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	02/19/2025

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 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 50764 Based on observation, interview and document review, the facility failed to ensure most recent survey results were readily accessible for residents or visitors to view. This had the potential to affect all residents who resided in the facility and visitors. Findings include: During observation on 2/18/25 at 1:42 p.m., a black three-ring binder labeled Survey Results was observed in a hanging bin on a wall near the front entrance of the facility. The survey results in the binder were dated 9/14/2022. The results of the most recent federal recertification survey were not included. There was no posted information indicating any other results were available. During interview on 2/18/25 at 2:24 p.m., social services director (SS-A) verified the most current survey results were not in the binder and stated she would have to find them and put them in the binder. SS-A further stated she was unsure why the results were not in the binder and they were not posted anywhere else in the facility for residents or visitors to access. During interview on 2/19/25 at 1:40 p.m., administrator stated he was unaware the most recent survey results were not in the binder for residents and visitors to view and they should have been available. No policy regarding posting of survey results was provided.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44630 Based on observation, interview, and record review the facility failed to assess the ability to safely operate power lift reclining chair and develop and implement policies and procedures related to the operation/use of power lift chairs for 1 of 1 (R137) resident reviewed for accidents. R137's admission Minimum Data Set (MDS) dated [DATE], indicated R137 was admitted to the facility on [DATE], no cognitive impairment, utilized a wheelchair, dependent on staff for toileting, lower body dressing, toilet transfer, sit to stand, chair transfer; required substantial/maximal assistance with personal hygiene, roll left to right, sit to lying and diagnoses included need for assistance with personal care, obesity, and surgery on the digestive system. R137's care plan dated 2/5/25, indicated history of falling, unsteady on feet, difficulty walking and interventions dated 2/19/25, indicated lift chair assessment completed; care plan revision on 1/31/25, bed in lowest position, call light within reach at all times, fall 2/14/25, R137 was reeducated on the importance of using call light for assistance; fall risk assessment completed 1/27/25, moderate risk for falls. R137's document titled Fall dated 2/14/25, indicated R137 was found on the floor in her room at 2:45 a.m., lying on her right side when found near her recliner .call light was attached to recliner and was not on, footrest in the up position, R137 stated she slid to the floor as she was trying to reposition herself in recliner. IDT (interdisciplinary team) met and R137 was reeducated on the importance of using call light for assistance. R137's document review failed to indicate R137 was assessed for the ability to safely operate the power lift reclining chair. On 2/18/25 at 3:25 p.m., R137 was seated in a power lift recliner in her room, the recliner was observed with a remote connected. R137 stated she used the remote to put the feet of the recliner up and down. On 2/19/25 at 9:05 a.m., physical therapy assistant (PTA)-C stated nursing was responsible to complete a resident's electric lift chair initial assessment. PTA-A stated R137 had communicated she had slid from the lift chair and was not injured. PTA-A stated physical therapy was currently working with R137 for strengthening. On 2/19/25 at 9:08 a.m., registered nurse (RN)-A, also known as the nurse manager, stated a resident's electric lift chair and recliners were expected assessed by a RN at the facility. RN-A stated herself or the director of nursing (DON) were responsible for the residents lift chair assessments. RN-A confirmed R137 did not have a lift chair assessment completed. RN-A stated the lift chair was not expected in R137's room or used by R137 until an assessment was completed. RN-A stated R137 had slid out of her electric recliner and was not injured. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/19/25 at 9:10 a.m., the DON stated any RN was responsible to ensure a resident had a lift chair assessment completed prior to the resident using the electric lift chair. The DON stated the assessment was expected completed in the electronic medical record (EMR). The DON confirmed R137 had slid out of the recliner when she was trying to reposition, and an assessment was not done at that time either to ensure R137 was safe to use the electric lift chair. The DON stated the intervention implemented after R137's fall included reeducation on the importance of using the call light. On 2/19/25 at 9:14 a.m., RN-A observed R137's chair and confirmed the chair was an electric lift chair. R137 was seated in the recliner and stated she was not educated on the use of the recliner, further stated she slid out of the recliner and was not hurt, and R137 stated after she slid from the chair nursing educated her to use her call light to reposition. On 2/19/25 at 11:12 a.m., the DON stated the facility did not have a policy on lift chairs. Facility admission packet included, Recliners and lift chairs may need to be looked at on an individual basis due to room lay out equipment needed for your loved one. Lift chairs-residents using these need to be assessed by nursing/therapy to determine if you are to use this.