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	06/05/2025

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

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** Based on observation, interview, and document review, the facility failed to provide physician ordered dressing changes and assess wounds during those dressing changes, monitor for signs and symptoms of a worsening known infection, notify the physician of a change of condition and the need to acquire antibiotics from the E-Kit, acquire needed dressing change supplies, follow professional standards of practice by dating wound dressings and educate staff on identifying early signs and symptoms of sepsis (life-threatening infection) for 3 of 3 resident (R1, R2, and R3) reviewed. Findings include: Review of the current, National Library of Medicine, Sepsis: Early recognition and Optimized Treatment article, located at https://pmc.ncbi.nlm.nih.gov/articles/PMC6304323/, identified sepsis is a life-threatening condition caused by infection and represents a substantial global health burden. Systemic inflammatory response syndrome (SIRS) criteria is defined as having a patient with a suspicious or known infection with additional 2 criteria, such as a temperature above 100.4 or below 96.8 degrees Fahrenheit (F), a heart rate over 90 beats per minute (bpm) or a respiratory rate over 20 breaths per minute (bpm). A systolic blood pressure equal to or under 100 millimeters of mercury (mm/hg), respirations equal to or over 22 bpm, and altered mental status are indications of being likely to be septic. Clinical evidence indicates that patients with acute deterioration or sepsis manifest clinical signs or symptoms several hours before the condition worsens. Review of the current, National Library of Medicine, Understanding Post-Sepsis Syndrome: How Can Clinicians Help article, located at https://pmc.ncbi.nlm.nih.gov/articles/PMC10546999, identified sepsis is a global health challenge, with over 49 million cases annually. Recent medical advancements have increased in-hospital survival rates to approximately 80%, but the escalating incidence of sepsis, owing to an ageing population, rise in chronic diseases, and antibiotic resistance, have also increased the number of sepsis survivors. Subsequently, there is a growing prevalence of post-sepsis syndrome (PSS). This syndrome includes long-term physical, medical, cognitive, and psychological issues after recovering from sepsis. Around 75% of sepsis survivors develop at least one new medical, psychological, or cognitive diagnosis after hospital discharge. Only half of the sepsis survivors (both ICU and non-ICU) achieve complete or near-complete recovery within two years after hospital discharge. On the other hand, one in six patients experiences persistent impairments. As such, sepsis survivors are at risk for re-hospitalization, recurrent infections and chronic illness and have a shorter life expectancy, and lower quality of life. sepsis survivors have a significantly increased risk of cardiac events up to 5 years after the sepsis episode. Early administration of appropriate antibiotics remains the cornerstone of bacterial sepsis treatment and is essential for infection control, particularly if administered in the critical early hours. (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

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	06/05/2025

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

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	R1 Review of 5/21/25 at 10:19 a.m., report to the State Agency (SA) identified LPN-A neglected to complete wound care per orders. Review of the 5/23/25 at 2:31 p.m. 5-day investigation report identified R1 was interviewed. R1 stated she had not refused wound care. The nurse had told her that she did not have enough supplies. The investigation found Facility nursing staff counted dressing supplies and there were enough supplies to complete the dressing change until follow-up appointment the following day. R1's dressing was changed on 5/19/2025, she did not have the dressing changed on 5/20/2025, went to the wound clinic on 5/21/2025, when she returned, wound clinic had outlined the redness on her leg. During the night, the redness grew outside of the lines and pain increased, went into the ER for further evaluation. The facility found evidence of neglect when R1 verified that she did not refuse the treatment, and there were adequate supplies. LPN-A was immediately put on the do not return list, and supervisor was notified. There was no documentation to show the facility had notified the Minnesota Board of Nursing of their findings. R1's 5/01/25, admission assessment Minimum Data Set (MDS) identified R1 was cognitively intact. R1 had a history of chronic venous hypertension [CVH] (damaged valves in legs causing high blood pressure in the veins) of her bilateral lower extremities, severe sepsis with septic shock (life-threatening infection that leads to low blood pressure and organ failure that requires immediate medical intervention) and a non-pressure chronic ulcer of her right foot. R1 was dependent on staff for toileting, dressing, and transfers. R1 had 7 venous and arterial ulcers upon admission. R1 was not noted to have any behaviors. R1's undated, current care plan identified R1 was at risk for pressure injury related to chronic venous ulcerations, inflammation, history of cellulitis, soft tissue infection and chronic lower extremity edema. Interventions was for facility staff to identify/document potential factors related to skin breakdown, monitor/documents location, size and treatment of wound, report abnormal failure to heal, signs and symptoms of infection to physician and wound nurse, inform charge nurse of skin impairments when providing R1's care, wound treatments to be completed as prescribed by the physician, and apply [NAME] cream to good skin, Aquacel AG to wounds, and change the dressing daily. R1's 5/1/25 at 8:44 a.m., admission progress note related to the wound clinic's assessment and orders identified: 1) The 1st wound had an irregular shape and was located at the pretibial (inner lower leg next to the tibial bone) area. The wound measured 7.0 centimeters (cm) in length, 6 cm in width, and 0.2 cm in depth. Clinic staff noted there was no tunneling, no undermining, the wound bed had granulation (new tissue) with no odor, but had large serosanguinous (bloody clear) drainage and had redness. 2) The 2nd wound was a venous (originating from vein) ulcer non-staged wound. The wound measured 3 cm length, 8.5 cm in width, and 0.1 cm in depth, with no tunneling or undermining. Clinic staff noted there was granulation and exposed tissue, but no odor, and there was a large amount of serosanguinous drainage. (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 06/05/2025

