Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 13, 2024

Administrator
Avera Morningside Heights Care Center
300 South Bruce Street
Marshall, MN 56258

RE: CCN: 245228
Cycle Start Date: October 30, 2024

Dear Administrator:

On October 30, 2024, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

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

DEPARTMENT CONTACT

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

Nicole Dahl, RN, Regional Operations Supervisor
Marshall District Office
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by January 30, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by April 30, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

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November 13, 2024

Administrator
Avera Morningside Heights Care Center
300 South Bruce Street
Marshall, MN 56258

Re: State Nursing Home Licensing Orders
Event ID: 9X4M11

Dear Administrator:

The above facility was surveyed on October 28, 2024 through October 30, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Nicole Dahl, RN, Regional Operations Supervisor
Marshall District Office
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245228	A. BUILDING _____ B. WING _____	C 10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MORNINGSIDE HEIGHTS CARE CENTER	300 SOUTH BRUCE STREET MARSHALL, MN 56258

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 10/28/24 through 10/30/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 10/28/24 through 10/30/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H52289821C (MN107372) and H52289822C(MN106935). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 677	ADL Care Provided for Dependent Residents	F 677		11/25/24

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

Electronically Signed | 11/19/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 677 SS=D	Continued From page 1 CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure hand hygiene was provided to 1 of 1 resident (R21) prior to mealtime and during morning cares and required staff assistance. Findings include: R21's quarterly Minimum Data Set (MDS) identified R21's cognition was severely impaired, she had continuous inattention and disorganized thinking present. She required set up assistance with eating and was dependent on staff for all other cares. R21 was incontinent of bowel and bladder. R21 had diagnoses of Alzheimer's disease, dementia, anxiety, and depression. R21's 5/10/24, care plan identified she had difficulty making needs known and she was rarely understood. She has a diagnosis of Alzheimer's disease and and Vascular dementia. R21 required her food to be cut up and she needed staff assistance. The nurtion assessment noted resident should not have silverware. Interview on 10/28/24 at 4:21 p.m., with family member (FM)-D identified there were concerns R21 was not getting her fingernails trimmed. FM-D states that R21 ate with her hands and at times had been known to put her hands down her pants.	F 677	Hand Hygiene not provided to resident prior to eating meal Direct education on resident hand hygiene given to staff working on unit on 10/29/24 by nurse manger. LTC Certified Nursing Assistants, Trained Medication Aides, Licenses Nursing Staff, and Activities will complete resident hand hygiene education on November 21st, November 22nd, or November 25th of 2024. The DON/Designee will complete 5 observations a week for 4 consecutive weeks on resident hand hygiene when at 100 % Observations will transition to 5 a month for 2 months. Results of audits completed will be reviewed at the facility QAPI meeting and regularly scheduled nurse and aide meetings to review results and develop action plans as needed. Date of Correction: 11/25/24 Responsible for correction: Director of Nursing	

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F 677	Continued From page 2 Observation on 10/28/24 at 5:28 p.m., of staff assisting R21 identified R21 had come from the common area where she had been seated in the recliner. Her hands were on the recliner and then placed on the EZ stand by staff as they moved her to the wheelchair. R21 placed her hands on the wheelchair arms and was wheeled to the dining room table. There was no observation of hand hygiene assistance despite R21 touching the recliner, wheelchair, and table area. R21 was provided with a grilled cheese "ripped" into pieces along with a bowl of grapes. R21 used both hands to feed herself the sandwich pieces and eat the grapes. Intermittently, R21 was observed touching her wheelchair, pushing herself away from the table with her hands, then pushed back in by staff, where she resumed eating. While she ate, R21would set one hand on the tabe to rest and then would use that same hand again to feed herself. R21 alternates using each hand. R21 nails were observed to be longer that the finger and had some darker debris under the nails. It is unclear the dark debris was food particles or other contaminants. Observation on 10/29/24 at 12:58 p.m., R21 during meal service identified she was at the table using her hands to eat a take-out meal the facility ordered-in for residents. She had orange chicken and noodles. There were chunks of chicken all over her bib and it appeared she struggled to pick up the noodles as they were hard to pick up with her hands. There was no silverware there and no staff assisting. During an interivew with (NA)B 10/29/24 at 1:27 p.m., she shared that R21 is only allowed one dish as she will get confused and she is not	F 677		

