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	11/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Richland Care Center	312 Northeast 1st Street New Richland, MN 56072

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49616 Based on observation, interview, and record review the facility failed to notify the physician and family/resident representative of new/existing wounds for 4 of 4 residents (R1, R2, R3, R4) reviewed for pressure injuries. Findings include: R1's quarterly Minimum Data Set (MDS) dated [DATE], identified R1 was cognitively intact. R1 was dependent on staff for lower body dressing, transferring, toileting, and toilet hygiene. R1's assessment identified R1 was at risk of developing pressure ulcers/injuries and had moisture associated skin damage (MASD). R1's medical provider note dated 7/29/24, identified no issues with R1's skin. R1's record reviewed between 8/7/24 through 8/26/24 included wound assessments and wound treatment orders however, there was no indication the physician was notified and nor evident the physician prescribed treatment orders at the time R1's impaired skin integrity was identified by facility nursing. The record identified the following: R1's Wound Assessment and corresponding wound picture dated 8/7/24, identified R1 had a wound on sacrum, no open areas, skin was moist, erythema (redness), and ecchymosis (bruising) was present. Treatment included to clean wound and apply foam dressing. Corresponding wound picture was not consistent with the assessment; The image of the wound was not on the sacrum, it was on left and right buttocks. On the right buttocks were seven open areas of undefined edge, reddened wound beds, peeling around periarea, macerated. The left buttock had a white colored substance attached to it. Perimeter of area appeared macerated. R1's weekly skin assessment, completed by the floor nurse, dated 8/13/24, identified shower completed with blisters noted to bilateral buttocks. Blisters were covered with a mepilex (name brand of a bordered foam dressing). No measurements or comprehensive assessment completed. R1's Wound assessment dated [DATE], identified R1 had left and right buttock MASD. Wound measurements were left buttock 3.5 centimeters (cm) x 2.0 cm. right buttock was left blank. Current treatment(s) set up for wound(s) identified above: buttocks-clean per facility protocol, apply foam dressing to open areas, change Monday, Wednesday, Friday and as needed. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R1's Wound assessment dated [DATE], identified type of wound is chronic tissue injury. Wound measurements were left buttock 2.0 cm x 2.0 cm and right buttock 1.5 cm x 2.0 cm. Current treatment(s) set up for wound(s) identified above: buttocks-clean per facility protocol, apply foam dressing to open areas, change Monday, Wednesday, Friday and as needed. Notification was not made to the medical provider. R1's progress note dated 8/26/24 at 3:03 p.m., identified nurse had to change the sacral patch twice during the shift for R1 due to it being soiled/saturated. licensed practical nurse (LPN)-B and infection preventionist wound nurse (IPWN)-A looked at the wound and decided a higher absorbency patch should be placed. IPWN-A also brought puracol (wound dressing with silver). R1's progress note dated 8/27/24 at 9:08 p.m., identified R1 declined shower/bath. Complained of buttocks hurting. Vital signs (VS) obtained. Bed bath received. Buttocks patch intact. R1 laying on his left side. R1's Wound assessment dated [DATE], identified R1 had MASD on left and right buttocks. Wound measurements were left buttock 1.0 cm x 1.0 cm and right buttock 2.5 cm x 2.5 cm with a depth of 0.2 cm. Overall impression of visible tissue: epithelial tissue present, granulation tissue present; beefy red tissue with shiny, moist, granular appearance, slough present; yellow, white, or tan tissue that adheres to the ulcer bed in strings or thick clumps or is mucinous, moist, erythema, dry/scaly tissue, swelling/edema, and scabbing to wound bed noted. In review of R1's record between 8/26/24 through 8/30/24, although documentation identified R1's wound was deteriorating, showed signs and symptoms of infection, and associated pain R1's physician was not notified until 8/30/24 when R1 reported not feeling well and was subsequently sent to the emergency room and found to have severe sepsis, sacral osteomyelitis. R1's progress note dated 8/30/24 at 2:17 p.m., identified LPN-C went to check on R1 after nursing assistants (NA) had said R1 was not feeling well. VS were taken at 10:00 a.m. Blood pressure and oxygen were slightly low. R1 drenched head to toe in sweat. R1 had not urinated since 9:00 p.m. on 8/29/24. R1 left with ambulance at 11:30 a.m. R1's emergency department (ED) notes dated 8/30/24, had new diagnoses of severe sepsis, sacral osteomyelitis. R1 had a large 4.0 cm dark area on upper right buttock that is draining purulent maroon material, also has a small erosion on left upper buttock. Computed tomography (CT) scan showed abscess formation with suspected sacral osteomyelitis. During a phone interview on 11/14/2024 at 3:44 p.m., family member (FM)-A stated when R1 got to the hospital they were not aware of a bedsore. The emergency department (ED) medical doctor told her that R1 had a really bad bedsore. FM-A was not aware of the pressure injury until the ED told her. During an interview on 11/18/24 at 11:42 a.m., LPN-B stated R1 had reddish/brown increased drainage without odor to the wound on 8/26/24. LPN-B notified IPWN-A to assess. LPN-B stated she did not notify the medical provider because she was directed not to as IPWN-A would do that. During an interview on 11/8/24 at 2:28 p.m., IPWN-A stated she began puracol dressing on 8/26/24 for more absorbency. IPWN-A was unsure why the medical provider was not notified of the increased drainage to the wound. IPWN-A verified the provider was not notified, and VS were not obtained. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/12/24 at 1:48 p.m., nurse practitioner (NP)-A was present in the facility on 8/27/24 and was not notified of any change in the wound to R1 on 8/26/24, furthermore, NP-A was unaware that R1 had wounds to his buttocks. NP-A stated the wound change on 8/26/24 for R1 could have been treated more aggressively by the facility for his wound. NP-A does not believe the facility has standing orders for wounds and would need to be followed up with the provider in a timely manner. R2's admission MDS dated [DATE], identified R2 was at risk for pressure ulcers but did not currently have any. R2's progress note dated 7/24/24 at 8:18 p.m., identified NA reported during cares that R2 had a white area on top of his left second toe. LPN observed and noted it to be swollen, warm, red to the touch and a small 0. 8 cm x 0.8 cm area on the top of his second toe knuckle area. Surrounding skin was intact and pink in color. Slough is present and no bleeding. Nurse cleansed wound, covered with dressing, and left a note for IPWN-A. R2's progress note dated 7/25/24 at 1:54 a.m., identified left foot second toe was pressure sore from shoes. R2's July treatment administration record (TAR) included a wound treatment dated 7/26/24 that directed staff for R2's left toe remove old dressing, clean per facility protocol, apply triple antibiotic ointment, cover with dry dressing, change Monday, Wednesday, Friday, and as needed with a discontinue date of 9/4/24. R2's progress note dated 9/27/24 at 1:54 p.m., identified social worker was working with R2's friend to get new shoes as his newer shoes he has rubbed on the top of his foot so he does not wear them. R2's progress note dated 10/8/24 at 9:27 a.m., identified R2's friend brought a different pair of shoes, and R2 was wearing the other pair that are newer and they were fine on his feet. Review of R2's documentation does not identify notification to the physician of R2's pressure injury to the left second toe from 7/24/24-10/15/24. R2's progress note dated 10/15/24 at 11:58 a.m., identified new orders from the physician for Epsom soaks to left foot, apply betadine to top of second toe (left foot), apply foam pad. Change daily and as needed. IPWN-A to also assess. R2's Wound assessment dated [DATE], identified R1 had a stage 3 pressure ulcer on left toes and ingrown toenail. Meaurements were 0.5cm x 0.5 cm and 0.5 cm. Record review does not identify provider notified of left great ingrown toenail identified on 11/6/24. During an observation on 11/8/24 at 9:34 a.m., IPWN-A entered R2's room and removed bordered dressing and lambs wool from left great toe and second toe. IPWN-A measured second toe pressure injury 0.5 cm x 0. 