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

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	3) The 3rd wound was a left lateral venous non-staged venous ulcer. The wound measured 4 cm in length, 6 cm in width, and 0.1 cm in depth. Clinic staff noted there was no tunneling, no undermining, had granulation with tissue exposed, no odor, a moderate amount of serosanguinous drainage, redness, maceration (when skin is in contact with moisture for too long) and was denuded (loss of epidermis caused by prolonged moisture and friction). Facility staff were ordered to use acetic acid (vinegar), Aquacel AG (anti-microbial silver impregnated dressing) as the primary dressing with an ABD pad (large gauze pad), Artiflex (soft foam dressing used as a wrap), a Rosidal dressing (soft compression bandage). In addition as a secondary dressing, staff were to use Lopress (elastic compression dressing) and ensure dressings were changed daily and as needed (PRN) for all wounds. R1's, May 2025 Treatment Administration Record (TAR) identified facility nurses was to complete skin/wound note on dressing changes daily. R1's medical record identified R1 had lacked skin/wound assessments and treatments on the following dates: 5/5/25, 5/12/25, 5/15/25, 5/16/25, 5/20/25 and 5/21/25. R1's wound assessments identified they were only done weekly on 5/8/25 and 5/14/25. Assessments were as follows: 1) 5/8/25: R1's right pretibial right leg venous ulcer was measured and assessed. It was noted to be 7.0 centimeters (cm) in length, 7.0 cm in width, and 0.2 cm in depth. Wound description included: wound had full thickness, copious serous drainage, maceration (wrinkled skin) and no odor. 2) 5/14/25, R1's right pretibial lateral venous ulcer was measured and assessed. Wound measurement was 7.0 cm X 9.0 cm X 0.2 cm depth (increase in size). Wound description included: wound bed had full thickness, granulation, copious serosanguineous drainage, maceration and no odor. There was no indication R1's physician was notified of the increase in size. There were no assessments conducted daily with dressing changes to identify if the wound had improved, worsened or stayed the same. Additionally, neither of R1's 2 other wounds were assessed during these weekly assessments. Further review of R1's progress notes identified on: 1) 5/18/25 at 4:43 p.m., R1 voiced concerns with staff of a shortage of absorbent pads for R1's dressing changes. The facility staff was to leave a message for supplies to be ordered with management and R1 was informed that the absorbent pads were on backorder. 2) 5/19/25 at 3:59 p.m., skin/wound note identified R1 had purulent (pus-like) drainage and a slight odor to R1's bilateral lower extremity (BLE). R1's right lower extremity appeared macerated (moisture related skin damage) and had 25% slough (layer of dead tissue) present. There was no indication staff had notified R1's physician of the changes in wound characteristics. 3) Later that day on 5/19/25 at 4:32 p.m., physical therapy (PT)-A noted R1 had increased drainage from her wound and bandage of the right lower leg. R1 had left PT prior to end of therapy in order for nursing staff to change R1's dressing. There was no indication staff had notified R1's physician of these additional changes in wound characteristics. (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	06/05/2025

