



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
March 25, 2024

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

RE: CCN: 245316
Cycle Start Date: January 24, 2024

Dear Administrator:

On March 20, 2024, the Minnesota Department of Health, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

A handwritten signature in black ink that reads 'H. Zahler'.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

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February 9, 2024

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

RE: CCN: 245316
Cycle Start Date: January 24, 2024

Dear Administrator:

On January 24, 2024, 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.

New Richland Care Center

February 9, 2024

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

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by April 24, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by July 24, 2024 (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) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

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

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


New Richland Care Center

February 9, 2024

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Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads "H. Zahler". The signature is cursive and somewhat stylized, with the first letter of each word being capitalized and larger than the others.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

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

PRINTED: 03/18/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245316	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/24/2024
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NAME OF PROVIDER OR SUPPLIER NEW RICHLAND CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 312 NORTHEAST 1ST STREET NEW RICHLAND, MN 56072
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>On 1/23/24 and 1/24/24, 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.</p> <p>The following complaints were reviewed. H53168954C (MN00099997), H53169125C (MN00099228) with citations issued at F550, F607, and F609.</p> <p>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.</p> <p>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.</p>	F 000		
F 550 SS=D	<p>Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2)</p> <p>§483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.</p> <p>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each</p>	F 550		3/15/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 02/16/2024
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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 550	<p>Continued From page 1</p> <p>resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.</p> <p>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.</p> <p>§483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.</p> <p>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure 1 of 3 residents (R1) was treated with respect, dignity, and provided with self-determination in choosing bedtime.</p> <p>Findings include:</p>	F 550	<p>F550 <input type="checkbox"/> NA <input type="checkbox"/> A and NA <input type="checkbox"/> B took action @ 1800 hrs when R1 requested to go to bed and helped R1 to bed upon request. Checking on R1 throughout their shift to ensure comfort. NA <input type="checkbox"/> A and NA <input type="checkbox"/> B then worked with RN -A to complete a report to management regarding LPN <input type="checkbox"/> A behavior</p>	

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F 550	<p>Continued From page 2</p> <p>R1's significant change Minimum Data Set (MDS) dated 1/10/24, indicated R1 was cognitively intact and had diagnoses that included Parkinson's disease, anxiety disorder and depression. R1 was substantial to max assist with chair to bed transfers, and was partial to moderate assist with sit to stand from chair, wheelchair and/or bed.</p> <p>Facility provided a written and signed statement by registered nurse (RN)-A that was not dated. The statement indicated during the evening shift of 1/14/24 at approximately 6:20 p.m., nursing assistant (NA)-A and NA-B reported a complaint involving licensed practical nurse (LPN)-A. The NA's report to RN-A included: R1 had requested to go to bed at approximately 6:00 p.m. and LPN-A told her she was not allowed to go to bed yet. The two argued back and forth and eventually R1 called LPN-A a derogatory name. LPN-A responded by giving R1 two middle fingers and walking out of R1's room. Earlier in the shift NA-B was in the dining room feeding another resident when LPN-A came in and told her "Do not let R1 go to bed, I have had it with her!"</p> <p>During an interview on 1/23/24 at 1:05 p.m., R1 stated a nurse had given her the double middle finger but she could not remember her name. R1 had asked the nurse to go to bed after supper but the nurse told R1 she did not need to go to bed yet. R1 thought the nurse "just did not want to put me to bed" at the time. R1 explained the nurse put up her two middle fingers at me. R1 reported the nurse made her feel angry; the nurse should not act like that, and it was not right. R1 reported her that night to several staff members.</p> <p>During an interview on 1/24/24 at 11:09 a.m., NA-A reported she had not worked with LPN-A</p>	F 550	<p>toward R1. At 1830 hrs, LPN □A shift was complete and left the building. Upon receiving report on 1/15, Management team made contact with agency recruiter suspending LPN □A from the building. A VA report was filed, and upon completion of investigation LPN -A agency contract was terminated.</p> <p>Facility recognizes all residents have the ability to be affected by this deficient practice. All residents are informed of Resident Rights upon admission, monthly at Resident Council, and feelings of safety and security within the building with our staff reviewed at Care Conferences. All staff members are educated on Resident Rights upon hire and annually or as needed.</p> <p>Staff on shift informed of Resident Rights and the urgency of reporting any potentially abusive situation immediately to Admin/DON/SW. Facility will mandate Resident Rights education to all facility staff on or before 03/15/2024. Temp agency staff will receive Resident Rights education on first shift worked. HR will maintain record of attendance/completion of all. Informative material will be posted within the facility.</p> <p>Admin or designee will perform weekly audits for 6 weeks and monthly audits for 3 months to improve understanding of Rights Rights. Report all results to QAPI for review.</p>	