5 cm and applied bandaid to site. Left great toe had an ingrown toenail that measured 1.0 cm x 0.2 cm. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R3's quarterly MDS dated [DATE], indicated R3 was cognitively intact. The MDS indicated R3 was dependent for all transfers and bed mobility. The MDS also indicated R3 was at risk for development of pressure ulcers and had two stage 2 pressure ulcers and was receiving pressure ulcer care. R3's record reviewed between 4/23/24 through 11/6/24 included wound assessments and wound treatment orders however, there was no indication the physician was notified and nor evident the physician prescribed treatment orders at the time R1's impaired skin integrity was identified by facility nursing. The record identified the following: R3's Wound assessment dated [DATE], identified a new wound on left buttocks measuring 0.5 cm x 1.5 cm identified, as moisture/chronic, and right gluteal fold measuring 4.5 cm x 3.0 cm, identified as moisture/chronic. Wound base identified as epithelial (thin layer of tissue) tissue, moist, dry, and scaly tissue with well-defined edges and no drainage. R3's April TAR included a wound treatment order dated 4/23/24 that directed staff to clean left buttock per facility protocol and apply foam dressing to change twice per week; order was discontinued on 5/22/24. In review of R3's record there was no indication R3's physician and family had been notified of the new skin issue identified on 4/23/24. R3's Wound assessment dated [DATE], identified as a new wound on left iliac crest (rear) as a blister measuring 1.5 cm x 7.5 cm, and left gluteal fold identified as moisture measuring 1.0 cm x 1.5 cm, marked as epithelial tissue present, granulation tissue, moist, erythema, blistering, well defined edges, serosanguinous drainage. R3's May 2024 TAR included a wound treatment dated 5/22/25 that directed staff to clean left lower flank per facility protocol, apply border dressing and change every Tuesday and Friday. May discontinue when healed; order was discontinued on 5/29/24. In review of R3's record there was no indication R3's physician and family had been notified of the new skin issue on left iliac crest identified on 5/15/24. R3's Wound assessment dated [DATE], identified blister on left iliac crest without measurement, blister on front of right thigh measuring 3.0 cm x 3.0 cm, and pressure ulcer on left lower leg (rear) without measurements. Note added that both areas have resolved and blister on right inner thigh. R3's May and June 2024 TAR included a wound treatment dated 5/29/24 that directed staff to clean the left thigh wound per facility protocol and apply foam dressing every Tuesday, Friday and as needed; discontinue date of 6/5/24. In review of R3's record there was no indication R3's physician and family had been notified of the new skin issue on left iliac crest identified on 5/29/24. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R3's Wound assessment dated [DATE], identified pressure ulcer on right buttocks measuring 1.0 cm x 8.0 cm, and pressure ulcer on left buttocks measuring 6.5 cm x 3.0 cm and marked a stage 1. Wound assessments completed between 7/26/24 through 11/8/24 continued to identified impaired skin integrity to R3's buttocks. The record also identified wound treatments were implemented. In review of R3's record it was not evident the physician was notified of the impaired skin integrity and not evident the physician prescribed treatments orders at the time of identification. During an observation on 11/7/24 at 2:22 p.m., registered nurse (RN)-A entered room, removed dressings off coccyx and right inner thigh. RN-A measured wound on buttocks and stated upper right side has skin off, reddened, and measured 3.0 cm x 2.5, stated area is blanchable. Fluid filled blister on coccyx measured 1.0 cm x 1.0 cm; left buttock open area measured 2.0 cm x 3.0 cm, skin off and reddened. Right inner thigh wound measured 6.0 cm x 9.0 cm and macerated. RN-A cleansed wound with wound cleanser and applied new sacral foam dressing. R4's face sheet dated 11/18/24, identified diagnoses of bilateral hearing loss. R4's Wound assessment dated [DATE], identified R4 had a new coccyx wound identified as a chronic tissue injury. Wound measurements were 3.0 cm x 2.0 cm x 0.2 cm depth. Current treatment(s) set up for wound(s) identified above: clean per facility protocol, apply foam dressing to area, change daily and as needed. R4's provider visit note dated 7/22/24, identified no open skin issues. R4's Wound assessment dated [DATE], identified the coccyx wound as MASD with measurements of 2.5 cm x 1.5 cm. R4's Wound assessment dated [DATE], identified coccyx wound as chronic tissue injury that measured 1.0 cm x 0.5 cm. R4's picture assessment of left inner ear on 8/29/24, identified a reddened area with a yellow color that appears to fall right on hearing aid placement area. In review of R4's record it was not evident the physician was notified of the impaired skin integrity to R4's coccyx or ear. During an observation on 11/15/24 at 10:22 a.m., R4 was in her recliner. R4 had a Band-Aid on her left inner ear. I think she put that on a long time ago. It was hurting and rubbing against it. I've got something on my butt, a little something so it doesn't hurt so much, when I am sitting, like now, for too long, it hurts. At 10:49 a.m., clinical manager (CM)-A was in bathroom with R4. R4 yelled out careful, don't press too hard. CM-A stated right side buttock was scarring and left side is probably 0.5 cm x 0.5 cm and a stage II. CM-A removed Band-Aid from left inner ear and R4 yelled in pain that ear hurts. CM-A stated blanching on bony prominence, that the wound was from her hearing aide, and had a scab on it. CM-A applied a new Band-Aid to site. During an interview on 11/8/24 at 2:28 p.m., IPWN-A stated she goes through two medical wound product folders or binders and go with my best judgement to choose what to use for treatments. Facility protocol for how to treat a wound is in the computer in one of the folders, felt it was in a public drive for nurses but was unsure. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/8/24 at 4:58 p.m., Administrator and DON, Administrator verified provider should be notified within a couple days, right away for increased drainage, pain, and measured once a week. During an interview on 11/12/24 at 1:48 p.m., nurse practitioner (NP)-A stated the facility fills out rounding sheet, the wounds should be added to the sheet with measurements. If the wounds are not on the rounding sheet or brought up to her, then she would not address the wounds. With a change of condition of a wound she would expect to be notified. NP-A does not believe the facility has standing orders for wounds and would need to be followed up with the provider in a timely manner. During an interview on 11/13/24 at 11:56 a.m., medical doctor (MD)-A stated she does not always look at the wound on rounding. MD-A relies on the nurse to tell her about the wound. If they have concerns, they would tell me about it and then would go with them to see it. For wound standing orders MD-A expected the provider would be notified of initiation and sign them the next time they were at the facility. During a phone interview on 11/13/24 at 2:10 p.m., MD-B stated providers rely on the nurses to give the appropriate characteristics of the wounds and this is relayed to the doctor seeing the resident. He stated he was unaware that the nurse did not receive any education on wounds. MD-B would expect staff writing any standing order for wounds to notify the provider of the new wound and obtain orders from them. The facilities Notification of Change in Resident's Condition dated 3/21, identified the charge nurse will promptly notify the resident, the attending physician, and resident representative of changes in residents medical/mental condition. The DON should also be notified of significant changes.