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

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	4) 5/20/25 at 1:57 p.m., PT noted R1 had refused wound care related to supplies. Staff also noted the facility lacked supplies to be able to change R1's wound dressings. R1 also had severe pain that morning and was found yelling for help. There was no indication R1's physician or the wound clinic had been notified of the increased pain or lack of being able to perform the dressing change. 5) 5/20/25 at 22:43 p.m., R1's had no pain and BLE wounds was not assessed. 6) 5/21/25 at 11:19 a.m., R1 had left for her wound care appointment. Facility nurse was made aware that R1's right knee, above the dressing was warm to touch and pink. R1's knee was not assessed by nursing staff before R1 had left the facility. 7) 5/21/25 at 4:44 p.m., PT note R1 had significant drainage from right lower extremity and had refused for facility staff to complete dressing change prior to scheduled wound clinic visit. 8) 5/21/25 at 10:01 p.m., R1 arrived back to the facility at 5:30 p.m. R1's legs were wrapped, and the redness was outline with a sharpie. R1 had concerns with the infection of her legs. The medical record lacked evidence that a physical baseline assessment had been completed 4 hours after R1 had arrived back to the facility from the wound clinic. 9) 5/21/25 at 9:57 p.m., vitals were 124/60 millimeters of mercury (mm/hg) blood pressure, a temperature of 99.1 degrees Fahrenheit (F), and respirations at 20 breaths per minute (bpm). 10) 5/22/25 at 2:44 a.m., progress note identified R1 complained of pain, had received oxycodone, reported chills, had a declining temperature of 98.6 degrees F, felt ill and had requested to be send to the ED. No other vital signs were assessed to identify sepsis criteria by assessing R1's oxygen saturation, respiratory rate, heart rate, blood pressure, or assessment of her mental status were obtained. (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	06/05/2025

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

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	R1's 5/22/25, local hospital admission summary identified R1 had a history of chronic lower extremity edema (swelling) with chronic ulcerations since July of 2024 receiving long-term chronic wound care. She recently was admitted to a regional hospital from 04/17 /25 to 04/24/25 for care after fall and found to be in septic shock suspected from soft skin and tissue infection with acute kidney injury (AKI), severe metabolic acidosis (serious condition when pH level in blood is at life-threatening levels), elevated potassium levels in her blood, atrial fibrillation with rapid ventricular response (AFib with RVR) (potentially life-threatening heartbeat irregularity). R1 was note to be treated with vancomycin and cefepime and then transitioned to Zosyn (antibiotics). R1required a Foley catheter for urinary retention during her stay. She was discharged at that time to the facility for admission of short-term rehabilitation on Levaquin 750 mg every 48 hours and Flagyl 500 mg t.i.d. (antibiotics) for an additional 3 days. R1 presented to the local emergency department (ED) from the facility on 5/22/25 with worsening cellulitis (skin infection) to the right leg. She had just been seen in wound clinic 5/21/25. It was noted she had new cellulitis forming at that time. Overnight she developed increasing right leg pain and nursing noticed increasing redness that extended past the marked borders. R1 complained of cold chills without fevers recorded. In the ED, R1 had shaking chills with tachycardia (fast abnormal heart rate) and atrial fib in the low 100's. Laboratory results showed abnormal levels of hemoglobin (iron level) at 8.6 (normal 12.5 to 17), high white blood cell count of 25.4 (normal 0 to11,000), therapeutic INR, bicarbonate 19 (normal 22 to 32), BUN (waste product in blood) 32 (normal 7 to 20), creatinine 1.7 (measures kidney function) (normal 0.59 to 1.04) with GFR (kidney filtration rate) of 31 (normal 100), glucose 143 (normal 72-99), albumin (measures protein in blood plasma that keeps fluid from leaking into bloodstream) 3.2 (normal 3.4 to 5.4), CRP (measures inflammation) 281.3 (normal is less than 10), lactate (measures acidity in blood) 2.3 (normal 0.5 to 2.2). Blood cultures were pending. R1 received Tylenol, meclizine (anti-nausea medication), oxycodone (pain medication) 500 ml IV , Vancomycin IV and Zosyn (antibiotics) R1 was then transferred to the regional hospital for a higher level of care required. Interview on 6/03/25 at 11:28 a.m., with agency licensed practical nurse (LPN)-A had worked the morning of 5/20/25. R1 had orders for dressing change to be completed in the morning. LPN-A had identified R1complained of leg pain was administered pain medication and stated R1 did not want LPN-A to assess her wound. LPN-A noted she could not complete R1's dressing change due to the facility not having adequate supplies for R1's dressing and had communicated the lack of supplies to the facility's administration. LPN-A had not communicated to the director of nursing (DON) nor the provider that R1's dressing changed was missed and that R1 had severe pain. Interview on 6/03/25 at 12:12 p.m., with staffing coordinator (SC) identified resident supply list was created by the infection preventionist (IP) and sent to SC on a weekly basis to order supplies from the Medline manufacturer. SC was not aware R1 had shortage of dressing supplies but was aware facility staff was to communicate to SC if nursing items were low in stock. SC had received notifications from the supply company that supplies were delayed for delivery to the facility on several occasions. The SC stated they did not have a process in place to communicate to floor staff of delayed supplies to the facility. Interview on 6/03/25 at 12:18 p.m., with LPN-B identified residents with dressing orders was not communicated to LPN-B upon admission. The facility storage room on the 200 hall was used for nursing supplies and was accessible to facility staff when needed. LPN-B had kept a treatment cart of supplies for resident dressing changes in LPN-B office that was not accessible for staff on the weekends. LPN-B stated residents had designated supplies for dressing changes in their rooms that were to be refilled weekly. (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	06/05/2025