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F 677	Continued From page 3 provided with silverware.She is set up with the dish and R21 eats with her hands. Observation on 10/30/24 at 9:52 a.m., of nursing assistant (NA)-A completing morning cares with R21 in the bathroom where NA-A washed R21's face, her back, under her arms, and lastly her personal area. NA-A did not wash R21's hands during morning cares before leaving R21's bathroom and room. NA-A then proceeded to take R21 to the dining room for breakfast. NA-A obtained R21's breakfast and placed it in front of her at the table. She was provided scrammbled eggs, bacon, and a pastry with a glass of juice. R21 was encouraged to start to eat. No staff provided hand hygiene to R21 prior to her eating her meal. R21 was placed in her wheelchair and NA-A proceeded to assist with dressing, pulling her arms through the holes, but grabbing her hands. Once dressed, NA-A pushed R21 to dining room as R21 placed hands on the wheelchair arm rests. NA-A stated they wash wheelchairs once a week. Interview on 10/30/24 at 10:20 a.m., with NA-A revealed she normally only washed R21's hands with a wipe or washcloth after she eats as that is when R21 has dirty hands. NA-A confirmed she had not washed R21's hands during morning cares or prior to her being served her breakfast. Therefore, R21 went from bed, hands in sheets (which were changed while R21 was in bathroom), to dining room, to eating with her hands withouth having any hand hygiene. Interview on 10/30/24 at 3:21 p.m., with nurse supervisor (NS)-A identified her expectation was that staff would provide hand hygiene to residents who are dependent for cares, prior to meals, after	F 677		

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F 677	Continued From page 4 toileting, and as needed throughout the day. Review of 11/21/23, Hand Hygiene policy identified staff were to encourage residents to perform hand hygiene before activities, before eating, and after using the rest room. R21 is dependent on staff for all ADL's.	F 677		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure appropriate infection control technique was followed during 1 of 1 meal service. This had the potential to affect all 20 residents residing on the Gardens unit. Findings include:	F 812	Gloves not changed cross-contamination. Facial Hair uncovered Direct education of proper hand hygiene, glove use, and facial hair education give to staff working on 10/29/24. Dietary aids will be educated on proper hand hygiene, glove use, and facial hair	11/25/24

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F 812	Continued From page 5 Observation on 10/28/24 of the supper meal served on the Gardens unit identified at: 1) 5:30 p.m., it was noted The meal being served by cook-A. During serving of the meal, cook-A demonstrated multiple incidents of potential cross-contamination and lack of appropriate hand hygiene as he plated the meal for residents. Cook-A was noted to have facial hair that was uncovered as he was dishing food items from the steam table and moving about the kitchenette, obtaining various food items and placing them onto plates. 2) 5:32 p.m., cook-A returned to the steam table wearing the same gloves with which he had opened cabinets to retrieve serving items, and opened the refrigerator and freezer doors to obtain items to place onto trays. Upon returning to the steam table, cook-A placed a plate on the counter in front of the steam table, picked up a grilled cheese sandwich with his same gloved hands, place it onto the plate, used a knife to cut the sandwich, and separated the half's with his gloved hands. He then picked up a bowl and ladled soup into the bowl and placed it onto the plate between the sandwich halves. He then turned to a counter behind him and dished up coleslaw into a cup and placed it onto the tray. While still wearing the same gloves, cook-A opened the freezer, and moved a cardboard box with his gloved hand to obtain an ice cream sandwich. He then brought the sandwich to the serving line and placed it on the tray. The meal was then delivered to the resident by dietary staff. 3) 5:33 p.m., cook-A was still wearing his same contaminated gloves. Cook-A went to a cabinet, opened the cabinet, obtained a divided plate, placed it on the steam table and continued the same process.	F 812	covering through the AveraLearn Hand Hygiene Education Module. The Dietary Manager/Designee will complete 5 observations a week for 4 consecutive weeks on staff hand hygiene/glove use. when at 100 % Observations will transition to 5 a month for 2 months. The Dietary Manager/Designee will complete 5 observations a week for 4 consecutive weeks on proper facial coverings. when at 100 % Observations will transition to 5 a month for 2 months. Results of audits completed will be reviewed at the facility QAPI meeting and regularly scheduled nurse and aide meetings to review results and develop action plans as needed. Date of Correction: 11/25/24 Responsible for correction: Director of Nursing	

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F 812	Continued From page 6 4) 5:34 p.m., still wearing his unchanged gloves, he moved to a clipboard lying on the counter, and picked up a pen and made a notation. Still with no glove change or hand hygiene cook-A repeated the same process of handling sandwich's with his gloved hands, and then touching cabinets, the refrigerator and various other items on the counter. 6) 5:38 p.m. cook-A continued serving wearing his unchanged gloves, as he dished a bowl with Cole slaw with his thumb inside the dish coming in contact with the with Cole slaw, he wiped his hand on a napkin and turned to write a note on the clip board. 7) 5:40 p.m. cook-A picked up a small bowl, that had a black mark on the inside, he touched the black area, which did not rub off and stated it looked like ink, he set the bowl aside and continued to serve food , no hand hygiene or glove change. Cook A was also observed to be a wearing a braided bracelet on his right wrist, (uncovered by his glove), as he reached into the steam table to pick up sandwich's. 8) 5:48 p.m. cook-A continued serving the supper meal continuing the same repeated process with no glove change or hand hygiene performed. 9) 5:55 p.m. a resident indicated she did not want the meal being served and indicated she would like a cheese burger and chips. Cook-A removed his gloves, left the kitchenette and went to the main kitchen where he obtained a burger patty in a container. He returned to the kitchenette, put on new gloves without performing hand hygiene. He placed the burger patty to the microwave, reporting the temperature needed to be at 150 F for beef. Cook-A removed gloves while microwave the patty for the second time. When the microwave sounded he removed the burger from the microwave and checked the	F 812		