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49616 Based on observation, interview and document review, the facility failed to have a system in place for pressure ulcer prevention and management that included comprehensive assessments, monitoring, physician involvement, and individualized wound treatments and interventions for 4 of 4 residents (R1, R2, R3, R4) who had ongoing, recurrent, and deteriorating pressure wounds. As a result of the facility's systemic failure, R1 developed a stage 4 pressure ulcer that resulted in sepsis, osteomyelitis, and death resulting in immediate jeopardy. The IJ began on [DATE], when the facility failed to monitor, assess, and immediately notify the physician when R1's wound had increased drainage and pain which resulted in delay of care for four days followed by hospitalization and death. The Director of Nursing (DON) was notified of the IJ on [DATE] at 5:30 p.m. The IJ was removed on [DATE] at 4:39 p.m., but noncompliance remained at the lower scope and severity level E, which indicated no actual harm with potential for more than minimal harm that is not IJ. Findings include Pressure Ulcer/Injury (PU/PI) is localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury occurs because of intense and/or prolonged pressure or pressure in combination with shear. Stage 1 Pressure Injury: Non-blanchable erythema of intact skin. Intact skin with a localized area of non-blanchable erythema (redness). Stage 2 Pressure Ulcer: Partial thickness skin loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink, or red, moist, and may also present as an intact or open/ruptured blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis, intertriginous dermatitis (inflammation of skin folds), medical adhesive related skin injury, or traumatic wounds (skin tears, burns, abrasions). Stage 3 Pressure Ulcer: Full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible but does not obscure the depth of tissue loss. Stage 4 pressure ulcer: Full thickness skin and tissue loss with exposed or directly palpable fascia, muscle tendon, ligament, cartilage, or bone in the ulcer. Slough and /or eschar may be visible on some parts of the wound bed. Unstageable pressure ulcer: Full thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar. If the slough or eschar is removed, a stage 3 or 4 pressure ulcer will be revealed. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Eschar: dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/ edges of the wound. Slough: non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy, and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed. Serosanguinous drainage: is a thin, watery fluid that's often slightly yellow and has a light pink tinge that can ooze from a wound as a part of the wound healing process. Moisture Associated Skin Damage: inflammation or skin erosion caused by prolonged exposure to a source of moisture such as urine, sweat, wound drainage, saliva or mucus. R1's face sheet dated [DATE], identified R1 had diagnoses that included of methicillin resistant staphylococcus aureus (MRSA) infection (type of bacteria that has developed defense mechanisms to antibiotics), osteomyelitis(infection of the bone) of sacral and sacrococcygeal region, Parkinson's disease (brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), heart failure, dementia, and morbid obesity (overweight). R1's quarterly Minimum Data Set (MDS) dated [DATE], identified R1 was cognitively intact. R1 was dependent on staff for lower body dressing, transferring, toileting, and toilet hygiene. R1 weighed 310 pounds (lb) and was 5 feet (ft) 7.5 inches (in) tall. R1 was at risk of developing pressure ulcers/injuries and had moisture associated skin damage (MASD). R1's care plan focus dated [DATE], identified R1 was at risk for potential impairment to skin integrity related to history of pressure injury. Interventions included barrier cream to buttocks after incontinent episodes, monitor skin integrity with showers and cares. Report any signs of skin breakdown to charge nurse. Pressure reduction mattress on bed and cushion in wheelchair. R1's Braden scale for predicting pressure sore risk dated [DATE], identified R1 was at a moderate risk for pressure injuries. R1's Weekly Skin assessment dated [DATE], indicated R1 did not have skin issues. R1's record which included wound treatment records, progress notes, and wound assessments with corresponding pictures between [DATE] and [DATE] identified the wound description(s) of the wound(s) and the recorded wound assessments for these dates were not accurate compared to the pictures taken by the facility. In addition, the wound assessments did not consistently include start dates of the wounds, progress toward healing and/or deterioration, and evaluation of the effectiveness of treatments and/or interventions. The assessments identified the following: (continued on next page)

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 11/18/2024

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R1's Wound assessment dated [DATE], identified the wound(s) were not new and it was a follow-up assessment. The date of original assessment was left blank. The assessment identified R1 had skin issues on his right and left buttocks; marked as moisture associated skin damage (MASD). No measurements were included. The assessment indicated wounds to both buttocks had resolved and indicated barrier cream was used for protection. Registered Nurse (RN) was notified. R1's corresponding photo of buttocks on [DATE], was not consistent with the assessment documentation. The photo identified peeling, flaky skin from the lower inner buttock to the upper with yellow/brown discolored areas along the left buttock on the lower inner buttock cheek. The discolored yellow/brown area also had a small area of redness consistent with a stage 1 pressure ulcer per definition. The right buttock had dry/peeling skin along the upper and lower buttock crease, additionally upper right buttock had an open area with pink wound bed consistent with a stage II pressure ulcer. R1's record had no evidence the physician was notified of the wound nor was R1's care plan revised to identify the wound. Also there was no indication the wound had deteriorated or healed since there were no wound assessment until [DATE], 33 days later. The physician had a medical noted dated [DATE], that identified no issues with R1's skin. R1's Wound assessment dated [DATE], nine days after [DATE] physician noticed of not skin issues. R1 had a sacral wound that was identified as chronic tissue injury. The date of original wound assessment and measurements of the wound were left blank. Wound description was moist, erythema (redness), ecchymosis present (bruising), wound edges were well defined, with no odor present. Current treatment(s) set up for wound(s) identified above: coccyx-clean per facility protocol, apply foam dressing. Change Monday, Friday, and as needed. Prevention measures identified as: pressure relieving chair, pressure relieving bed, turning/repositioning, nutrition/dehydration. RN notified areas were not open at