blood is at life-threatening levels), elevated potassium levels in her blood, atrial fibrillation with rapid ventricular response (AFib with RVR) (potentially life-threatening heartbeat irregularity). R1 was note to be treated with vancomycin and cefepime and then transitioned to Zosyn (antibiotics). R1required a Foley catheter for urinary retention during her stay. She was discharged at that time to the facility for admission of short-term rehabilitation on Levaquin 750 mg every 48 hours and Flagyl 500 mg t.i.d. (antibiotics) for an additional 3 days. R1 presented to the local emergency department (ED) from the facility on 5/22/25 with worsening cellulitis (skin infection) to the right leg. She had just been seen in wound clinic 5/21/25. It was noted she had new cellulitis forming at that time. Overnight she developed increasing right leg pain and nursing noticed increasing redness that extended past the marked borders. R1 complained of cold chills without fevers recorded. In the ED, R1 had shaking chills with tachycardia (fast abnormal heart rate) and atrial fib in the low 100's. Laboratory results showed abnormal levels of hemoglobin (iron level) at 8.6 (normal 12.5 to 17), high white blood cell count of 25.4 (normal 0 to11,000), therapeutic INR, bicarbonate 19 (normal 22 to 32), BUN (waste product in blood) 32 (normal 7 to 20), creatinine 1.7 (measures kidney function) (normal 0.59 to 1.04) with GFR	F 684		

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F 684	Continued From page 9 (kidney filtration rate) of 31 (normal 100), glucose 143 (normal 72-99), albumin (measures protein in blood plasma that keeps fluid from leaking into bloodstream) 3.2 (normal 3.4 to 5.4), CRP (measures inflammation) 281.3 (normal is less than 10), lactate (measures acidity in blood) 2.3 (normal 0.5 to 2.2). Blood cultures were pending. R1 received Tylenol, meclizine (anti-nausea medication), oxycodone (pain medication) 500 ml IV , Vancomycin IV and Zosyn (antibiotics) R1 was then transferred to the regional hospital for a higher level of care required. Interview on 6/03/25 at 11:28 a.m., with agency licensed practical nurse (LPN)-A had worked the morning of 5/20/25. R1 had orders for dressing change to be completed in the morning. LPN-A had identified R1complained of leg pain was administered pain medication and stated R1 did not want LPN-A to assess her wound. LPN-A noted she could not complete R1's dressing change due to the facility not having adequate supplies for R1's dressing and had communicated the lack of supplies to the facility's administration. LPN-A had not communicated to the director of nursing (DON) nor the provider that R1's dressing changed was missed and that R1 had severe pain. Interview on 6/03/25 at 12:12 p.m., with staffing coordinator (SC) identified resident supply list was created by the infection preventionist (IP) and sent to SC on a weekly basis to order supplies from the Medline manufacturer. SC was not aware R1 had shortage of dressing supplies but was aware facility staff was to communicate to SC if nursing items were low in stock. SC had received notifications from the supply company that supplies were delayed for delivery to the	F 684		

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F 684	Continued From page 10 facility on several occasions. The SC stated they did not have a process in place to communicate to floor staff of delayed supplies to the facility. Interview on 6/03/25 at 12:18 p.m., with LPN-B identified residents with dressing orders was not communicated to LPN-B upon admission. The facility storage room on the 200 hall was used for nursing supplies and was accessible to facility staff when needed. LPN-B had kept a treatment cart of supplies for resident dressing changes in LPN-B office that was not accessible for staff on the weekends. LPN-B stated residents had designated supplies for dressing changes in their rooms that were to be refilled weekly. Interview on 6/03/25 at 1:31 p.m., with LPN-C identified newly admitted resident orders was placed on point click care (PCC), and online software for medical record and was to be viewed on the TAR. LPN-C had identified on two occasions that R1 lacked supplies for R1's dressing change and had to use alternative supplies to complete the dressing change. LPN-C had informed LPN-B and SC supplies were needed for R1's wound care. Interview on 6/03/25 at 3:03 p.m., with agency registered nurse (RN)-A had received report from LPN-A on 5/20/25 that R1's dressing change had not been completed. RN-A had identified R1 had no change in her condition that required a call to the physician during RN-A's shift. RN-A had assessed R1's pain, however, R1's dressing change was not completed nor was R1's wound assessed to identify any signs or symptoms of potential infection. Interview on 6/04/25 at 8:30am, with RN-B	F 684		

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F 684	Continued From page 11 identified R1 was seen at the local wound clinic December 2024. R1 had scheduled visits twice a week and she noticed a decline in wound healing. R1 had voiced concerns to RN-B that the facility was not completing R1's dressing changes as ordered. On 5/21/25, the clinic had completed cultures of R1's wound and RN-B stated R1 appeared to have an infection. Antibiotic orders were written, and dressing change orders were noted. RN-B identified the nursing home was to provide supplies and follow the providers wound orders to ensure appropriate wound healing. Interview on 6/04/25 at 8:52 a.m., with RN-C had assisted with R1's wound dressing change on 5/21/25. RN-C identified R1's leg had severe redness and was outline with a blue surgical marker before R1 had left the wound clinic. Interview on 6/04/25 at 9:12 a.m., family member (FM)-A identified R1 had chronic issues with R1's leg wounds. FM-A would pick up R1 from the nursing home and transport her to the wound clinic, weekly. R1 was concern with R1's wound healing but did not share personal information with FM-A on R1's treatment plan. On 5/21/25, R1 was dropped off at the facility between 5:30 p.m. and 6:00 p.m. from the wound clinic. FM-A was not aware of the severity of R1's wound until the following day, when the nursing home and informed FM-A that R1's was sent to the ER for evaluation. Interview on 6/04/25 at 10:15 a.m., with licensed pharmacist identified the facility had faxed the pharmacy on 5/21/25 at approximately 6:07 p.m., of R1's antibiotic order from the wound clinic. The antibiotic was delivered to the facility on the evening of 5/22/25. The pharmacist identified the	F 684		

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F 684	Continued From page 12 facility had a supply in the emergency (E-kit). For situations that warranted more immediate intervention, staff could call the provider and request to use medication from the E-Kit until such time as the medication would be available during routine business hours. Observation on 6/04/25 at 10:25 a.m., identified the facility had one uncontrolled and one controlled Ekit boxes. The box contained six tablets labeled doxycycline 100 mg and was available for use. Interview on 6/04/25 at 10:30 a.m., with LPN-C had worked the morning of 5/21/25 and identified R1 was in a wheelchair had worn basketball shorts and noted R1 had redness of her left lower leg. LPN-C notified LPN-D, who was R1's nurse of the redness. LPN-C had not communicated to R1's physician of the wound findings. Interview on 6/04/25 at 10:53 a.m., with LPN-D had worked the morning of 5/21/25 and identified R1 had scheduled dressing changes in the morning. LPN-D did not complete a dressing change on R1, because R1 had an appointment at the wound clinic. LPN-D had administered a pain pill prior to R1leaving the facility and did not have time to assess R1's leg when LPN-C had notified LPN-D of the change. LPN-D did not notify R1's physician during LPN-D shift of the findings. Interview on 6/04/25 at 1:41 p.m., with RN-D had worked the evening shift on 5/21/25. R1 arrived to the facility approximately at 5:30 p.m. and had not completed a baseline assessment. RN-D had received R1's wound and antibiotic orders and staff faxed them to the pharmacy. R1 had	F 684		