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F 550	<p>Continued From page 3</p> <p>before the shift on 1/14/24. LPN-A seemed to be in a bad mood, she made negative comments during shift report. Later when NA-A was in the breakroom, LPN-A came in appearing agitated and was complaining how she hated always being assigned to same hallway with the same residents. NA-A reported LPN-A's face was red, body was tense, and her voice was raised. NA-A stated after she returned from her break around 6:00 p.m. when she helped R1 to bed, NA-A noticed R1 appeared to be upset. R1 reported to NA-A that LPN-A had refused to put her to bed and they had argued. R1 reported LPN-A had yelled at her, stuck up both her middle fingers, and then left her room. NA-A indicated she then reported the incident to RN-A and assisted R1 to bed. NA-A stated she felt R1's rights were being violated and LPN-A was being "slightly abusive" to R1.</p> <p>During an interview on 1/24/24, at 12:35 p.m. NA-B stated on 1/14/24 around 5:30 p.m., she had been in the dinning room when LPN-A came "storming in"; LPN-A told her not to put R1 in bed, that she was sick of her, and it was too early for her to go to bed. At around 6:00 p.m. after supper LPN-A had gone to break. That's when NA-A told NA-B about R1's report of LPN-A arguing, yelling at R1, refusing to put R1 to bed when she asked, and giving R1 the double middle fingers. NA-B stated she felt like LPN-A was disrespectful to residents and co-workers.</p> <p>During an interview on 1/24/24 at 1:30 p.m., RN-A stated she was not really involved in the incident between R1 and LPN-A other than filing the report. RN-A stated when she had gotten the report, LPN-A had already left the building after her shift. RN-A reported NA-A and NA-B had told</p>	F 550		

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F 550	Continued From page 4 her LPN-A had refused to allow R1 to go to bed, yelled at her, and gave her the two middle fingers. NA-A and NA-B assisted RN-A in writing the report. She stated she checked on R1 and she was calm in bed and since LPN-A had left R1 felt comfortable. RN-A stated staff should never treat residents like that. During an interview on 1/24/24 at 9:34 a.m., social worker (SW) stated she came to work on 1/15/24 in the morning and found a written statement that was put under her office door that pertained to the incident between LPN-A and R1 . SW stated she took the letter to the business office, found the management team already had their own copies, and were already discussing it. SW stated she filed the report and began the investigation at that time. SW indicated the verbal altercation and LPN-A giving R1 obscene gestures was not witnessed. LPN-A did not return to the building after her shift on 1/14/24. During an interview on 1/24/24, at 12:51 p.m. director of nursing (DON) stated she knew that the allegation of abuse for this incident was substantiated because of all the evidence. R1 should not have been treated like that. DON stated the LPN-A would not be allowed to come back into the building.	F 550			
F 607 SS=C	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,	F 607			3/15/24