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

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	Interview on 6/03/25 at 1:31 p.m., with LPN-C identified newly admitted resident orders was placed on point click care (PCC), and online software for medical record and was to be viewed on the TAR. LPN-C had identified on two occasions that R1 lacked supplies for R1's dressing change and had to use alternative supplies to complete the dressing change. LPN-C had informed LPN-B and SC supplies were needed for R1's wound care. Interview on 6/03/25 at 3:03 p.m., with agency registered nurse (RN)-A had received report from LPN-A on 5/20/25 that R1's dressing change had not been completed. RN-A had identified R1 had no change in her condition that required a call to the physician during RN-A's shift. RN-A had assessed R1's pain, however, R1's dressing change was not completed nor was R1's wound assessed to identify any signs or symptoms of potential infection. Interview on 6/04/25 at 8:30am, with RN-B identified R1 was seen at the local wound clinic December 2024. R1 had scheduled visits twice a week and she noticed a decline in wound healing. R1 had voiced concerns to RN-B that the facility was not completing R1's dressing changes as ordered. On 5/21/25, the clinic had completed cultures of R1's wound and RN-B stated R1 appeared to have an infection. Antibiotic orders were written, and dressing change orders were noted. RN-B identified the nursing home was to provide supplies and follow the providers wound orders to ensure appropriate wound healing. Interview on 6/04/25 at 8:52 a.m., with RN-C had assisted with R1's wound dressing change on 5/21/25. RN-C identified R1's leg had severe redness and was outline with a blue surgical marker before R1 had left the wound clinic. Interview on 6/04/25 at 9:12 a.m., family member (FM)-A identified R1 had chronic issues with R1's leg wounds. FM-A would pick up R1 from the nursing home and transport her to the wound clinic, weekly. R1 was concern with R1's wound healing but did not share personal information with FM-A on R1's treatment plan. On 5/21/25, R1 was dropped off at the facility between 5:30 p.m. and 6:00 p.m. from the wound clinic. FM-A was not aware of the severity of R1's wound until the following day, when the nursing home and informed FM-A that R1's was sent to the ER for evaluation. Interview on 6/04/25 at 10:15 a.m., with licensed pharmacist identified the facility had faxed the pharmacy on 5/21/25 at approximately 6:07 p.m., of R1's antibiotic order from the wound clinic. The antibiotic was delivered to the facility on the evening of 5/22/25. The pharmacist identified the facility had a supply in the emergency (E-kit). For situations that warranted more immediate intervention, staff could call the provider and request to use medication from the E-Kit until such time as the medication would be available during routine business hours. Observation on 6/04/25 at 10:25 a.m., identified the facility had one uncontrolled and one controlled Ekit boxes. The box contained six tablets labeled doxycycline 100 mg and was available for use. Interview on 6/04/25 at 10:30 a.m., with LPN-C had worked the morning of 5/21/25 and identified R1 was in a wheelchair had worn basketball shorts and noted R1 had redness of her left lower leg. LPN-C notified LPN-D, who was R1's nurse of the redness. LPN-C had not communicated to R1's physician of the wound findings. (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	06/05/2025