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F 684	Continued From page 13 informed RN-D of the wound clinics findings for staff to monitor R1's leg for increase in her wound's redness and noted at the time of her visit, wound clinic staff had outlined the area with a marker. RN-D identified R1's leg was easy to observe and identified leg wraps were in place. RN-B stated indication of sepsis was a resident has a fever, an elevated blood pressure or confusion. The primary physician was to be notified of the change in condition. RN-D did not identify complications that would warrant a call to R1's physician, however she did state she failed to perform a baseline assessment for R1's wound after it had been deemed infected and had redness. Staff were to measure and monitor that redness. RN-D thought she had monitored R1 every 2 hours but indicated she failed to document any information of monitoring in R1's medical record. Interview on 6/04/25 at 2:48 p.m., with agency RN-E stated RN-D during handover communication reported R1 had visited the wound clinic that afternoon and had new orders. RN-E was not informed that R1's leg was to be monitored, nor had she viewed the orders. R1 had complained of severe pain. RN-E took her temperature had administered an oxycodone. R1 had complained of increase leg pain after the administration of the oxycodone. RN-E identified R1's leg was warm to the touch and had prominent redness passed the marked line on R1's leg indicated an infection. R1 appeared uncomfortable and had complained of increased pain in both legs. Only at that time had RN-E reviewed R1's wound orders and called for a non-emergent transport to the local hospital. The ambulance had arrived at the facility within approximately 45 minutes to transport R1 to the	F 684		

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F 684	Continued From page 14 local hospital. RN-E had completed a physical assessment of R1's skin before R1 was discharged from the facility but agreed that was not documented in R1's medical record. Interview on 6/04/25 at 4:32 p.m., with licensed physical therapist (LPT) had seen R1 on 5/19/25 for a therapy session and identified R1's dressing was weeping. R1 was sent to her room and had informed R1's nurse that R1's dressing was to be changed. R1 was seen again on 5/21/25 and identified R1 had increase weeping of her dressing. R1 had refused for facility nurses to change the dressing and LPT had placed towels on the floor, during R1's therapy session, to prevent R1's drainage from leaking on the floor. Interview on 6/04/25 at 4:31 p.m., with agency LPN-E had worked the morning of 5/19/25. LPN-E was notified by the PT that R1 dressing was soiled. LPN-E had administered a pain medication to R1 before R1's dressing change that afternoon and did not place a date or initials R1's dressing once completed. LPN-E was aware R1's wound had a smell and odor during the dressing change. LPN-E and the DON had assisted R1 with her initial skin assessment and dressing change upon admit to the facility and identified R1's wound appeared to have no change in healing. LPN-E thought sepsis occurred when a resident had a fever and was unaware of specific criteria staff should monitor for to prevent sepsis from occurring and identify the need for immediate intervention. LPN-E identified R1 had no changes in behavior and appeared normal. LPN-E identified R1's physician had not been notified of the increase drainage or odor that was present.	F 684		

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F 684	Continued From page 15 Interview on 6/05/25 at 10:48 a.m., with medical director (MD) expectation was for nurses to follow physician's orders, provide care, and document dressing changes. Nurses were to monitor for changes in condition and contact the resident's physician to determine the next steps and document the communication and interventions discussed. Staff should assess wounds at a minimum weekly, or with each dressing change to identify any changes. If, a resident was routinely seen at the wound clinic, the facility was to rely on the wound clinic orders and would be expected staff to update and follow the plan of care. If, there was an emergent need, leading to a potential problem that was to cause a resident to have a change in condition or altered level of consciousness staff were to call 911 for immediate assessment and exam by a provider in the ED. Interview on 6/05/25 at 1:46 p.m., with R1's primary physician (MD)-B identified they expected facility nurses to contact them or the wound clinic of the suspected findings of R1's increased wound drainage for recommendations and/or re-evaluation of R1's wound. In addition, facility nurses should have contacted the physician or the on-call provider for clearance to use the antibiotic medication that was ordered and use the supply in the E-Kit and not delay medication until the next day during routine pharmacy drop-off for a resident with a known infection and history of previous sepsis. MD-B stated a baseline assessment should have been completed for R1 when R1 had returned from the wound clinic on 5/21/25. Staff should have documented R1's physical assessment and monitor R1 to identify signs and symptoms of sepsis.	F 684		

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F 684	Continued From page 16 Interview on 6/05/25 at 2:30 p.m., with director of nursing (DON) identified nurses was to complete scheduled dressing changes for residents on the day shift. If, dressing changes was not done during the document the details from that dressing change. R1's wound measurement and skin assessments were completed once a week on Mondays, with the DON and the nurse consultant on the unit. The DON did not document on R1's TAR when dressing changes were completed. Facility staff had received training related to infection control, but did not have training specific to signs and symptoms of sepsis development. Nurses were expected to complete a baseline assessment for R1 when R1 had returned from the wound clinic and was at risk for complications due to R1's infection of the wound. The DON identified the facility nurse on the evening shift of 5/21/25, should have called R1's provider and ask for an order to remove and administer the initial dose of antibiotic from the E-kit. The DON agreed nurses should have provided documentation to corroborate when nurses had assessed R1's wound to identify a potential spread of infection and to notify R1's physician if there was a potential decline in R1's condition. The DON stated it was a standard expectation for nurses to date and initial on all dressing changes, however, she was aware they found it difficult to write on the dressings with a pen. DON was not aware if the facility wound policy identified for dressings to be labeled once changed. R2 R2 undated, current face sheet identified R2 had a diagnosis of osteomyelitis (infection in the bone) of left tibia and fibula, anxiety, chronic pain	F 684		

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F 684	Continued From page 17 syndrome, pressure ulcer of left ankle, cellulitis, dementia, and traumatic brain injury (TBI). R2 was on enhanced barrier (use of gown and gloves for healthcare workers to be used during high contact resident care) precautions. R2's 4/21/25, Significant Change Minimum Data Set (MDS) identified R2 had severe cognitive impairment and had little interest or pleasure in doing things, felt down, depressed or hopeless never to 1 day. R2 was 6 ft and 2 inches, weighed 180 lbs. in and was on hospice services. R2 was at risk for developing pressure ulcers and had a stage 1 or greater over bony prominence, or a non-removable dressing/device. R2 had two stage 4 pressure ulcers that was present on admission, one unstageable pressure ulcer due to coverage of wound bed by slough and/or eschar and one venous and arterial ulcer present. R2's undated, current care plan identified R2 was at risk for pressure injury related to current pressure and skin injuries ot the left lateral food, left posterior leg and ankle. Interventions was for facility nurses to apply lamb's wool in between toes PRN, barrier cream to buttocks after incontence episodes, blue boots to both feet for protection and comfort, use of air mattress, monitor/document location, size and treatment of wound, report abnormalities, failure to heal, signs and symptoms of infection, maceration to physician and wound nurse, reposition every 2 hours related to immobility and incontinence, administer scheduled pain medication before dressing changes, use of braden assessment, treatments to be completed as order by physician.	F 684		

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F 684	Continued From page 18 R2's undated, current Order Summary Report of R2's wound treatment orders identified: 1) Left distal lateral foot deep tissue injury (DTI) pressure was to cleanse with wound cleanser, pat dry, apply calcium alginate, cover with foam border dressing every Monday, Wednesday, Friday, and PRN with a start date of 1/29/25. 2) Left lateral ankle- unstageable pressure ulcer and left lateral foot pressure DTI was to cleanse with wound cleanser, pat dry, apply calcium alginate, cover with foam border dressing every Monday, Wednesday, Friday, and PRN with a start date of 2/12/25. 3) Left posterior lower leg was to apply calcium alginate to open area with foam composite dressing every Monday, Wednesday, and Friday with a start date of 4/25/25. 4) Complete skin/wound note on wound dressing change days. R2's 4/21/25, braden scale identified R2 was high risk for pressure injuries. R2's 6/02/25, Wound Assessment identified R2's left lateral ankle was 3.0 cm in length, 2.0 cm in width, and 0.1 cm in depth. Wound description identified: had purulent, moderate amount of thick green drainage, no odor, 50% granulated tissues and 50% beefy pink tissue. Wound treatment identified: cleanse with wound cleanser, pat dry, apply calcium alginate, cover with foam border dressing every Monday, Wednesday and Friday. R2's left lateral distal foot was 3.5 cm in length, 0.6cm in width, and 0.1 cm depth. Wound description identified: was scant amount of thick green drainage, no odor and peri wound was dry with 100% granulation of tissue. Wound treatment identified: cleanse with wound cleanser, pat dry, apply calcium alginate, cover	F 684		