this time, dressing applied for comfort and prevention. There were no notification to the medical provider about the chronic tissue injury. R1's corresponding wound photograph of buttocks dated [DATE], was not consistent as described in the assessment. The image of the wound was not on the sacrum, it was on left and right buttocks. On the right buttocks were seven open areas of undefined edge, reddened wound beds, peeling around periarea, macerated. The left buttock could not be fully visualized because of a white substance that covered the skin, however at the perimeter the skin was consistent with macerated skin per definition. R1's care plan was not updated to reflect interventions for turning/repositioning. R1's August treatment administration record (TAR) included wound treatment instructions however, there was no indication the physician had prescribed the treatments on the dates the treatments were transcribed/entered into the electronic health record (EHR). August TAR included the following wound treatments: -Treatment dated [DATE] directed to apply barrier cream with dimethicione, NA's may apply for every shift for three days, stop date [DATE]. -Treatment dated [DATE], directed staff for the coccyx wound-clean per facility protocol (protocol not defined), apply foam dressing. Change Monday, Friday, and as needed daily. (continued on next page)

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	11/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Richland Care Center	312 Northeast 1st Street New Richland, MN 56072

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R1's weekly skin assessment, completed by the floor nurse, dated [DATE], identified shower completed with blisters noted to bilateral buttocks. Blisters were covered with a mepilex (name brand of a bordered foam dressing). No measurements or comprehensive assessment were completed. R1's Wound Assessment, completed by the licensed practical nurse (LPN) Infection Preventionist/Wound nurse (IPWN)-A dated [DATE], identified the wound(s) were not new. The assessment did not address R1's sacral wound identified on [DATE] nor addressed the blisters identified on [DATE]. The assessment identified R1's wound type as chronic tissue injury also noted to be reoccurring, MASD to left and right buttocks. Wound measurements were left buttock 3.5 centimeters (cm) x 2.0 cm. Measurements for the right buttock were left blank. Description included, wound edges well defined, epithelial tissue present; new (pink) skin growing, moist, and dry/scaly tissue. Scant amount of serous drainage with no odor. Treatment was same as per the [DATE] assessment. Prevention measures same as per [DATE] assessment with the addition of ulcer care. The assessment did not identify progress of wound nor evaluation of treatments/interventions for appropriateness. R1's corresponding wound photo of buttocks dated [DATE], was not consistent as described in the assessment. The image of the wound was not on the sacrum, it was on left and right buttocks. On the right buttocks were seven open areas of undefined edge, reddened wound beds, peeling around periarea, macerated. Unable to identify if the seven open areas were MASD or pressure injuries secondary to the MASD. The left buttock could not be visualized because it was covered with a thick, white substance however the periphery of the wound was consistent with macerated skin. R1's care plan continued to not identify a turning and repositioning program nor any other interventions added. Further there was no indication the physician was notified of the wound. R1's August treatment administration record (TAR) included wound treatment instructions however, there was no indication the physician had prescribed the treatments on the dates the treatments were transcribed/entered into the electronic health record (EHR). August TAR included the following wound treatments: -Treatment dated start [DATE], buttocks clean per facility protocol (protocol not defined), apply foam dressing to open areas, change Monday, Wednesday, Friday, and as needed in the morning, stop date [DATE]. R1's Wound Assessment, completed by IPWN-A, dated [DATE], identified R1 had chronic tissue injury (type of injury was not defined) to right and left buttock. Wound measurements were left buttock 2.0 cm x 2.0 cm and right buttock 1.5 cm x 2.0 cm. Wound description: well defined wound edges, epithelial, moist, erythema, dry/scaly skin with scant amount of serous drainage and no odor. Treatments and interventions were unchanged from previous. The assessment did not identify progress of wound nor evaluation of the current treatments/interventions to identify if the interventions were appropriate for the current wound . R1's photo of buttocks dated [DATE], could not differentiate between left and right buttock and could not be determined based on the description in the assessment. One buttock had an open oval area unable to determine size. This area had a white area in the center and was full of a viscous red drainage. Surrounding tissue appears white in color, rolled edges, and disproportion. This buttock also had small yellow flaky pieces of skin peeling off. The other buttock has a large area of flaky skin, open reddened area, and another area with viscous red drainage. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R1's August TAR did not include or indicate a treatment had been implemented or completed on [DATE] and [DATE]. However, on [DATE] R1's TAR included wound treatment instructions however, there was no indication the physician had prescribed the treatments on the dates the treatments were transcribed/entered into the electronic health record (EHR). August TAR included the following wound treatments: buttocks-clean per facility protocol (protocol not defined), cut hydrogel dressing to fit wound, cover with foam dressing to open areas, change Monday, Wednesday, Friday, and as needed stop date [DATE]. R1's progress note dated [DATE] at 3:03 p.m., identified LPN-B had to change the sacral dressing twice during the shift due to it being soiled/saturated. LPN-B and IPWN-A looked at the wound and decided a higher absorbency patch should be placed. IPWN-A also brought puracol ([NAME] dressing). In review of R1's record there was no indication the physician was notified of the increase in drainage. R1's TAR included a wound treatment dated [DATE] that directed nursing to apply puracol dressing (collagen dressing, dissolve in wound bed and change up to 7 days later) cover with absorbent dressing on open areas, change every shift and as needed with stop date of [DATE]. There was no indication the physician had prescribed the treatment on the date the treatment was transcribed/entered into the electronic health record (EHR). During an interview on [DATE] at 11:42 a.m., LPN-B stated R1 had reddish/brown increased drainage without odor to the wound on [DATE]. LPN-B notified IPWN-A to further assess the wound. LPN-B stated she did not notify the medical provider because she was directed not to as IPWN-A would do that. During an interview on [DATE] at 2:28 p.m., IPWN-A stated she began puracol dressing on [DATE] for more absorbency. IPWN-A indicated she was not aware increased drainage was a sign/symptoms of infection and R1's vital signs had not been collected. IPWN-A confirmed R1's physician had not been notified of the increase in drainage. R1's weekly skin assessment, completed by the floor nurse, dated [DATE], identified shower was not completed I had it yesterday and R1 complained of pain in the buttocks area. Wound identified as coccyx with description being buttocks wound, covered, repo (reposition) onto sides. Offload buttocks. Skin is intact. Treatment to buttocks wound. No measurements or comprehensive skin assessment completed. R1's progress note dated [DATE] at 9:08 p.m., identified R1 declined shower/bath. Complained of buttocks hurting. Vital signs (VS) obtained. Bed bath received. Buttocks patch intact. R1 laying on his left side. Blood pressure ,d+[DATE], oxygen 98% room air, pain ,d+[DATE] at 5:05 p.m., pulse 74, respirations 16, temperature 96.6 Fahrenheit R1's record had no indication R1's physician was notified of R1's new onset of pain to buttock. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R1's Wound assessment dated [DATE], identified R1 had MASD to left and right buttock. Wound measurements were left buttock 1.0 cm x 1.0 cm and right buttock 2.5 cm x 2.5 cm with a depth of 0.2 cm. Wound description included: well defined edges, scabbing to wound bed, epithelial and granulation tissue present; beefy red tissue with shiny, moist, granular appearance, slough present, moist, erythema, dry/scaly tissue, swelling/edema. Minimal amount of serosanguinous drainage and no odor. Current treatment(s): buttocks-clean per facility protocol, apply Puracol dressing (does not need to be removed for up to 7 days) cover with absorbent dressing on open areas, change every shift and as needed. Prevention measures that were no already identified previously were application of dressings and ointments/medications. The assessment did not identify progress of wound nor evaluation of treatments/interventions for appropriateness. R1's photo of buttocks dated [DATE], could not differentiate between left from right buttock and it could not be determined based on the description in the assessment. The photo identified an open area on one buttock, the upper portion of the wound was covered by black eschar (unstageable) the base of the lower portion of the wound was yellowish grey matter. Surrounding the wound the skin was peeling white flakes. The full buttock area was pink/red color. The other buttock had a circular area with a white center and some pink on the top half. The surrounding skin was peeling and pink. There was an area near the crease of the buttock that had a section of three areas of impaired skin integrity. During a phone interview on [DATE] at 1:22 p.m., LPN-A stated she remembered that R1 had a sore on his bottom but did not remember observing it on [DATE] during the evening shift. R1's progress note dated [DATE] at 2:17 p.m., identified LPN-C went to check on R1 after nursing assistants (NA) had said R1 was not feeling well. Vital signs were taken at 10:00 a.m. Blood pressure and oxygen were slightly low. R1 drenched head to toe in sweat. R1 had not urinated since 9:00 p.m. on [DATE] 16 hours earlier (normal 30 ml per hour of urine). Family and provider requested R1 be sent to the emergency department for evaluation. Ambulance arrived at 11:15 a.m. and R1 left with ambulance at 11:30 a.m. Oxygen was 88% on room air (normal is ,d+[DATE]%), and blood pressure was ,d+[DATE] (normal is , d+[DATE]). During a phone interview on [DATE] at 9:37 a.m., registered nurse (RN)-B stated she was unaware R1 not urinated during the shift on [DATE] into [DATE], however stated, I think he was incontinent right before we left [morning of [DATE]] and he had a sore on his bottom. RN-B did not recall changing his dressing on his buttocks during the night on [DATE]. During a phone interview on [DATE] at 1:01 p.m., LPN-C stated there had not been anything brought up in the nurse's report about R1 the morning of [DATE]. It had been the NA's who reported to LPN-C that R1 had not urinated during the night. LPN-C did not verify that information with the RN-B during morning report. LPN-C stated R1 was not assessed until the morning medication pass around 9:30 a.m. That was when LPN-C called IPWN-A to assess R1 and then R1 was sent to the ED. (continued on next page)

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 11/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Richland Care Center	312 Northeast 1st Street New Richland, MN 56072

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R1's emergency department (ED) notes dated [DATE], had new diagnoses of severe sepsis, sacral osteomyelitis. R1 had a large 4.0 cm dark area on upper right buttock that is draining purulent maroon material, also has a small erosion on left upper buttock. R1 also has new onset heel ulcer to right heel without skin breakdown currently. Computed tomography (CT) scan showed abscess formation with suspected sacral osteomyelitis. R1 was given intravenous (IV) antibiotics and recommended surgical debridement (removal of tissue). Recommended that R1 be transferred to a higher-level facility for care and treatment. The ED included wound assessments of R1's right and left buttocks: -Wound assessment time stamped at 12:45 p.m. of the right buttock R1 had an oval shaped deep tissue injury with pain rating 5 (,d+[DATE] pain scale, 10 being the worst pain experienced) that measured 3.0 cm x 4.0 cm, wound surface 12 cm^2, wound bed was black, red and purple, appeared boggy underneath wound, drainage-erythema; odor foul, Exudate=small with brown drainage. Peri wound: blanchable erythema, fragile, friable. -Wound assessment time stamped 12:55 p.m. of left buttock R1 had a stage 3 pressure injury with pain rating a 5. ED wound assessment of left buttock first assessment on [DATE] at 12:55 p.m. labeled as stage 3 pressure injury. Pain-5. The wound was round/oval and measured 1.0 cm x 1.0 cm x 0.4 cm depth, wound surface area 1.0 cm^2. Undermining from 9 o'clock to 12 o'clock, Wound bed-open; full thickness; pink; red, Tissue exposed-fat, Exudate-moderate with sanguineous drainage, Peri wound-blanchable; erythema; fragile, Drainage and odor. R1's hospital discharge paperwork dated [DATE], which encompassed a stay from [DATE]-[DATE], included diagnoses of sacral osteomyelitis, hospice, severe sepsis, gram-positive bacteremia, presacral abscess. Review of R1's care plan identified no changes were made to the skin integumentary interventions and goals after return from hospital on [DATE]. R1's death certificate indicated R1 died on [DATE]; listed cause of death was complications of sepsis, osteomyelitis, and sacral decubitus ulcer that began approximately 6 weeks prior to onset of death. During an interview on [DATE] at 12:18 p.m., NA-D stated the only residents on turning and repositioning logs were the residents on hospice. During an interview on [DATE] at 2:30 p.m., NA-A stated no residents were turned and repositioned unless they were on hospice. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 2:48 p.m., IPWN-A indicated she was the wound nurse for the facility however, did not have any formalized training for wound management. The facility had a contract with a company that supplied a certified wound nurse however, the nurse did not manage all the wounds in the facility and would call the nurse if she needed. IPWN-A explained she would complete the weekly wound assessments and then a registered nurse or director or nursing (DON) would review and sign the assessments she had completed. However, could not articulate if the assessments were reviewed by a trained registered nurse. IPWN-A stated she would use reference materials with pictures to determine classification of wounds and chose a treatment for the wound based on my best judgement. IPWN-A further explained she would label a wound a chronic tissue injury if the wound was in the same that spot that kept opening or did not heal. IPWN-A indicated residents at risk for pressure injuries were not on a turning and repositioning program and was not aware how to determine a turning and repositioning program and/or comprehensively assess resident's for tissue load or tolerance to pressure over time. During an interview on [DATE] at 4:58 p.m., Administrator and DON stated a Braden pressure ulcer risk assessment was completed to determine appropriative interventions. DON and Administrator stated IPWN-A had wound training and completed all the wound care herself. IPWN-A writes the orders she thinks is best and the provider goes through and signs them. Administrator