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F 607	<p>Continued From page 5</p> <p>§483.12(b)(2) Establish policies and procedures to investigate any such allegations, and</p> <p>§483.12(b)(3) Include training as required at paragraph §483.95,</p> <p>§483.12(b)(4) Establish coordination with the QAPI program required under §483.75.</p> <p>§483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements.</p> <p>§483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act.</p> <p>§483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and document review, the facility failed to develop written policy and procedure for the time frame in which allegations of abuse and neglect must be reported to the State Agency (SA).</p> <p>Finding include:</p> <p>Review of the facility's Reporting Abuse to State Agencies and Other Entities/Individuals: revised 11/3/2023, was not consistent with the federal regulation. The facility policy included, 2. Verbal/written notices to agencies will be made immediately or within 2 hours if there is serious</p>	F 607	<p>F607 <input type="checkbox"/> Admin and SW discussed the verbiage of facility Reporting Abuse Policy and made changes directly that day to reflect the 2-hour timeframe to report abuse within State Operations Manual Appendix PP</p> <p>Facility recognizes all residents have the ability to be affected by this deficient practice.</p> <p>Staff on shift informed of Resident Rights and the urgency of reporting any potentially abusive situation immediately to Admin/DON/SW. All staff will receive Education on or before 03/15/2024</p>	

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F 607	Continued From page 6 bodily injury and within twenty-four (24) hours of the occurrence of such incident if there is not serious bodily injury. Such notice may be submitted via special carrier, fax, e-mail, or by telephone. During interview 1/25/23, at 11:44 a.m. administrator stated, he was not aware that the policy was not up to date and would expect that the facility policy would be within regulation. Administrator indicated he would need to review the facility policy to insure it was accurate and update accordingly. State Operations Manual Appendix PP - (Rev. 211, 02-03-23) included §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	F 607	regarding policy changes to Abuse and Neglect and Reporting of Abuse and Neglect. Temp agency staff will receive education upon first shift worked. HR will maintain record of attendance/completion. Admin or designee will perform weekly audits for 4 weeks and monthly for 3 months to improve understanding of the change in Reporting Abuse Policy. DON registered for updates from CMS and Leadership will complete Annual review of Policies or change as warranted by CMS updates. Report to QAPI for review.		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 609		3/15/24	

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F 609	<p>Continued From page 7</p> <p>§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.</p> <p>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of abuse were reported immediately, within two hours, to the State Agency (SA) for 1 of 3 residents (R1) reviewed for allegations of abuse.</p> <p>Findings include</p> <p>R1's significant change Minimum Data Set (MDS) dated 1/10/24 indicated R1 was cognitively intact, and exhibited verbal behavioral symptoms directed towards others on 1 to 3 days reviewed</p>	F 609	<p>F609 <input type="checkbox"/> Immediate education of staff members involved by SW/DON to review the urgency of timely reporting to management team and state reporting agency. Facility recognizes all residents have the ability to be affected by this deficient practice. Staff on shift informed of the urgency of reporting any potentially abusive situation immediately to Admin/DON/SW. Education on or before 03/15/2024</p>	