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F 684	Continued From page 19 with foam border dressing every Monday, Wednesday and Friday. R2's left posterior calf was 2.0 cm in length, 1.0 cm in width, and 0 in depth. Wound description identified: was a superficial open area with no drainage or odor. Wound treatments identified: apply calcium alginate to open area with foam composite dressing and change every Monday, Wednesday, and Friday and PRN. R2's June 2025, Treatment Administration Record (TAR) identified R2 refused a dressing change on 6/04/24. R2's, progress noted identified on: 1) 6/4/25 at 10:38 a.m., R2 was due to have a wound dressing change. R2's wife stated R1 was to leave for the local emergency department (ED). Facility nurse had asked if R2 wanted the dressing change before R2 was transported out of the facility. R2 had refused the facility nurse to complete the dressing change. 2) 6/4/25 at 5:18 p.m., R2 was not transferred to the local ED, due to R2'S transportation service had not picked up R2 who was scheduled to leave at 1:00 p.m. R2 was notified by the facility nurse of R2's scheduled wound treatment was to be completed. There was no mention on R2's medical record that R2's dressing change was done. Observation and interview on 6/05/25 at 7:44 a.m., with LPN-D had applied hand sanitizer to her hands and rubbed them together. LPN-D grabbed a yellow isolation gown and applied it to LPN-D body and tied the personal protection equipment (PPE) behind LPN-D neck and waist. LPN-D applied gloves and had knocked on R2's door. LPN-D opened R2's door and informed R2	F 684		

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	245316	A. BUILDING _____ B. WING _____	C 06/05/2025

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F 684	Continued From page 20 and R2's wife that LPN-D wanted to see the dressing on R2's legs. R2's wife and LPN-D grabbed R2's cover and LPN-D identified R2's dressing was changed the night prior on the evening shift and was not due for a dressing change today. LPN-D pulled back R2's covers R2's left lower leg had 3 areas that was covered with a brown foam dressing and R2' skin around the dressing appeared clean and intact. R2's left ankle, left lower leg and the lateral side of R2's leg did not have dates or initials when it was last changed. R2's wife identified R2's nurse on the evening shift on 5/04/25 had completed the dressing change and appeared surprised that R2's dressing was not dated. R2's wife stated, the nurses dated them when changed. R3 R3's undated, current face sheet identified R3 had a diagnoses of myasthenia gravis (autoimmune neuromuscular disorder that causes weakness in the skeletal muscles weakness), obesity, heart failure, and hypothyroidism (low production of thyroid hormone that leads to a slowdown in metabolism). R3 was on enhanced barrier precautions. R3's 4/15/25, quarterly MDS identified R3 was cognitively intact. R3 had little interest or pleasure in doing things, felt down, depressed or hopeless never to 1 day. R3 had a diagnoses of heart failure, hypertension (elevated blood pressure), and arthritis. R3 required substantial/maximal assistance with showering, personal hygiene, dressing, and with turning and repositioning. R3 was dependent on staff for transfers. R3 was 6 ft tall, weighed 221 lbs and was on hospice services. R3 was at risk for developing pressure	F 684		

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F 684	Continued From page 21 ulcers, however, did not have any pressure ulcers or wounds noted. R3's 4/15/25, Braden scaled identified R3 was not at risk for pressure injuries. R3's progress notes identified on: 1) 5/25/25 at 11:39 a.m., R3 had a new wound on the coccyx. Hospice and R3's spouse was notified and standing orders were to be implemented until further instructions. R3's wound measurements identified: 1.5 cm in length and 1.4 cm in width. R3's wound was cleansed with wound cleanser, patted dry, and a Mepilex dressing was applied to R3's coccyx. 2) 5/27/25 at 7:51 p.m., R3's coccyx wound measurement was 1.2 cm in length, 1.0 cm width and 1.0 cm in depth. R3's wound bed had 100% slough and the peri wound was dry. 3) 5/30/25 at 10:48 p.m., R3 was placed on enhanced barrier precautions due to R3's wound. 4) 6/1/25 at 2:58 p.m., R3 had a stage 2 open area of R3's coccyx. The area appeared yellowish/white in the wound bed and was measured to be 1.0 cm in length, 1.0 cm in width. Skin prep and Mepilex was applied to R3's coccyx. 5) 6/03/25 at 10:13 a.m., R3 had open area to coccyx and was measured to be 1.2 cm in length, 1.0 cm in width and 100% slough. R3's peri wound was dry and had remained unchanged from the previous week. There was no documentation to support R3's physician had been notified of the wound. R3's undated, current care plan identified R3 was at risk for skin impairment related to incontinence, impaired mobility, terminal diagnosis with anticipated decline in status, and heart failure.	F 684		

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F 684	Continued From page 22 Interventions was for facility staff to assist with one staff with turning and repositioning, two hour off-load, use of Braden assessment, apply Calmoseptine (barrier ointment) after each incontinent episode and PRN, informed the nurse of further skin impairment while completing cares, has an open area on the coccyx, and apply Mepilex (adhesive dressing) to the site. R3's undated, current Order Summary Report of R3's wound treatment identified: 1) Clean wound with wound cleanser. 2) Apply skin prep to peri wound area and adhesive contact area. 3) Apply foam bordered dressing and change every 3 days and PRN. There was no mention on the Order Summary Report that indicated for a skin/wound assessment to be completed. R3's June 2025, Treatment Administration Record (TAR) identified R3 had a wound dressing change on 6/03/25. Observation on 6/05/25 at 08:35 a.m., with LPN-D had hand applied hand sanitizer to her hands and rubbed them together. LPN-D grabbed a yellow isolation gown and applied it to LPN-D body and tied the PPE behind LPN-D neck and waist. LPN-D applied gloves and had knocked on R3's door. LPN-D opened R3's door and informed R3 that LPN-D wanted to see the dressing on R3's bottom. R3 stated, "okay". LPN-D had instructed R3 that she was to pull R3 to the right side of the bed and would then turn R3 towards the left. LPN-D pulled R3's by the bedsheet and assisted R3 to turn towards the left side of the bed. R3, grabbed the left mobility bar. LPN-D had pulled down R3's incontinence brief had a foam dressing on his coccyx. The site	F 684		

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F 684	Continued From page 23 appeared dry with no drainage. However, the dressing did not have a date or initial when it was last changed. Review of skin Policy for admission/Change in Condition policy identified the facility was to use a comprehensive assessment, such as Braden scale to determine a resident risk factor for skin breakdown and was to be care planned. The facility was to determine if skin protocol was to implement and monitor, accordingly. In addition, facility staff was to: 1) Report open skin ulcers to the wound nurse. 2) Remove sources of pressure or trauma. 3) Keep area clean and dry. 4) Improve circulation. 5) Reposition frequently. 6) Repeat Braden scale. 7) Review interventions to ensure appropriate pressure relieving/reducing devices. 8) Provide would care as indicated by the facility wound care guidelines. wound care nurse recommendations and physician orders. 9) Refer resident to dietician for nutritional needs PRN. 10) If not showing improvement in the last 2 to4 weeks, contact the physician for new treatment orders. Documentation for unstable residents with potential or actual ulcers, required facility staff to include reasons why interventions was not appropriate, refusal of treatment must have documentation that addresses the residents' concerns, as well as alternative treatments. Lastly, non-compliance should be assessed and care planned, include family/resident feedback, consider resident past goals for care and address concerns in a timely manner.	F 684		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 30, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: XVT811