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

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	Interview on 6/04/25 at 10:53 a.m., with LPN-D had worked the morning of 5/21/25 and identified R1 had scheduled dressing changes in the morning. LPN-D did not complete a dressing change on R1, because R1 had an appointment at the wound clinic. LPN-D had administered a pain pill prior to R1leaving the facility and did not have time to assess R1's leg when LPN-C had notified LPN-D of the change. LPN-D did not notify R1's physician during LPN-D shift of the findings. Interview on 6/04/25 at 1:41 p.m., with RN-D had worked the evening shift on 5/21/25. R1 arrived to the facility approximately at 5:30 p.m. and had not completed a baseline assessment. RN-D had received R1's wound and antibiotic orders and staff faxed them to the pharmacy. R1 had informed RN-D of the wound clinics findings for staff to monitor R1's leg for increase in her wound's redness and noted at the time of her visit, wound clinic staff had outlined the area with a marker. RN-D identified R1's leg was easy to observe and identified leg wraps were in place. RN-B stated indication of sepsis was a resident has a fever, an elevated blood pressure or confusion. The primary physician was to be notified of the change in condition. RN-D did not identify complications that would warrant a call to R1's physician, however she did state she failed to perform a baseline assessment for R1's wound after it had been deemed infected and had redness. Staff were to measure and monitor that redness. RN-D thought she had monitored R1 every 2 hours but indicated she failed to document any information of monitoring in R1's medical record. Interview on 6/04/25 at 2:48 p.m., with agency RN-E stated RN-D during handover communication reported R1 had visited the wound clinic that afternoon and had new orders. RN-E was not informed that R1's leg was to be monitored, nor had she viewed the orders. R1 had complained of severe pain. RN-E took her temperature had administered an oxycodone. R1 had complained of increase leg pain after the administration of the oxycodone. RN-E identified R1's leg was warm to the touch and had prominent redness passed the marked line on R1's leg indicated an infection. R1 appeared uncomfortable and had complained of increased pain in both legs. Only at that time had RN-E reviewed R1's wound orders and called for a non-emergent transport to the local hospital. The ambulance had arrived at the facility within approximately 45 minutes to transport R1 to the local hospital. RN-E had completed a physical assessment of R1's skin before R1 was discharged from the facility but agreed that was not documented in R1's medical record. Interview on 6/04/25 at 4:32 p.m., with licensed physical therapist (LPT) had seen R1 on 5/19/25 for a therapy session and identified R1's dressing was weeping. R1 was sent to her room and had informed R1's nurse that R1's dressing was to be changed. R1 was seen again on 5/21/25 and identified R1 had increase weeping of her dressing. R1 had refused for facility nurses to change the dressing and LPT had placed towels on the floor, during R1's therapy session, to prevent R1's drainage from leaking on the floor. Interview on 6/04/25 at 4:31 p.m., with agency LPN-E had worked the morning of 5/19/25. LPN-E was notified by the PT that R1 dressing was soiled. LPN-E had administered a pain medication to R1 before R1's dressing change that afternoon and did not place a date or initials R1's dressing once completed. LPN-E was aware R1's wound had a smell and odor during the dressing change. LPN-E and the DON had assisted R1 with her initial skin assessment and dressing change upon admit to the facility and identified R1's wound appeared to have no change in healing. LPN-E thought sepsis occurred when a resident had a fever and was unaware of specific criteria staff should monitor for to prevent sepsis from occurring and identify the need for immediate intervention. LPN-E identified R1 had no changes in behavior and appeared normal. LPN-E identified R1's physician had not been notified of the increase drainage or odor that was present. (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	06/05/2025

