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	01/08/2025

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

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49616 Based on interview and document review the facility failed to comprehensively assess and monitor for signs/symptoms of fluid overload and evaluate the effectiveness of physician prescribed treatments for 1 of 3 residents (R1) who had diagnosis of congestive heart failure. Findings include R1's face sheet dated 1/8/25, identified R1 had diagnosis that included chronic right heart failure. R1's comprehensive minimum data set (MDS) dated [DATE], identified R1 was cognitively intact. R1 had no rejection of cares, and had no shortness of breath. R1's care plan focus created 11/6/23, identified R1 had atrial fibrillation (a-fib), chronic right heart failure, and tachycardia. Interventions included providing a-fib medication as ordered, educate R1 on the importance of taking medications, and monitor/document/report to provider signs and symptoms of a-fib. The care plan did not address individualized interventions or goals for the management of fluid overload. R1's physician order dated 11/21/24, included daily weights to be checked in the morning, weight to be checked prior to meal intake. R1's weight monitoring record identified on 11/21/24, R1 weighed 187.5 pounds (lbs) R1's December 2024 treatment administration record (TAR) identified the aforementioned order to obtain weights. The TAR identified weights were not obtained according to physician order. Between 12/1/24 through 12/18/24 the TAR identified the following: -No weights documented between 12/1/24 through 12/11/24 with charting codes of either '2'-indicating refusal or '8' indicating see nurses note. On 12/2/24 and 12/10/24 the boxes were left blank. -On 12/12/24: weight was 189.4 -On 12/13/24: weight was 189.4 -On 12/14/24: no weight was documented and indicated refused. (continued on next page)

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.

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 12/15/24: weigh was 189.4 -No weights were documented between 12/16/24 through 12/18/24 and indicated refused. In review of R1's record between 12/1/24 through 12/17/24 there was no indication the physician had been notified the ordered weights were not obtained. Additionally not evident R1 was monitored for signs/symptoms of fluid overload which would include edema monitoring. R1's physician visit note dated 12/18/24, identified an assessment of chronic right heart failure with an order for furosemide (diuretic medication) 10 milligrams (mg) three times a week. Weight most recently was 189.4 and stable. R1's December 2024 TAR identified daily weights were not obtained between 12/18/24 through 12/26/24; on 4 entries directed to see progress notes, 3 entries identified refused, one box was blank, and one box was marked not applicable. There was no indication the physician was notified R1 was refusing weights nor evident R1 was monitored for signs/symptoms of fluid overload. R1's December 2024 TAR identified on 12/27/24, R1 weighed 205 lbs. R1's progress notes dated 12/27/24, identified a significant weight gain noted of 17# in 2 weeks. R1 was weighed on both the wheelchair scale and mechanical lift scale for accuracy. Slight edema was noted to right outer shin but no edema on left shin. The progress note did not identify the extent of the edema. R1's physician order dated 12/27/24, included the order that directed nursing to monitor every shift for shortness of breath, edema, and blood pressure. Recheck weight on Monday 12/30/24 and update the physician. R1's progress notes dated 12/28/24, identified no edema, no SOB, lung sounds had left clear, right lower lobe crackles. R1's progress notes dated 12/29/24, identified no edema, no SOB, lung sounds left clear, right lower lobe crackles. Remained in bed all shift. R1's progress notes on 12/30/24, identified R1 denied SOB, slept with head of bed flat, lung sounds clear. R1's progress note did not include edema assessment per physician orders. R1's progress note dated 12/31/24 at 2:40 p.m., identified R1 was sent to the emergency department due to having SOB. During an interview on 1/8/24 at 7:34 a.m., nursing assistant (NA)-A stated R1 always refused to get out of bed. R1 would be adamant about not getting up so it was hard to get the weight on the scale. NA-A could not recall swelling on R1 but R1's feet were always sore. During an interview on 1/8/25 at 9:46 a.m., NA-B stated R1 would refuse weights. NA-B stated R1 would occasionally allow staff to weigh her on the mechanical lift. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/8/24 at 7:45 a.m., licensed practical nurse (LPN)-A stated R1 refused a lot of cares. There was quite a gap of weights documented for R1. The weight should be obtained prior to eating and if staff could not get it, it would not be accurate after eating. LPN-A did not notify R1's physician of her refusals to obtain weights. During an interview on 1/8/25 at 9:53 a.m., LPN-B stated R1 refused weights a lot and residents have the right to refuse. LPN-B did not notify MD-A of weight refusals. During an interview on 1/8/25 at 12:46 p.m., registered nurse (RN)-A stated R1 had diagnoses of congestive heart failure and the care plan did not include goals/interventions for that diagnosis. During an interview on 1/8/25 at 11:55 a.m., nurse manager (NM)-A and Director of Nursing (DON) stated R1 had a lack of weights because she refused. NM-A stated the physician was not notified of R1's weight refusals from December 17-26, 2024. DON stated she would expect the notification, explanation of weight refusal in the resident progress notes, and dictation from provider. The facility did not have a protocol for when to notify the physician when prescribed weights were refused. DON stated edema would be monitored weekly with the skin checks unless ordered by a prescriber. NM-A explained if new edema was identified, she would review weights, SOB, any other symptoms and notify the provider of the change of condition. DON would expect the care plan to direct monitoring for signs/symptoms of congestive heartfailure. During an interview on 1/8/25 at 9:07 a.m., MD-A was not aware of the weight refusals. MD-A would expect some sort of notification on refusal of prescribed orders. MD-A indicated nurses were responsible to assess and monitor for signs and symptoms of fluid overload and notify the physician of changes. Further felt the frequency of edema monitoring along with other symptoms would be determined by nursing assessment and judgement. No policy was provided.