Dear Administrator:

The above facility was surveyed on June 2, 2025 through June 5, 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:

Nicole Dahl, RN, Regional Operations Supervisor
Marshall District Office
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102 Marshall, Minnesota 56258-2504
Email: Nicole.Dahl@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

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 06/05/2025

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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 6/02/25 through 6/05/25, 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	2 000		

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2 000	Continued From page 1 and identify the date when they will be completed. The following complaints were reviewed: H53165607C (MN113293) with a licensing order issued at 0830. H53166208C (MN113459) was also investigated; however, NO licensing orders were issued. 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 surveyor ' s 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 <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	2 000		

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2 000	Continued From page 2 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 the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide physician ordered dressing changes and assess wounds during those dressing changes, monitor for signs and symptoms of a worsening known infection, notify the physician of a change of condition and the need to acquire antibiotics from the E-Kit, acquire needed dressing change supplies, follow professional standards of practice by dating wound dressings and educate staff on identifying	2 830	Plan of Correction for F684 Quality of Care Facility: New Richland Care Center Survey Dates: 6/02/25 6/05/25 Tag Number: F684 Date of Completion: 08/01/2025 1. Corrective Action for Affected Residents: Resident R1 experienced a significant change in condition and was transferred to	8/1/25

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2 830	Continued From page 3 early signs and symptoms of sepsis (life-threatening infection) for 3 of 3 resident (R1, R2, and R3) reviewed. Findings include: Review of the current, National Library of Medicine, Sepsis: Early recognition and Optimized Treatment article, located at https://pmc.ncbi.nlm.nih.gov/articles/PMC6304323/, identified sepsis is a life-threatening condition caused by infection and represents a substantial global health burden. Systemic inflammatory response syndrome (SIRS) criteria is defined as having a patient with a suspicious or known infection with additional 2 criteria, such as a temperature above 100.4 or below 96.8 degrees Fahrenheit (F), a heart rate over 90 beats per minute (bpm) or a respiratory rate over 20 breaths per minute (bpm). A systolic blood pressure equal to or under 100 millimeters of mercury (mm/hg), respirations equal to or over 22 bpm, and altered mental status are indications of "being likely to be septic". Clinical evidence indicates that patients with acute deterioration or sepsis manifest clinical signs or symptoms several hours before the condition worsens. Review of the current, National Library of Medicine, Understanding Post-Sepsis Syndrome: How Can Clinicians Help article, located at https://pmc.ncbi.nlm.nih.gov/articles/PMC10546999, identified sepsis is a global health challenge, with over 49 million cases annually. Recent medical advancements have increased in-hospital survival rates to approximately 80%, but the escalating incidence of sepsis, owing to an ageing population, rise in chronic diseases, and antibiotic resistance, have also increased the number of sepsis survivors. Subsequently, there	2 830	a higher level of care due to worsening infection. A facility-level investigation determined neglect had occurred related to missed dressing changes, failure to assess wounds as ordered, and lack of timely provider notification. LPN-A was immediately removed from the schedule and placed on a "do not return" list. All documentation related to the event was reviewed and submitted per regulatory requirements. 2. Identification of Other Residents at Risk: The facility determined the event was isolated to R1. No additional residents were identified as affected. Therefore, this section is not applicable. 3. Systemic Changes: An in-service training was completed on 7/7/25 for nursing staff. The training covered Change in Condition, Sepsis Awareness, and Risk Management and included educational slides and a follow-up quiz to verify comprehension. The training materials are being uploaded into Relias to ensure that current staff who missed the in-person session and new hires can be assigned this education as part of orientation and competency reviews. A master list of all clinical staff was compiled to track completion of this education and to ensure 100% compliance. On 7/1/25, a Medline representative evaluated and reorganized the central supply room to ensure timely access to wound care supplies, including availability during weekends and after-hours. Nurse Practitioner Alanna Valadez to be consulted for recommendations regarding	

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2 830	Continued From page 4 is a growing prevalence of "post-sepsis syndrome" (PSS). This syndrome includes long-term physical, medical, cognitive, and psychological issues after recovering from sepsis. Around 75% of sepsis survivors develop at least one new medical, psychological, or cognitive diagnosis after hospital discharge. Only half of the sepsis survivors (both ICU and non-ICU) achieve complete or near-complete recovery within two years after hospital discharge. On the other hand, one in six patients experiences persistent impairments. As such, sepsis survivors are at risk for re-hospitalization, recurrent infections and chronic illness and have a shorter life expectancy, and lower quality of life. sepsis survivors have a significantly increased risk of cardiac events up to 5 years after the sepsis episode. Early administration of appropriate antibiotics remains the cornerstone of bacterial sepsis treatment and is essential for infection control, particularly if administered in the critical early hours. R1 Review of 5/21/25 at 10:19 a.m., report to the State Agency (SA) identified LPN-A neglected to complete wound care per orders. Review of the 5/23/25 at 2:31 p.m. 5-day investigation report identified R1 was interviewed. R1 stated she had not refused wound care. The nurse had told her that she did not have enough supplies. The investigation found Facility nursing staff counted dressing supplies and there were enough supplies to complete the dressing change until follow-up appointment the following day. R1's dressing was changed on 5/19/2025, she did not have the dressing changed on 5/20/2025, went to the wound clinic on 5/21/2025, when she returned, wound clinic had outlined the redness on her leg. During the night, the redness grew	2 830	wound care standing orders and preferred dressing products. She will also advise on best practices for monitoring infections associated with chronic wounds. Dr. Wilcox, the facility Medical Director, is reviewing all current standing orders for wound care to ensure alignment with current clinical standards. Nurses were instructed on the proper protocol for using the emergency medication kit (E-Kit), including obtaining physician authorization to initiate antibiotics in a timely manner if pharmacy delivery would be delayed. All dressing changes are now required to be dated and initialed by the staff member completing them. Compliance with this practice is being monitored through ongoing direct observation and routine audits. 4. Monitoring: The Director of Nursing or designee is completing wound care audits five times per week for two weeks, followed by three times per week for an additional two weeks. Each audit verifies that wound care has been completed as ordered, that assessments are thorough and up to date, that physicians are notified appropriately, and that the Braden Scale is completed and current. Audit results will be brought to QAPI meetings for review and action planning as needed. Staff who fail to meet documentation or treatment expectations will be re-educated immediately, and progressive discipline will be implemented as necessary. 5. Completion Date: 08/01/2025 This Plan of Correction addresses the deficient practice cited under F684 and outlines steps taken to correct the issue,	

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2 830	Continued From page 5 outside of the lines and pain increased, went into the ER for further evaluation. The facility found evidence of neglect when R1 verified that she did not refuse the treatment, and there were adequate supplies. LPN-A was immediately put on the "do not return list, and supervisor was notified". There was no documentation to show the facility had notified the Minnesota Board of Nursing of their findings. R1's 5/01/25, admission assessment Minimum Data Set (MDS) identified R1 was cognitively intact. R1 had a history of chronic venous hypertension [CVH] (damaged valves in legs causing high blood pressure in the veins) of her bilateral lower extremities, severe sepsis with septic shock (life-threatening infection that leads to low blood pressure and organ failure that requires immediate medical intervention) and a non-pressure chronic ulcer of her right foot. R1 was dependent on staff for toileting, dressing, and transfers. R1 had 7 venous and arterial ulcers upon admission. R1 was not noted to have any behaviors. R1's undated, current care plan identified R1 was at risk for pressure injury related to chronic venous ulcerations, inflammation, history of cellulitis, soft tissue infection and chronic lower extremity edema. Interventions was for facility staff to identify/document potential factors related to skin breakdown, monitor/documents location, size and treatment of wound, report abnormal failure to heal, signs and symptoms of infection to physician and wound nurse, inform charge nurse of skin impairments when providing R1's care, wound treatments to be completed as prescribed by the physician, and apply Vani cream to good skin, Aquacel AG to wounds, and change the dressing daily.	2 830	prevent recurrence, and monitor for continued compliance. Documentation and supporting materials are available for review upon request.	