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

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	Interview on 6/05/25 at 10:48 a.m., with medical director (MD) expectation was for nurses to follow physician's orders, provide care, and document dressing changes. Nurses were to monitor for changes in condition and contact the resident's physician to determine the next steps and document the communication and interventions discussed. Staff should assess wounds at a minimum weekly, or with each dressing change to identify any changes. If, a resident was routinely seen at the wound clinic, the facility was to rely on the wound clinic orders and would be expected staff to update and follow the plan of care. If, there was an emergent need, leading to a potential problem that was to cause a resident to have a change in condition or altered level of consciousness staff were to call 911 for immediate assessment and exam by a provider in the ED. Interview on 6/05/25 at 1:46 p.m., with R1's primary physician (MD)-B identified they expected facility nurses to contact them or the wound clinic of the suspected findings of R1's increased wound drainage for recommendations and/or re-evaluation of R1's wound. In addition, facility nurses should have contacted the physician or the on-call provider for clearance to use the antibiotic medication that was ordered and use the supply in the E-Kit and not delay medication until the next day during routine pharmacy drop-off for a resident with a known infection and history of previous sepsis. MD-B stated a baseline assessment should have been completed for R1 when R1 had returned from the wound clinic on 5/21/25. Staff should have documented R1's physical assessment and monitor R1 to identify signs and symptoms of sepsis. Interview on 6/05/25 at 2:30 p.m., with director of nursing (DON) identified nurses was to complete scheduled dressing changes for residents on the day shift. If, dressing changes was not done during the document the details from that dressing change. R1's wound measurement and skin assessments were completed once a week on Mondays, with the DON and the nurse consultant on the unit. The DON did not document on R1's TAR when dressing changes were completed. Facility staff had received training related to infection control, but did not have training specific to signs and symptoms of sepsis development. Nurses were expected to complete a baseline assessment for R1 when R1 had returned from the wound clinic and was at risk for complications due to R1's infection of the wound. The DON identified the facility nurse on the evening shift of 5/21/25, should have called R1's provider and ask for an order to remove and administer the initial dose of antibiotic from the E-kit. The DON agreed nurses should have provided documentation to corroborate when nurses had assessed R1's wound to identify a potential spread of infection and to notify R1's physician if there was a potential decline in R1's condition. The DON stated it was a standard expectation for nurses to date and initial on all dressing changes, however, she was aware they found it difficult to write on the dressings with a pen. DON was not aware if the facility wound policy identified for dressings to be labeled once changed. R2 R2 undated, current face sheet identified R2 had a diagnosis of osteomyelitis (infection in the bone) of left tibia and fibula, anxiety, chronic pain syndrome, pressure ulcer of left ankle, cellulitis, dementia, and traumatic brain injury (TBI). R2 was on enhanced barrier (use of gown and gloves for healthcare workers to be used during high contact resident care) precautions. (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	06/05/2025