indicated the physician should be notified of wounds within a couple days, right away for increased drainage, pain, and measured once a week. DON expected the staff to have notified the physician on [DATE] of R1's change of condition. DON verified R2 had a pressure injury on his toe on [DATE], and expected it to be assessed and evaluated weekly, I don't understand how you can have a blister for two days and then nothing. Our turning and repositioning program is every two hours and and we go by what the hospital tells us, and then you have the residents that would refuse and you document that. DON stated a sheet is kept at the nurses station for anyone who is on the two hour turn and reposition schedule. DON stated she does not do anything with wounds, IPWN-A consults with wound consultant and will communicate if something different is going on with wounds. During an interview on [DATE] at 1:48 p.m., nurse practitioner (NP)-A stated she was present in the facility on [DATE] and was not notified of any change in the wound to R1 on [DATE], furthermore, NP-A was unaware that R1 had wounds to his buttocks. NP-A stated the wound change on [DATE] for R1 could have been treated more aggressively by the facility for his wound. NP-A indicated when there were new wounds or changes to wounds the resident would be added to the physician rounding sheet, if the wounds were not on the rounding sheet or brought up to her, then she would not address them. NP-A expected to be notified right away if there was a change in condition. NP-A does not believe the facility has standing orders for wounds and would all wound care would need to be followed up with the provider in a timely manner. During an interview on [DATE] at 11:56 a.m., medical doctor (MD)-A stated she did not always look at the wounds on rounding. MD-A relied on the nurse to tell her about the wound. For R1 she would expect a change in a wound to trigger the facility to evaluate the wound, do vital signs and notify the provider. MD-A confirmed that a serious infection of osteomyelitis could lead to death. MD-A stated R1's cause of death was due to the pressure ulcer causing osteomyelitis and death. For wound standing orders MD-A expected the provider would be notified of initiation and sign them the next time they were at the facility. R2 (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R2's admission MDS dated [DATE], identified R2 was at risk for pressure ulcers but did not currently have any. R2's care plan dated [DATE], identified risk for skin impairment with pressure injury to left foot second toe. Braden dated [DATE], identified low risk for developing pressure injury. Interventions included to monitor for location, size, and treatment of skin injury and report abnormalities, failure to heal, signs/symptoms of infection, maceration, etc to physician. R2's weekly skin assessment dated [DATE], identified no areas of concern. R2's record reviewed between [DATE] through [DATE], indicated R2 had ongoing pressure injury from shoes that deteriorated to a stage III pressure ulcer. R2's record identified weekly wound assessments were not completed. The assessments that were completed did not consistently identify type or stage of wound, progress toward healing, did not address causal factors of skin breakdown or impaired healing, lacked evaluation of treatments/interventions, and was not evident new interventions were developed and implemented that would improve wound healing, prevent deterioration, and/or prevent new ulcer development. R2's progress note dated [DATE] at 8:18 p.m., identified NA reported during cares that R2 had a white area on top of his left second toe. LPN observed and noted it to be swollen, warm, red to the touch and a small 0. 8 cm x 0.8 cm area on the top of his second toe knuckle area. Surrounding skin was intact and pink in color. Slough is present and no bleeding. Nurse cleansed wound, covered with dressing, and left a note for IPWN-A. R2's progress note dated [DATE] at 1:54 a.m., identified left foot second toe was pressure sore from shoes. R2's Wound assessment dated [DATE], identified R2 had a blister on his left toe that measured 2.0 cm by 1. 5 cm with epithelial tissue, moist and macerated. Minimal amount of serous drainage. Treatment: left 2nd toe-remove old dressing, clean per facility protocol, apply triple antibiotic ointment, cover with dry dressing, change Monday, Wednesday, Friday, and as needed. Interventions included pressure relieving chair, turning/repositioning, nutrition/dehydration, and ulcer care. R2's record did not include comprehensive wound assessments between [DATE] through [DATE]. R2's progress note dated [DATE] at 1:54 p.m., identified social worker was working with R2's friend to get new shoes as his newer shoes he has rubbed on the top of his foot so he does not wear them. R2's weekly skin dated [DATE], identified left toes scab on left second toe 0.5 cm x 0.5 cm and scab on right great toe 0.7 cm x 0.5 cm. Comments included that R2 stated his scab was from a recent podiatry visit and the scab on the left great toe is not new, no change in size noted, left open to air. R2's progress note dated [DATE] at 9:27 a.m., identified R2's friend brought a different pair of shoes, and R2 was wearing the other pair that are newer and they were fine on his feet. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R2's Wound assessment dated [DATE], identified the wound(s) to left second toe started on [DATE]. R2 had a scab on left toe, it is now an open sore that measured 1.0 cm x 1.0 cm. The wound type was identified as open. Wound edges are fragile, slightly macerated, pale. Moderate amount sanguineous drainage this shift. Entire toe is very reddened and very swollen. Treatment included wound cleansed and dried, band aid applied and directed R2 to not wear shoes again until situation can be assessed. Plan to wear grippy socks. Offload any pressure to area. IPWN-A to assess due to concerns of toe infection. R2's progress note dated [DATE] at 11:58 a.m., identified new orders from the physician for Epsom soaks to left foot, apply betadine to top of second toe (left foot), apply foam pad. Change daily and as needed. IPWN-A to also assess. R2's physician order dated [DATE], identified left second toe, continue Epsom soaks daily. Dry completely, cut Puracol dressing to fit wound bed, cover with foam dressing, lightly wrap with lambs wool. Grippy socks until healed. Avoid shoe for prolonged time. This order was discontinued [DATE]. R2's Wound assessment dated [DATE], the left toe wound had progressed to stage III pressure ulcer that measured 1.0 cm x 1.0 cm x 0.2 cm depth, well defined wound edges with scant serious drainage. Epithelial and granulation tissue, erythema, swelling/edema. The assessment indicated treatment from [DATE] continued with no new interventions, however noted No shoes at this time!. R2's physician order dated [DATE], identified toe looks good this morning, continue with wound care and avoid shoes rubbing on second toe left foot. R2's Wound assessment dated [DATE] identified left second toe stage III toe wound and ingrown toenail. Wound measured 0.5 cm x 0.5 cm and 0.5 cm., had well defined edges, epithelial and granulation tissue, and swelling/edema. Noted as improved. Treatment included right great toe-clean per facility protocol, apply Keralite cool border. Left second toe-apply padded dressing (band aid) NO SHOE. During an interview on [DATE] at 12:18 p.m., NA-D stated R2 had an infection on his toe that bothers him. During an interview on [DATE] at 12:58 p.m., R2 stated he had a sore foot. R2 stated he had it for at least a couple of weeks. On [DATE] at 8:01 a.m., R2 stated the toe dressing gets done whenever they do it. During an observation on [DATE] at 9:34 a.m., IPWN-A entered R2's room. Removed bordered dressing and lamb's wool from left great toe and second toe. Cut kerlix (type of gauze) and sprayed it with wound cleanser. Measured second toe pressure injury 0.5 cm x 0.5 cm and applied band aid to site. Left great toe had an ingrown toenail that measured 1.0 cm x 0.2 cm. Cut carelite cool border moisture balance hydrogel dressing and put the unused half of the cut dressing back into R2's wound bucket for next dressing change. Took lamb's wool, that was open and not in a package, from the wound bucket and weaved it between left toes. She applied yellow gripper sock back to foot and had R2's feet pressed against the foot board in his bed. During an interview on [DATE] at 2:28 p.m., IPWN-A was unsure why she did not measure the wound from July to October. It is not open now, dressing change is for protection. Currently the orders are different than what the provider ordered on [DATE]. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 4:58 p.m., DON stated R2's wound started from his shoe on [DATE], a blister from pressure probably. DON would expect wounds to be assessed each week and if healed there should have been