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2 830	Continued From page 6 R1's 5/1/25 at 8:44 a.m., admission progress note related to the wound clinic's assessment and orders identified: 1) The 1st wound had an irregular shape and was located at the pretibial (inner lower leg next to the tibial bone) area. The wound measured 7.0 centimeters (cm) in length, 6 cm in width, and 0.2 cm in depth. Clinic staff noted there was no tunneling, no undermining, the wound bed had granulation (new tissue) with no odor, but had large serosanguinous (bloody clear) drainage and had redness. 2) The 2nd wound was a venous (originating from vein) ulcer non-staged wound. The wound measured 3 cm length, 8.5 cm in width, and 0.1 cm in depth, with no tunneling or undermining. Clinic staff noted there was granulation and exposed tissue, but no odor, and there was a large amount of serosanguinous drainage. 3) The 3rd wound was a left lateral venous non-staged venous ulcer. The wound measured 4 cm in length, 6 cm in width, and 0.1 cm in depth. Clinic staff noted there was no tunneling, no undermining, had granulation with tissue exposed, no odor, a moderate amount of serosanguinous drainage, redness, maceration (when skin is in contact with moisture for too long) and was denuded (loss of epidermis caused by prolonged moisture and friction). Facility staff were ordered to use acetic acid (vinegar), Aquacel AG (anti-microbial silver impregnated dressing) as the primary dressing with an ABD pad (large gauze pad), Artiflex (soft foam dressing used as a wrap), a Rosidal dressing (soft compression bandage). In addition as a secondary dressing, staff were to use Lopress (elastic compression dressing) and ensure dressings were changed daily and as needed (PRN) for all wounds.	2 830		

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2 830	Continued From page 7 R1's, May 2025 Treatment Administration Record (TAR) identified facility nurses was to complete skin/wound note on dressing changes daily. R1's medical record identified R1 had lacked skin/wound assessments and treatments on the following dates: 5/5/25, 5/12/25, 5/15/25, 5/16/25, 5/20/25 and 5/21/25. R1's wound assessments identified they were only done weekly on 5/8/25 and 5/14/25. Assessments were as follows: 1) 5/8/25: R1's right pretibial right leg venous ulcer was measured and assessed. It was noted to be 7.0 centimeters (cm) in length, 7.0 cm in width, and 0.2 cm in depth. Wound description included: wound had full thickness, copious serous drainage, maceration (wrinkled skin) and no odor. 2) 5/14/25, R1's right pretibial lateral venous ulcer was measured and assessed. Wound measurement was 7.0 cm X 9.0 cm X 0.2 cm depth (increase in size). Wound description included: wound bed had full thickness, granulation, copious serosanguineous drainage, maceration and no odor. There was no indication R1's physician was notified of the increase in size. There were no assessments conducted daily with dressing changes to identify if the wound had improved, worsened or stayed the same. Additionally, neither of R1's 2 other wounds were assessed during these weekly assessments. Further review of R1's progress notes identified on: 1) 5/18/25 at 4:43 p.m., R1 voiced concerns with staff of a shortage of absorbent pads for R1's dressing changes. The facility staff was to leave a message for supplies to be ordered with	2 830		

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2 830	Continued From page 8 management and R1 was informed that the absorbent pads were on backorder. 2) 5/19/25 at 3:59 p.m., skin/wound note identified R1 had purulent (pus-like) drainage and a slight odor to R1's bilateral lower extremity (BLE). R1's right lower extremity appeared macerated (moisture related skin damage) and had 25% slough (layer of dead tissue) present. There was no indication staff had notified R1's physician of the changes in wound characteristics. 3) Later that day on 5/19/25 at 4:32 p.m., physical therapy (PT)-A noted R1 had increased drainage from her wound and bandage of the right lower leg. R1 had left PT prior to end of therapy in order for nursing staff to change R1's dressing. There was no indication staff had notified R1's physician of these additional changes in wound characteristics. 4) 5/20/25 at 1:57 p.m., PT noted R1 had "refused wound care" related to supplies. Staff also noted the facility "lacked supplies" to be able to change R1's wound dressings. R1 also had severe pain that morning and was found "yelling for help". There was no indication R1's physician or the wound clinic had been notified of the increased pain or lack of being able to perform the dressing change. 5) 5/20/25 at 22:43 p.m., R1's had no pain and BLE wounds was not assessed. 6) 5/21/25 at 11:19 a.m., R1 had left for her wound care appointment. Facility nurse was made aware that R1's right knee, above the dressing was warm to touch and pink. R1's knee was not assessed by nursing staff before R1 had left the facility. 7) 5/21/25 at 4:44 p.m., PT note R1 had significant drainage from right lower extremity and had refused for facility staff to complete dressing change prior to scheduled wound clinic visit.	2 830		

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2 830	Continued From page 9 8) 5/21/25 at 10:01 p.m., R1 arrived back to the facility at 5:30 p.m. R1's legs were wrapped, and the redness was outline with a sharpie. R1 had concerns with the infection of her legs. The medical record lacked evidence that a physical baseline assessment had been completed 4 hours after R1 had arrived back to the facility from the wound clinic. 9) 5/21/25 at 9:57 p.m., vitals were 124/60 millimeters of mercury (mm/hg) blood pressure, a temperature of 99.1 degrees Fahrenheit (F), and respirations at 20 breaths per minute (bpm). 10) 5/22/25 at 2:44 a.m., progress note identified R1 complained of pain, had received oxycodone, reported chills, had a declining temperature of 98.6 degrees F, felt ill and had requested to be send to the ED. No other vital signs were assessed to identify sepsis criteria by assessing R1's oxygen saturation, respiratory rate, heart rate, blood pressure, or assessment of her mental status were obtained. R1's 5/22/25, local hospital admission summary identified R1 had a history of chronic lower extremity edema (swelling) with chronic ulcerations since July of 2024 receiving long-term chronic wound care. She recently was admitted to a regional hospital from 04/17 /25 to 04/24/25 for care after fall and found to be in septic shock suspected from soft skin and tissue infection with acute kidney injury (AKI), severe metabolic acidosis (serious condition when pH level in blood is at life-threatening levels), elevated potassium levels in her blood, atrial fibrillation with rapid ventricular response (AFib with RVR) (potentially life-threatening heartbeat irregularity). R1 was note to be treated with vancomycin and cefepime and then transitioned to Zosyn (antibiotics). R1required a Foley catheter for urinary retention during her stay. She was discharged at that time	2 830		