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

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	R2's 4/21/25, Significant Change Minimum Data Set (MDS) identified R2 had severe cognitive impairment and had little interest or pleasure in doing things, felt down, depressed or hopeless never to 1 day. R2 was 6 ft and 2 inches, weighed 180 lbs. in and was on hospice services. R2 was at risk for developing pressure ulcers and had a stage 1 or greater over bony prominence, or a non-removable dressing/device. R2 had two stage 4 pressure ulcers that was present on admission, one unstageable pressure ulcer due to coverage of wound bed by slough and/or eschar and one venous and arterial ulcer present. R2's undated, current care plan identified R2 was at risk for pressure injury related to current pressure and skin injuries ot the left lateral food, left posterior leg and ankle. Interventions was for facility nurses to apply lamb's wool in between toes PRN, barrier cream to buttocks after incontence episodes, blue boots to both feet for protection and comfort, use of air mattress, monitor/document location, size and treatment of wound, report abnormalities, failure to heal, signs and symptoms of infection, maceration to physician and wound nurse, reposition every 2 hours related to immobility and incontinence, administer scheduled pain medication before dressing changes, use of braden assessment, treatments to be completed as order by physician. R2's undated, current Order Summary Report of R2's wound treatment orders identified: 1) Left distal lateral foot deep tissue injury (DTI) pressure was to cleanse with wound cleanser, pat dry, apply calcium alginate, cover with foam border dressing every Monday, Wednesday, Friday, and PRN with a start date of 1/29/25. 2) Left lateral ankle- unstageable pressure ulcer and left lateral foot pressure DTI was to cleanse with wound cleanser, pat dry, apply calcium alginate, cover with foam border dressing every Monday, Wednesday, Friday, and PRN with a start date of 2/12/25. 3) Left posterior lower leg was to apply calcium alginate to open area with foam composite dressing every Monday, Wednesday, and Friday with a start date of 4/25/25. 4) Complete skin/wound note on wound dressing change days. R2's 4/21/25, braden scale identified R2 was high risk for pressure injuries. R2's 6/02/25, Wound Assessment identified R2's left lateral ankle was 3.0 cm in length, 2.0 cm in width, and 0.1 cm in depth. Wound description identified: had purulent, moderate amount of thick green drainage, no odor, 50% granulated tissues and 50% beefy pink tissue. Wound treatment identified: cleanse with wound cleanser, pat dry, apply calcium alginate, cover with foam border dressing every Monday, Wednesday and Friday. R2's left lateral distal foot was 3.5 cm in length, 0.6cm in width, and 0.1 cm depth. Wound description identified: was scant amount of thick green drainage, no odor and peri wound was dry with 100% granulation of tissue. Wound treatment identified: cleanse with wound cleanser, pat dry, apply calcium alginate, cover with foam border dressing every Monday, Wednesday and Friday. R2's left posterior calf was 2.0 cm in length, 1.0 cm in width, and 0 in depth. Wound description identified: was a superficial open area with no drainage or odor. Wound treatments identified: apply calcium alginate to open area with foam composite dressing and change every Monday, Wednesday, and Friday and PRN. (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	06/05/2025

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

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	R2's June 2025, Treatment Administration Record (TAR) identified R2 refused a dressing change on 6/04/24. R2's, progress noted identified on: 1) 6/4/25 at 10:38 a.m., R2 was due to have a wound dressing change. R2's wife stated R1 was to leave for the local emergency department (ED). Facility nurse had asked if R2 wanted the dressing change before R2 was transported out of the facility. R2 had refused the facility nurse to complete the dressing change. 2) 6/4/25 at 5:18 p.m., R2 was not transferred to the local ED, due to R2'S transportation service had not picked up R2 who was scheduled to leave at 1:00 p.m. R2 was notified by the facility nurse of R2's scheduled wound treatment was to be completed. There was no mention on R2's medical record that R2's dressing change was done. Observation and interview on 6/05/25 at 7:44 a.m., with LPN-D had applied hand sanitizer to her hands and rubbed them together. LPN-D grabbed a yellow isolation gown and applied it to LPN-D body and tied the personal protection equipment (PPE) behind LPN-D neck and waist. LPN-D applied gloves and had knocked on R2's door. LPN-D opened R2's door and informed R2 and R2's wife that LPN-D wanted to see the dressing on R2's legs. R2's wife and LPN-D grabbed R2's cover and LPN-D identified R2's dressing was changed the night prior on the evening shift and was not due for a dressing change today. LPN-D pulled back R2's covers R2's left lower leg had 3 areas that was covered with a brown foam dressing and R2' skin around the dressing appeared clean and intact. R2's left ankle, left lower leg and the lateral side of R2's leg did not have dates or initials when it was last changed. R2's wife identified R2's nurse on the evening shift on 5/04/25 had completed the dressing change and appeared surprised that R2's dressing was not dated. R2's wife stated, the nurses dated them when changed. R3 R3's undated, current face sheet identified R3 had a diagnoses of myasthenia gravis (autoimmune neuromuscular disorder that causes weakness in the skeletal muscles weakness), obesity, heart failure, and hypothyroidism (low production of thyroid hormone that leads to a slowdown in metabolism). R3 was on enhanced barrier precautions. R3's 4/