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49616 Based on interview, and record review, the facility failed to ensure 1 of 1 licensed nursing staff were trained and competent in pressure ulcer assessment and management. This had the potential to affect all residents who were at risk for pressure ulcers and/or residents with existing pressure ulcers. Findings include The Facility Wide assessment dated [DATE], included a section Staff competency and care area requirements as identified in the Resident Population Assessment to include The section included Pressure ulcer prevention and treatment. During an interview on 11/8/24, infection preventionist/wound nurse (IPWN)-A, identifed herself as a licensed practical nurse (LPN). IPWN-A stated she had never been trained on wound care. During an interview on 11/13/24 at 3:28 p.m., licensed practical nurse (LPN)-D stated she had not had wound training at the facility. During an interview on 11/15/24 at 2:05 p.m., LPN-B stated she received training on wounds from IPWN-A when she started. LPN-B stated a pressure injury can be staged backwards while healing. During an interview on 11/8/24 at 4:58 p.m., Director of Nursing (DON) and Administrator stated a wound consultant comes monthly to review wounds with IPWN-A. IPWN-A took training for wounds and DON does not assist with wound management. DON and Administrator believed IPWN-A had training in wounds last year. DON would expect IPWN-A to see changes in the wounds and review with medical provider. Review of the facility Relias education transcripts from 2021-2024 for IPWN-A, identified on 11/13/24, IPWN-A completed a training 'Identification and Assessment of Wounds'. No other wound training was provided. Training did not include wound care from 2021-10/31/24. During a phone interview on 11/13/24 at 2:10 p.m., medical doctor (MD)-B stated he would expect the facility nurse to have expertise with background and provide additional training for staff dealing with wound issues on a daily basis. During an interview on 11/18/24 at 3:55 p.m., Administrator stated it was out of my [NAME] on what the staff get for education but felt it was standard education from annual reviews and monitoring from the registered nurses (RN). It would be all written competencies and tracking, it should be in each employees file, we could get that for you from Human Resources. Requested competencies and education from facility and did not receive.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 49616 Based on observation, interview, and document review, the facility failed to maintain a Quality Assurance Performance Improvement/Quality Assurance Activity (QAPI/QAA) that was effective in identifying, assessing, performing, developing, and implementing appropriate plans of action related to impaired skin integrity and/or pressure injuries. This deficient practice had the potential to affect all 34 residents currently residing in the facility. Findings include On 11/15/24, the director of nursing (DON) provided the facility's Quality Assurance Performance Improvement/Quality Assurance Activity (QAPI/QAA) project documents and plans. Documents were reviewed from January through October 2024 which indicated QA meetings were held in January, June, and October which identified the following: January 2024: QA files did not include meeting agenda and minutes. Further did not include documentation that demonstrated identification and development of corrective actions for opportunities for performance improvement nor was there documentation that identified a comprehensive evaluation of previous project performance activities. June 2024: QA files did not include meeting agenda and minutes. The file did include document titled Action Plan which included the only area of concern for nursing was Grievances with a goal of ASAP. The document did not include a compressive action plan but rather a Desired outcome. Although data was provided for falls and infection control, no comprehensive actions plans were evaluated, completed and/or revised. Further not evident any new quality improvement projects with action plan based on problem prone issues pertaining to quality of care of residents were developed even though review of four resident records identified ongoing impaired skin integrity issues such as moisture associated skin damage and various stages of pressure ulcers at least from April 2024 through June 2024. SEE F580 and F686. October 2024: QA filed included a document titled QAPI Meeting Agenda dated 10/24/2024, the form included the names of the attendees who were present, otherwise the form was left blank with no areas of focus identified. The Consultant Dietician Report dated 10/2/24 indicated three residents had skin issues. No other data nursing department data was provided. It was not evident problem prone focus areas pertaining to quality of care were identified, not evident action plans were developed and implemented even though through review of four resident records identified ongoing impaired skin integrity issues, one in which resulted in death between June 2024 and October 2024. SEE F580 and F686. During an interview on 11/8/24 at 2:28 p.m., infection preventionist/wound nurse (IPWN)-A stated she had not had wound care training. During an interview on 11/18/24 at 3:55 p.m., Administrator stated QAPI is quarterly and QAA is monthly. Administrator stated the facility's current performance improvement project (PIP) was on falls and the quality improvement project (QIP) was focused on quality of life. Administrator did not believe that pressure ulcers or skin issues had been identified as a problem area. (continued on next page)

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	245316	A. Building B. Wing	11/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Richland Care Center	312 Northeast 1st Street New Richland, MN 56072

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a phone interview on 11/13/24 at 2:10 p.m., medical doctor (MD)-B indicated an unawareness of the facility's issues with pressure ulcer management, there was improvement needed, and the facility would work on a system to correct areas of concern to protect the residents. The facility QAPI program reviewed 10/24, identified the facility shall develop, implement, and maintain an ongoing, facility-wide, data-driven QAPI program that is focused on indicators of the outcomes of care and quality of life for the residents. Implementation will include: A. Tracking and measuring performance B. Establishing goals and thresholds for performance measurement C. Identifying and prioritizing quality deficiencies D. Systematically analyzing underlying causes of systemic quality deficiencies, E. Developing an implementing corrective action or PIP F. Monitoring or evaluating the effectiveness of corrective action/PIP activities and revising as needed