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2 830	Continued From page 10 to the facility for admission of short-term rehabilitation on Levaquin 750 mg every 48 hours and Flagyl 500 mg t.i.d. (antibiotics) for an additional 3 days. R1 presented to the local emergency department (ED) from the facility on 5/22/25 with worsening cellulitis (skin infection) to the right leg. She had just been seen in wound clinic 5/21/25. It was noted she had new cellulitis forming at that time. Overnight she developed increasing right leg pain and nursing noticed increasing redness that extended past the marked borders. R1 complained of cold chills without fevers recorded. In the ED, R1 had shaking chills with tachycardia (fast abnormal heart rate) and atrial fib in the low 100's. Laboratory results showed abnormal levels of hemoglobin (iron level) at 8.6 (normal 12.5 to 17), high white blood cell count of 25.4 (normal 0 to11,000), therapeutic INR, bicarbonate 19 (normal 22 to 32), BUN (waste product in blood) 32 (normal 7 to 20), creatinine 1.7 (measures kidney function) (normal 0.59 to 1.04) with GFR (kidney filtration rate) of 31 (normal 100), glucose 143 (normal 72-99), albumin (measures protein in blood plasma that keeps fluid from leaking into bloodstream) 3.2 (normal 3.4 to 5.4), CRP (measures inflammation) 281.3 (normal is less than 10), lactate (measures acidity in blood) 2.3 (normal 0.5 to 2.2). Blood cultures were pending. R1 received Tylenol, meclizine (anti-nausea medication), oxycodone (pain medication) 500 ml IV , Vancomycin IV and Zosyn (antibiotics) R1 was then transferred to the regional hospital for a higher level of care required. Interview on 6/03/25 at 11:28 a.m., with agency licensed practical nurse (LPN)-A had worked the morning of 5/20/25. R1 had orders for dressing change to be completed in the morning. LPN-A had identified R1complained of leg pain was	2 830		

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2 830	Continued From page 11 administered pain medication and stated R1 did not want LPN-A to assess her wound. LPN-A noted she could not complete R1's dressing change due to the facility not having adequate supplies for R1's dressing and had communicated the lack of supplies to the facility's administration. LPN-A had not communicated to the director of nursing (DON) nor the provider that R1's dressing changed was missed and that R1 had severe pain. Interview on 6/03/25 at 12:12 p.m., with staffing coordinator (SC) identified resident supply list was created by the infection preventionist (IP) and sent to SC on a weekly basis to order supplies from the Medline manufacturer. SC was not aware R1 had shortage of dressing supplies but was aware facility staff was to communicate to SC if nursing items were low in stock. SC had received notifications from the supply company that supplies were delayed for delivery to the facility on several occasions. The SC stated they did not have a process in place to communicate to floor staff of delayed supplies to the facility. Interview on 6/03/25 at 12:18 p.m., with LPN-B identified residents with dressing orders was not communicated to LPN-B upon admission. The facility storage room on the 200 hall was used for nursing supplies and was accessible to facility staff when needed. LPN-B had kept a treatment cart of supplies for resident dressing changes in LPN-B office that was not accessible for staff on the weekends. LPN-B stated residents had designated supplies for dressing changes in their rooms that were to be refilled weekly. Interview on 6/03/25 at 1:31 p.m., with LPN-C identified newly admitted resident orders was placed on point click care (PCC), and online	2 830		

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2 830	Continued From page 12 software for medical record and was to be viewed on the TAR. LPN-C had identified on two occasions that R1 lacked supplies for R1's dressing change and had to use alternative supplies to complete the dressing change. LPN-C had informed LPN-B and SC supplies were needed for R1's wound care. Interview on 6/03/25 at 3:03 p.m., with agency registered nurse (RN)-A had received report from LPN-A on 5/20/25 that R1's dressing change had not been completed. RN-A had identified R1 had no change in her condition that required a call to the physician during RN-A's shift. RN-A had assessed R1's pain, however, R1's dressing change was not completed nor was R1's wound assessed to identify any signs or symptoms of potential infection. Interview on 6/04/25 at 8:30am, with RN-B identified R1 was seen at the local wound clinic December 2024. R1 had scheduled visits twice a week and she noticed a decline in wound healing. R1 had voiced concerns to RN-B that the facility was not completing R1's dressing changes as ordered. On 5/21/25, the clinic had completed cultures of R1's wound and RN-B stated R1 appeared to have an infection. Antibiotic orders were written, and dressing change orders were noted. RN-B identified the nursing home was to provide supplies and follow the providers wound orders to ensure appropriate wound healing. Interview on 6/04/25 at 8:52 a.m., with RN-C had assisted with R1's wound dressing change on 5/21/25. RN-C identified R1's leg had severe redness and was outline with a blue surgical marker before R1 had left the wound clinic. Interview on 6/04/25 at 9:12 a.m., family member	2 830		

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2 830	Continued From page 13 (FM)-A identified R1 had chronic issues with R1's leg wounds. FM-A would pick up R1 from the nursing home and transport her to the wound clinic, weekly. R1 was concern with R1's wound healing but did not share personal information with FM-A on R1's treatment plan. On 5/21/25, R1 was dropped off at the facility between 5:30 p.m. and 6:00 p.m. from the wound clinic. FM-A was not aware of the severity of R1's wound until the following day, when the nursing home and informed FM-A that R1's was sent to the ER for evaluation. Interview on 6/04/25 at 10:15 a.m., with licensed pharmacist identified the facility had faxed the pharmacy on 5/21/25 at approximately 6:07 p.m., of R1's antibiotic order from the wound clinic. The antibiotic was delivered to the facility on the evening of 5/22/25. The pharmacist identified the facility had a supply in the emergency (E-kit). For situations that warranted more immediate intervention, staff could call the provider and request to use medication from the E-Kit until such time as the medication would be available during routine business hours. Observation on 6/04/25 at 10:25 a.m., identified the facility had one uncontrolled and one controlled Ekit boxes. The box contained six tablets labeled doxycycline 100 mg and was available for use. Interview on 6/04/25 at 10:30 a.m., with LPN-C had worked the morning of 5/21/25 and identified R1 was in a wheelchair had worn basketball shorts and noted R1 had redness of her left lower leg. LPN-C notified LPN-D, who was R1's nurse of the redness. LPN-C had not communicated to R1's physician of the wound findings.	2 830		

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2 830	Continued From page 14 Interview on 6/04/25 at 10:53 a.m., with LPN-D had worked the morning of 5/21/25 and identified R1 had scheduled dressing changes in the morning. LPN-D did not complete a dressing change on R1, because R1 had an appointment at the wound clinic. LPN-D had administered a pain pill prior to R1leaving the facility and did not have time to assess R1's leg when LPN-C had notified LPN-D of the change. LPN-D did not notify R1's physician during LPN-D shift of the findings. Interview on 6/04/25 at 1:41 p.m., with RN-D had worked the evening shift on 5/21/25. R1 arrived to the facility approximately at 5:30 p.m. and had not completed a baseline assessment. RN-D had received R1's wound and antibiotic orders and staff faxed them to the pharmacy. R1 had informed RN-D of the wound clinics findings for staff to monitor R1's leg for increase in her wound's redness and noted at the time of her visit, wound clinic staff had outlined the area with a marker. RN-D identified R1's leg was easy to observe and identified leg wraps were in place. RN-B stated indication of sepsis was a resident has a fever, an elevated blood pressure or confusion. The primary physician was to be notified of the change in condition. RN-D did not identify complications that would warrant a call to R1's physician, however she did state she failed to perform a baseline assessment for R1's wound after it had been deemed infected and had redness. Staff were to measure and monitor that redness. RN-D thought she had monitored R1 every 2 hours but indicated she failed to document any information of monitoring in R1's medical record. Interview on 6/04/25 at 2:48 p.m., with agency RN-E stated RN-D during handover	2 830		