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42073 Based on interview and record review, the facility failed to develop a Quality Assurance and Performance Improvement (QAPI) plan to guide facility efforts in assuring care and services were maintained at acceptable levels of performance and continually improved. This had the potential to affect all 38 residents residing in the facility. Findings include: During entrance conference on 2/18/25 at 11:25 a.m., with the administrator and director of nursing (DON), the facility QAPI plan was requested. During an interview on 2/19/25 at 3:00 p.m., the QAPI plan was requested again. The administrator stated the facility did not have a written QAPI plan. The administrator presented a template from TMF Quality Innovation Network, titled Quality Improvement Initiative Plan, which he intended to use to develop the facility QAPI plan but had not done so yet. During an interview on 2/19/25 at 3:20 p.m., the administrator and director of nursing (DON) stated they were both responsible for QAPI program at the facility. The DON stated following recent citations, the QAPI committee was meeting monthly, setting goals, and coming up with measurable outcomes, with falls and pressure wound management being their current performance improvement projects (PIP). The DON and administrator were able to describe work being done for falls, and the DON was able to describe work being done for pressure wounds. The administrator stated he was planning to take an executive management class through a state organization of aging services providers serving older adults to learn more about QAPI. A QAPI plan was requested and a QAPI Program policy was received, updated 10/2024. The policy indicated the administrator was responsible for assuring the facility QAPI program complied with federal, state, and local regulatory requirements. The policy did not include how the facility obtained and used feedback from residents, resident representatives, and staff to identify high-risk, high-volume, or problem prone issues as well as opportunities for improvement. The policy did not indicate how the facility would maintain effective systems to identify, collect, use and monitor data for all departments, and based on the facility assessment. The policy did not identify how the facility would identify, report, track, investigate and analyze adverse events, and high risk, high volume, and/or problem-prone concerns. The policy did not indicate how the facility would develop, monitor and evaluate performance indicators including the frequency of which that would be conducted. The policy did not indicate how the facility developed, monitored, and evaluated its performance indicators. The policy did not describe how the facility would use systematic approaches (such as root cause analysis, reverse tracker methodology, or health-care failure and effects analysis) to assist in determining underlying causes of problems impacting larger systems. The policy did not describe how the facility developed corrective action designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems. The policy did not describe how the facility monitored the effectiveness of its performance improvement activities to ensure improvements are sustained. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Facility assessment dated [DATE], did not indicate how the QAPI program integrated with the facility assessment.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 50764 Based on observation, interview, and record review the facility failed to ensure Centers for Disease Control (CDC) guidance was followed for fit testing for N95 filtering facepiece respirators prior to use and annually. Findings include: During observation on 2/18/25 at 11:49 a.m., the facility had signs posted on the front entrance door indicating mask use required due to respiratory outbreak. During observation and interview on 2/18/25 at 12:35 p.m., housekeeping assistant (H-A) was observed putting an N95 mask over a regular surgical mask prior to entering a resident room requiring N95 use due to Covid isolation. H-A stated he was not aware of having fit testing for the N95 mask. During observation and interview on 2/18/24 at 5:40 p.m., nursing assistant (NA)-A was observed putting on an N95 mask to enter a resident room requiring N95 use due to Covid isolation. NA-A stated she could not recall if she had completed fit testing for the N95 respirator. During interview on 2/19/25 at 1:12 p.m., licensed practical nurse (LPN)-A stated she had been fit tested in the past, but did not recall if it was at this facility or with her previous employer. During interview on 2/19/25 at 1:37 p.m., licensed practical nurse (LPN)-B also known as infection preventionist stated the facility had two Power Air-Purifying Respirators (PAPRs), one for each hallway, and those were expected to be worn in the rooms requiring precautions due to Covid. LPN-B stated she does not have staff complete fit testing at the time of hire or annually, and only completes on-the-spot testing when requested by staff. LPN-B further stated staff wearing N95 respirators should be fit tested for them prior to use to ensure a tight seal and staff safety. During interview on 2/19/25 at 2:16 p.m., director of nursing (DON) stated she would have expected staff entering Covid isolation rooms to have been fit tested for N95 mask use prior to using the N95 mask. DON further stated she was aware of the PAPRs but was not sure what the plan was for them or how the infection preventionist intended them to be used. During observation on 2/18/25 and 2/19/25, no PAPR use was observed in the facility. During observation and interview on 2/19/25 at 2:12 p.m., NA-B and NA-C were observed putting on N95 masks to enter a resident room requiring N95 masks due to Covid isolation. NA-B and NA-C both stated they had not ever been fit tested for an N95 mask. Further, NA-B and NA-C stated they were not aware of a PAPR in the facility and had not had training on PAPR use. An untitled facility document provided 2/21/25, included a section for staff to decline fit testing and choose the risk of exposure, but did not identify those risks. The facility policy titled Coronavirus Disease (Covid-19)-Occupational Health dated 10/2024, stated the following: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Facility practices are in place to protect Healthcare personnel from exposure to Covid-19 to the extent possible, in accordance with Occupational Health and Safety Administration (OSHA) and Center for Disease Control and Prevention (CDC) recommendations. Employee safety and health standards related to Covid-19 are based on the following guidance: https://www.osha.gov/SLTC/covid-19/healthcare-workers.html. Review of the above referenced link from the facility policy directed use of respiratory protection as part of a comprehensive respiratory protection program that meets the requirements of OSHA's Respiratory Protection standard (29CFR 1910.134) and included medical exams, fit testing, and training. The CDC National Institute for Occupational Safety and Health guidance sheet publication number 2018-129, indicated fit testing must be completed upon initially selecting a model of respirator, annually, and repeated whenever an employee has a change in physical condition that could affect respirator fit.