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

PRINTED: 03/18/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245316	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/24/2024
NAME OF PROVIDER OR SUPPLIER NEW RICHLAND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 312 NORTHEAST 1ST STREET NEW RICHLAND, MN 56072		
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F 609	<p>Continued From page 8</p> <p>that did not significantly interfered with R1's care.</p> <p>On 1/15/24 at 9:05 a.m. a Facility Reported Incident (FRI) submitted to the stated agency (SA) indicated at approximately 6:00 p.m. on 1/14/24, R1's licensed practical nurse (LPN) refused to allow R1 to go to bed and argued with her, resulting in R1 swearing at LPN and LPN giving R1 the middle finger on both hands. LPN was heard saying, R1 was not allowed to go to bed, and had "had it with her."</p> <p>During an interview on 1/23/24, at 1:05 p.m., R1 stated she remembered an incident recently when she had requested to go to bed and her nurse told her she did not need to go to bed yet. R1 stated her and LPN argued and LPN gave her two middle fingers and refused to allow her to go to bed. R1 stated that it wasn't the first time LPN had refused to allow her to go to bed but was the first time R1 told someone.</p> <p>During an interview on 1/24/24, at 11:09 a.m. nursing assistant (NA)-A stated she worked with LPN on 1/14/24. NA stated after supper she had gone to assist R1 to bed as she had her light on and knew R1 liked to go to bed right after supper. NA-A noted R1 was upset so NA inquired about why. R1 informed her that LPN refused to allow her to go to bed after supper and argued with her, resulting in LPN yelling, giving R1 the "double birds," and leaving her in her wheelchair in her room. NA-A stated she asked R1 if it was ok for her to go and tell someone and R1 stated it was so she left and went and told registered nurse (RN)-A around 6:00 p.m.</p> <p>During an interview on 1/24/24, at 1:30 p.m. RN-A reported she remembered an incident between</p>	F 609	<p>covering the Reporting of Alleged Violations per State Operations Manual. Temp agency staff will receive education upon the first shift worked. HR will maintain record of attendance/completion. Admin or designee will perform weekly audits for 4 weeks and monthly for 3 months to improve understanding of the change in Reporting Abuse Policy. DON registered for updates from CMS and Leadership will complete Annual review of Policies or change as warranted by CMS updates. Report to QAPI for review.</p>	

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F 609	<p>Continued From page 9</p> <p>R1 and LPN that had been reported to her by NA-A and NA-B. RN-A stated she wrote up the report and made multiple copies giving one to each of the NA's and sliding one under the door of the director of nursing's (DON) office door and one under the door of the administrator's office door. RN-A stated she felt like what LPN did was abuse and felt she had reported it right away. R1 stated LPN had left the building and R1 was content so she felt she had done the right thing. RN-A stated she called the facility the next day to follow-up and was educated that she should have called the DON and or administrator right away with any reports of abuse.</p> <p>During and interview on 1/24/24, at 9:34 a.m. social worker (SW)-A stated she arrived to work on 1/15/24 around 8:20 a.m. and had found the report had been slid under her office door. SW-A stated she immediately brought the report to the management and they filed the report at 8:58 a.m. on 1/15/24. SW stated she did her investigation and provided education to staff that abuse needs to be reported immediately. SW-A stated the nurse that took the report was agency staff and had not received the facility abuse education.</p> <p>During on interview on 1/24/24, at 12:51 p.m. DON stated she couldn't remember the day but could recall finding a report under her door and bringing it to the administrator and SW. DON stated when she brought it to them she found they already had a copy of the report and the SW was working on the investigation and filing the report. DON stated with all the evidence the report was substantiated and the facility was not allowing the LPN to come back into the building.</p>	F 609		

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F 609	Continued From page 10 The facility's policy, Reporting Abuse to State Agencies and Other Entities/Individuals, revised 11/3/23, directed the facility will ensure all suspected violations or substantiated incident of mistreatment, neglect, injuries of unknown source, or abuse (including resident to resident abuse) and misappropriation of resident property, that may constitute reasonable suspicion of a crime are reported immediately, but not later than 2 hours if there was serious bodily injury. Policy lacked direction to report all allegations of abuse to state agencies immediately but no later than 2 hours.	F 609		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 9, 2024

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

Re: Event ID: XY0011

Dear Administrator:

The above facility survey was completed on January 24, 2024, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'H. Zahler'.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00748	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/24/2024
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NAME OF PROVIDER OR SUPPLIER NEW RICHLAND CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 312 NORTHEAST 1ST STREET NEW RICHLAND, MN 56072
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2 000	<p>Initial Comments</p> <p style="text-align: center;">*****ATTENTION*****</p> <p style="text-align: center;">NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS: On 1/23/24 and 1/24/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.</p>	2 000		
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Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 02/16/24
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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00748	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/24/2024
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2 000	<p>Continued From page 1</p> <p>The following complaints were reviewed. H53168954C (MN00099997), H53169125C (MN00099228) with no licensing orders issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.</p>	2 000		