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2 830	Continued From page 15 communication reported R1 had visited the wound clinic that afternoon and had new orders. RN-E was not informed that R1's leg was to be monitored, nor had she viewed the orders. R1 had complained of severe pain. RN-E took her temperature had administered an oxycodone. R1 had complained of increase leg pain after the administration of the oxycodone. RN-E identified R1's leg was warm to the touch and had prominent redness passed the marked line on R1's leg indicated an infection. R1 appeared uncomfortable and had complained of increased pain in both legs. Only at that time had RN-E reviewed R1's wound orders and called for a non-emergent transport to the local hospital. The ambulance had arrived at the facility within approximately 45 minutes to transport R1 to the local hospital. RN-E had completed a physical assessment of R1's skin before R1 was discharged from the facility but agreed that was not documented in R1's medical record. Interview on 6/04/25 at 4:32 p.m., with licensed physical therapist (LPT) had seen R1 on 5/19/25 for a therapy session and identified R1's dressing was weeping. R1 was sent to her room and had informed R1's nurse that R1's dressing was to be changed. R1 was seen again on 5/21/25 and identified R1 had increase weeping of her dressing. R1 had refused for facility nurses to change the dressing and LPT had placed towels on the floor, during R1's therapy session, to prevent R1's drainage from leaking on the floor. Interview on 6/04/25 at 4:31 p.m., with agency LPN-E had worked the morning of 5/19/25. LPN-E was notified by the PT that R1 dressing was soiled. LPN-E had administered a pain medication to R1 before R1's dressing change that afternoon and did not place a date or initials	2 830		

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2 830	Continued From page 16 R1's dressing once completed. LPN-E was aware R1's wound had a smell and odor during the dressing change. LPN-E and the DON had assisted R1 with her initial skin assessment and dressing change upon admit to the facility and identified R1's wound appeared to have no change in healing. LPN-E thought sepsis occurred when a resident had a fever and was unaware of specific criteria staff should monitor for to prevent sepsis from occurring and identify the need for immediate intervention. LPN-E identified R1 had no changes in behavior and appeared normal. LPN-E identified R1's physician had not been notified of the increase drainage or odor that was present. Interview on 6/05/25 at 10:48 a.m., with medical director (MD) expectation was for nurses to follow physician's orders, provide care, and document dressing changes. Nurses were to monitor for changes in condition and contact the resident's physician to determine the next steps and document the communication and interventions discussed. Staff should assess wounds at a minimum weekly, or with each dressing change to identify any changes. If, a resident was routinely seen at the wound clinic, the facility was to rely on the wound clinic orders and would be expected staff to update and follow the plan of care. If, there was an emergent need, leading to a potential problem that was to cause a resident to have a change in condition or altered level of consciousness staff were to call 911 for immediate assessment and exam by a provider in the ED. Interview on 6/05/25 at 1:46 p.m., with R1's primary physician (MD)-B identified they expected facility nurses to contact them or the wound clinic of the suspected findings of R1's increased	2 830		

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2 830	Continued From page 17 wound drainage for recommendations and/or re-evaluation of R1's wound. In addition, facility nurses should have contacted the physician or the on-call provider for clearance to use the antibiotic medication that was ordered and use the supply in the E-Kit and not delay medication until the next day during routine pharmacy drop-off for a resident with a known infection and history of previous sepsis. MD-B stated a baseline assessment should have been completed for R1 when R1 had returned from the wound clinic on 5/21/25. Staff should have documented R1's physical assessment and monitor R1 to identify signs and symptoms of sepsis. Interview on 6/05/25 at 2:30 p.m., with director of nursing (DON) identified nurses was to complete scheduled dressing changes for residents on the day shift. If, dressing changes was not done during the document the details from that dressing change. R1's wound measurement and skin assessments were completed once a week on Mondays, with the DON and the nurse consultant on the unit. The DON did not document on R1's TAR when dressing changes were completed. Facility staff had received training related to infection control, but did not have training specific to signs and symptoms of sepsis development. Nurses were expected to complete a baseline assessment for R1 when R1 had returned from the wound clinic and was at risk for complications due to R1's infection of the wound. The DON identified the facility nurse on the evening shift of 5/21/25, should have called R1's provider and ask for an order to remove and administer the initial dose of antibiotic from the E-kit. The DON agreed nurses should have provided documentation to corroborate when nurses had assessed R1's wound to identify a	2 830		

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2 830	Continued From page 18 potential spread of infection and to notify R1's physician if there was a potential decline in R1's condition. The DON stated it was a standard expectation for nurses to date and initial on all dressing changes, however, she was aware they found it difficult to write on the dressings with a pen. DON was not aware if the facility wound policy identified for dressings to be labeled once changed. R2 R2 undated, current face sheet identified R2 had a diagnosis of osteomyelitis (infection in the bone) of left tibia and fibula, anxiety, chronic pain syndrome, pressure ulcer of left ankle, cellulitis, dementia, and traumatic brain injury (TBI). R2 was on enhanced barrier (use of gown and gloves for healthcare workers to be used during high contact resident care) precautions. R2's 4/21/25, Significant Change Minimum Data Set (MDS) identified R2 had severe cognitive impairment and had little interest or pleasure in doing things, felt down, depressed or hopeless never to 1 day. R2 was 6 ft and 2 inches, weighed 180 lbs. in and was on hospice services. R2 was at risk for developing pressure ulcers and had a stage 1 or greater over bony prominence, or a non-removable dressing/device. R2 had two stage 4 pressure ulcers that was present on admission, one unstageable pressure ulcer due to coverage of wound bed by slough and/or eschar and one venous and arterial ulcer present. R2's undated, current care plan identified R2 was at risk for pressure injury related to current pressure and skin injuries ot the left lateral food, left posterior leg and ankle. Interventions was for facility nurses to apply lamb's wool in between	2 830		

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2 830	Continued From page 19 toes PRN, barrier cream to buttocks after incontence episodes, blue boots to both feet for protection and comfort, use of air mattress, monitor/document location, size and treatment of wound, report abnormalities, failure to heal, signs and symptoms of infection, maceration to physician and wound nurse, reposition every 2 hours related to immobility and incontinence, administer scheduled pain medication before dressing changes, use of braden assessment, treatments to be completed as order by physician. R2's undated, current Order Summary Report of R2's wound treatment orders identified: 1) Left distal lateral foot deep tissue injury (DTI) pressure was to cleanse with wound cleanser, pat dry, apply calcium alginate, cover with foam border dressing every Monday, Wednesday, Friday, and PRN with a start date of 1/29/25. 2) Left lateral ankle- unstageable pressure ulcer and left lateral foot pressure DTI was to cleanse with wound cleanser, pat dry, apply calcium alginate, cover with foam border dressing every Monday, Wednesday, Friday, and PRN with a start date of 2/12/25. 3) Left posterior lower leg was to apply calcium alginate to open area with foam composite dressing every Monday, Wednesday, and Friday with a start date of 4/25/25. 4) Complete skin/wound note on wound dressing change days. R2's 4/21/25, braden scale identified R2 was high risk for pressure injuries. R2's 6/02/25, Wound Assessment identified R2's left lateral ankle was 3.0 cm in length, 2.0 cm in width, and 0.1 cm in depth. Wound description identified: had purulent, moderate amount of	2 830		