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 51576 Based on observations, interview, and document review the facility failed to ensure enhanced barrier precautions (EBP) was used for 3 of 3 (R2, R3, R5) residents. In addition, the facility failed to ensure proper cleaning of vital sign equipment for 2 of 2 (R5, R6) residents and failed to ensure handwashing/hand hygiene was implemented for 5 of 7 (R2, R3, R5, R7, R8) residents observed for handwashing/hand hygiene. Findings include: R5's face sheet dated 11/19/24, identified diagnoses of osteomyelitis (infection of the bone), pressure ulcer of left buttocks and left ankle (bedsores). During an observation and interview on 11/7/24 at 12:52 p.m., R5 was put on EBP for pressure ulcer care. R5's door to room had signage to use EBP-gown, gloves for close contact cares . Licensed practical nurse (LPN-A) entered room for R5 with vital sign equipment. Hand hygiene was not performed prior to entering room nor did LPN-A put on the required EBP. LPN-A obtained R5's vital signs, touched R5's skin and adjusted R5's clothing. LPN-A did not perform hand hygiene prior to leaving R5's room. Vital sign equipment was placed back at the nursing station and equipment was not disinfected after use. LPN-A stated EBP would not be needed when taking vital signs and only needed for wound care or foley care. LPN-A stated the equipment was disinfected each shift or immediately after use if the resident was on isolation. R6's face sheet dated 11/19/24, identified diagnoses of non-traumatic subarachnoid hemorrhage (stroke); essential hypertension (high blood pressure); chronic obstructive pulmonary disease (respiratory disease). During a continuous observation from 12:52 p.m. to 1:00 p.m., nursing assistant (NA-A) took the vital sign equipment from the nursing station used on R5 that had not been disinfected to R6's room and took R6's vital signs. During an interview on 11/7/24 at 1:05 p.m., NA-A stated the equipment was to be disinfected after each use and unsure if equipment was disinfected prior to use on R6. R3's face sheet dated 11/15/24, identified R3 had diagnoses that included chronic kidney disease (condition where kidneys have been damaged), and benign prostatic hyperplasia (condition where prostate enlarges and causes urination difficulty). During an observation on 11/7/24 at 1:42 p.m., R3 had an indwelling urinary catheter in place. R3's door to room had signage for EBP-gown, gloves for close contact cares. NA-A entered R3's room without putting on EBP. NA-A assisted R3 to sitting position in bed. LPN-A entered R3's room and did not apply EBP's. LPN-A and NA-A assisted R3 to the toilet, then at 2:19 p.m. NA-A transferred R3 off toilet and no EBP was applied. During an interview on 11/7/24 at 2:30 p.m., NA-A stated that EBP was needed for any wound care or catheter care, and EBP would not need to be used during a transfer. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/7/24 at 2:34 p.m., NA-B stated EBP would be needed for wound or catheter care, and EBP would not need to be used during a transfer. During an interview on 11/7/24 at 3:08 p.m., registered nurse (RN-A) stated EBP would only need to be used for wound care or catheter care, and EBP would not need to be used during a transfer. During an observation on 11/8/24 at 8:43 a.m., dietary aide (DA-A) entered R3's room with breakfast tray; R3's door had EBP signage on the door with breakfast tray. DA-A did not perform hand hygiene nor apply EBP. DA-A moved bedside table and adjusted R3's bed. Without first performing hand hygiene, DA-A removed lids off food and took silverware out of the napkin. DA-A then applied a clothing protector to R3. DA-A's uniform was touching R3's bed/body while putting on protector. DA-A did not perform hand hygiene prior to leaving R3's room. During an observation on 11/08/24 at 11:01 a.m., R3 was in tub room and just received a bath. NA-C applied clothing and did not apply EBP prior to dressing. R2's face sheet dated 11/13/24, identified diagnoses of heart failure (condition where heart doesn't pump as well as it should), hypertension (high blood pressure), dementia (decline in mental ability). During an observation on 11/8/24 at 9:30 a.m., DA-A entered R2's room. No hand hygiene was performed prior to entering R2's room. DA-A removed breakfast tray from bedside table and adjusted table to the side of bed. DA-A did not perform hand hygiene after leaving R3's room. During an observation on 11/8/24 at 9:34 a.m., infection preventionist wound nurse (IPWN)-A entered R2's wound to complete wound care on left foot. IPWN-A did not apply EBP when she entered room. IPWN-A had gloves on, removed old dressing and gloves. Applied new gloves without hand hygiene. Put bandaid on left second toe. Cut carelite cool border moisture balanced hydrogel dressing, put unused portion of dressing back into R2's wound supply bucket. Took unpackaged lambs wool from bucket and wove in-between toes on foot. removed gloves and sanitized hands while leaving room. During an interview on 11/13/24 at 3:28 p.m., LPN-D stated it was her understanding that EBP should be used on anyone with wounds, catheters, or touching body fluids. Verified R2 was not on EBP and was unsure why he was not. R7's face sheet dated 11/19/24, identified diagnoses of diabetes mellitus type 2 (A condition that affects how the body uses sugar as fuel), fibromyalgia (condition that involves widespread pain and tiredness). During an observation on 11/8/24 at 9:06 a.m., DA-A entered R7's room. DA-A did not perform hand hygiene prior to entering R7's room. DA-A removed breakfast tray from bedside table and adjusted table to the side of the bed. DA-A did not perform hand hygiene after leaving R7's room. R8's face sheet dated 11/19/24, identified diagnoses of heart failure (condition where heart doesn't pump as well as it should), dementia (decline in mental ability). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 11/8/24 at 9:11 a.m., DA-A entered R8's room. DA-A did not perform hand hygiene prior to entering R8's room. DA-A removed breakfast tray from bedside table and adjusted table to the side of the bed. DA-A did not perform hand hygiene after leaving R8's room. During an interview on 11/8/24 at 9:15 a.m., DA-A stated she is not aware what EBP was or what needed to be done for a person on this precaution. DA-A stated that hand hygiene should be done upon entering and leaving a room. DA-A confirmed that she did not perform the proper hand hygiene when entering R2. R3. R7 and R8's room. DA-A stated. I know better and should have done it. During an interview on 11/18/24, at 10:31 a.m., nurse consultant (NC)-A stated all residents that have wounds with dressing changes should have had EBP in place. During an interview on 11/8/24 at 2:28 p.m., IPWN-A stated EBP would be needed for high contact activities if the resident has open wounds or a catheter but would not need to use EBP when transferring residents. IPWN-A stated that she has no documentation of any competency of staff with EBP, and that dietary staff were not trained on EBP. IPWN-A stated handwashing/hand hygiene should be done before/leaving a room and in between residents. The facility Hand Hygiene policy dated 10/2024, identified hand hygiene to be performed before and after direct contact with residents, after contact with objects in the immediate vicinity of the resident. The facility policy on Enhanced Barrier Precautions dated 10/2024, identified enhanced barrier precautions will be used for any wound or skin openings that require dressings or indwelling medical device. Personal protective equipment is required for all staff providing high contact care activities. The facility policy for Cleaning and Disinfecting of Semi-critical Equipment and Devices dated 10/2024 identified that resident care devices and equipment will be disinfected between each resident.