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2 830	Continued From page 20 thick green drainage, no odor, 50% granulated tissues and 50% beefy pink tissue. Wound treatment identified: cleanse with wound cleanser, pat dry, apply calcium alginate, cover with foam border dressing every Monday, Wednesday and Friday. R2's left lateral distal foot was 3.5 cm in length, 0.6cm in width, and 0.1 cm depth. Wound description identified: was scant amount of thick green drainage, no odor and peri wound was dry with 100% granulation of tissue. Wound treatment identified: cleanse with wound cleanser, pat dry, apply calcium alginate, cover with foam border dressing every Monday, Wednesday and Friday. R2's left posterior calf was 2.0 cm in length, 1.0 cm in width, and 0 in depth. Wound description identified: was a superficial open area with no drainage or odor. Wound treatments identified: apply calcium alginate to open area with foam composite dressing and change every Monday, Wednesday, and Friday and PRN. R2's June 2025, Treatment Administration Record (TAR) identified R2 refused a dressing change on 6/04/24. R2's, progress noted identified on: 1) 6/4/25 at 10:38 a.m., R2 was due to have a wound dressing change. R2's wife stated R1 was to leave for the local emergency department (ED). Facility nurse had asked if R2 wanted the dressing change before R2 was transported out of the facility. R2 had refused the facility nurse to complete the dressing change. 2) 6/4/25 at 5:18 p.m., R2 was not transferred to the local ED, due to R2'S transportation service had not picked up R2 who was scheduled to leave at 1:00 p.m. R2 was notified by the facility nurse of R2's scheduled wound treatment was to be completed. There was no mention on R2's	2 830		

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2 830	Continued From page 21 medical record that R2's dressing change was done. Observation and interview on 6/05/25 at 7:44 a.m., with LPN-D had applied hand sanitizer to her hands and rubbed them together. LPN-D grabbed a yellow isolation gown and applied it to LPN-D body and tied the personal protection equipment (PPE) behind LPN-D neck and waist. LPN-D applied gloves and had knocked on R2's door. LPN-D opened R2's door and informed R2 and R2's wife that LPN-D wanted to see the dressing on R2's legs. R2's wife and LPN-D grabbed R2's cover and LPN-D identified R2's dressing was changed the night prior on the evening shift and was not due for a dressing change today. LPN-D pulled back R2's covers R2's left lower leg had 3 areas that was covered with a brown foam dressing and R2' skin around the dressing appeared clean and intact. R2's left ankle, left lower leg and the lateral side of R2's leg did not have dates or initials when it was last changed. R2's wife identified R2's nurse on the evening shift on 5/04/25 had completed the dressing change and appeared surprised that R2's dressing was not dated. R2's wife stated, the nurses dated them when changed. R3 R3's undated, current face sheet identified R3 had a diagnoses of myasthenia gravis (autoimmune neuromuscular disorder that causes weakness in the skeletal muscles weakness), obesity, heart failure, and hypothyroidism (low production of thyroid hormone that leads to a slowdown in metabolism). R3 was on enhanced barrier precautions. R3's 4/15/25, quarterly MDS identified R3 was	2 830		

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2 830	Continued From page 22 cognitively intact. R3 had little interest or pleasure in doing things, felt down, depressed or hopeless never to 1 day. R3 had a diagnoses of heart failure, hypertension (elevated blood pressure), and arthritis. R3 required substantial/maximal assistance with showering, personal hygiene, dressing, and with turning and repositioning. R3 was dependent on staff for transfers. R3 was 6 ft tall, weighed 221 lbs and was on hospice services. R3 was at risk for developing pressure ulcers, however, did not have any pressure ulcers or wounds noted. R3's 4/15/25, Braden scaled identified R3 was not at risk for pressure injuries. R3's progress notes identified on: 1) 5/25/25 at 11:39 a.m., R3 had a new wound on the coccyx. Hospice and R3's spouse was notified and standing orders were to be implemented until further instructions. R3's wound measurements identified: 1.5 cm in length and 1.4 cm in width. R3's wound was cleansed with wound cleanser, patted dry, and a Mepilex dressing was applied to R3's coccyx. 2) 5/27/25 at 7:51 p.m., R3's coccyx wound measurement was 1.2 cm in length, 1.0 cm width and 1.0 cm in depth. R3's wound bed had 100% slough and the peri wound was dry. 3) 5/30/25 at 10:48 p.m., R3 was placed on enhanced barrier precautions due to R3's wound. 4) 6/1/25 at 2:58 p.m., R3 had a stage 2 open area of R3's coccyx. The area appeared yellowish/white in the wound bed and was measured to be 1.0 cm in length, 1.0 cm in width. Skin prep and Mepilex was applied to R3's coccyx. 5) 6/03/25 at 10:13 a.m., R3 had open area to coccyx and was measured to be 1.2 cm in length, 1.0 cm in width and 100% slough. R3's peri	2 830		

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2 830	Continued From page 23 wound was dry and had remained unchanged from the previous week. There was no documentation to support R3's physician had been notified of the wound. R3's undated, current care plan identified R3 was at risk for skin impairment related to incontinence, impaired mobility, terminal diagnosis with anticipated decline in status, and heart failure. Interventions was for facility staff to assist with one staff with turning and repositioning, two hour off-load, use of Braden assessment, apply Calmoseptine (barrier ointment) after each incontinent episode and PRN, informed the nurse of further skin impairment while completing cares, has an open area on the coccyx, and apply Mepilex (adhesive dressing) to the site. R3's undated, current Order Summary Report of R3's wound treatment identified: 1) Clean wound with wound cleanser. 2) Apply skin prep to peri wound area and adhesive contact area. 3) Apply foam bordered dressing and change every 3 days and PRN. There was no mention on the Order Summary Report that indicated for a skin/wound assessment to be completed. R3's June 2025, Treatment Administration Record (TAR) identified R3 had a wound dressing change on 6/03/25. Observation on 6/05/25 at 08:35 a.m., with LPN-D had hand applied hand sanitizer to her hands and rubbed them together. LPN-D grabbed a yellow isolation gown and applied it to LPN-D body and tied the PPE behind LPN-D neck and waist. LPN-D applied gloves and had knocked on R3's door. LPN-D opened R3's door and informed R3 that LPN-D wanted to see the	2 830		

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2 830	Continued From page 24 dressing on R3's bottom. R3 stated, "okay". LPN-D had instructed R3 that she was to pull R3 to the right side of the bed and would then turn R3 towards the left. LPN-D pulled R3's by the bedsheet and assisted R3 to turn towards the left side of the bed. R3, grabbed the left mobility bar. LPN-D had pulled down R3's incontinence brief had a foam dressing on his coccyx. The site appeared dry with no drainage. However, the dressing did not have a date or initial when it was last changed. Review of skin Policy for admission/Change in Condition policy identified the facility was to use a comprehensive assessment, such as Braden scale to determine a resident risk factor for skin breakdown and was to be care planned. The facility was to determine if skin protocol was to implement and monitor, accordingly. In addition, facility staff was to: 1) Report open skin ulcers to the wound nurse. 2) Remove sources of pressure or trauma. 3) Keep area clean and dry. 4) Improve circulation. 5) Reposition frequently. 6) Repeat Braden scale. 7) Review interventions to ensure appropriate pressure relieving/reducing devices. 8) Provide would care as indicated by the facility wound care guidelines. wound care nurse recommendations and physician orders. 9) Refer resident to dietician for nutritional needs PRN. 10) If not showing improvement in the last 2 to4 weeks, contact the physician for new treatment orders. Documentation for unstable residents with potential or actual ulcers, required facility staff to include reasons why interventions was not appropriate, refusal of treatment must have	2 830		

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2 830	Continued From page 25 documentation that addresses the residents' concerns, as well as alternative treatments. Lastly, non-compliance should be assessed and care planned, include family/resident feedback, consider resident past goals for care and address concerns in a timely manner. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should review all residents at risk for wounds to assure they are receiving the necessary treatment/services to prevent wounds from developing and to promote healing. The director of nursing or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk for pressure ulcer development. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		