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F 812	Continued From page 7 temperature which was at 145 F, cook-A again returned the burger to the microwave and heated again. On the third time microwave the burger the temperature was at 160 F, and cook-A applied gloves, retrieved a bun from a plastic package, opened the refrigerator and obtained a package of cheese slices, which he separated with his gloved hands and placed a slice on the burger patty. Cook-A again opened the refrigerator, picked up a bottle of catsup with his same gloved hands, squirted some on the burger and replaced the bottle in the the refrigerator and closed the door. Throughout the process of preparing the burger cook-A neither changed his gloves or performed any hand hygiene. Cook-A set the plate on the counter, opened a cabinet, and reached into a box to retrieve a package of potato chips which he opened and placed on the plate with the burger and served to the waiting resident. Cook-A then removed his gloves and indicated he was finished serving. Interview on 10/28/24 at 6:04 p.m. with cook-A identified he did not think he needed to use a facial hair covering because he kept his facial hair cut short. When asked about glove changing and hand hygiene he reported he did not realize he had not changed his gloves between tasks during the meal service when he needed to retrieve items not at the serving line. Cook-A reported he had received education on infection control practices, and reported he should have been changing his gloves and washing his hands between touching surfaces and food items. Interview on 10/29/24 at 8:32 a.m. with the dietary manager (DM) reported her expectation for a person serving food, to change gloves and perform hand hygiene when they touched food	F 812		

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	245228	A. BUILDING _____ B. WING _____	C 10/30/2024

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F 812	Continued From page 8 and then touched other items in the kitchen or area, and returned to touching food items. She also reported she was not aware of the need to cover facial hair. Review of the October 2024 LTC Food Safety and Sanitation Policy identified gloves were to be worn when handling ready to eat foods. Gloves were to be changed anytime a contaminated surface was touched with handwashing performed after removing the soiled gloves and prior to applying a new pair. Hair was to be restrained with hairnets, hats and/or beard restraints. Hair restraints were to be worn when preparing or serving of food items.	F 812		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment	F 880		11/25/24

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F 880	Continued From page 9 conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of	F 880		

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F 880	Continued From page 10 infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to appropriately discard personal protective equipment (PPE) after use inside the resident's room and perform appropriate hand hygiene with soap and water, and put on new gloves when carrying infection waste to the soiled utility room for 1 of 2 residents (R12) with a highly infectious disease (Clostridium Difficile (C-Difficile)). This practice had the potential to affect 8 of 73 residents who resided on the wing. Furthermore, the facility failed to ensure Enhanced Barrier Precautions (EBP) PPE use was followed for 1 of 1 resident (R19), who had an open scalp wound due to a drug resistent bacteria. That had the potential to affect 18 of 19 other residents who resided on that wing. The facility also failed to ensure gloves were discarded and hand hygiene occured after touching multiple surfaces and before administration of an eye ointment for 1 of 1 resident (R32) during medication pass observation. R12 Review of the 4/3/24, US Centers for Disease Control and Prevention (CDC) Transmission-Based Precautions guidelines, located at https://www.cdc.gov/infection-control/hcp/basics/transmission-based-precautions.html, identified staff were to use Contact Precautions for patients with known or suspected infections that represent	F 880	Infection preventionist provided verbal real time education on hand hygiene with C-Diff to staff working on 10/29/2024, and 10/30/2024. Avera C. Difficle Education module number- Avera286 via the Avera Learning Center deployed to all LTC Certified Nursing Assistants, Trained Medication Aides, Licensed Nursing Staff, and Activities on with completion date by November 25th. Avera C. Difficle Education module number- Avera286 via the Avera Learning Center added to annual education training schedule for LTC Certified Nursing Assistants, Trained Medication Aides, Licensed Nursing Staff, Activities by their leader, to be completed by 11/25/2024. LTC Certified Nursing Assistants, Trained Medication Aides, Licenses Nursing Staff, and Activities will complete hand hygiene and proper donning and doffing of Personal Protective Equipment on Transmission Based Precaution education on November 21st, November 22nd, or November 25th of 2024. The Infection Preventionist/Designee will complete 5 hand hygiene knowledge checks a week for 4 weeks on use of soap and water on white contact precautions. Once at 100% will transition to 5 a month for 2 months.	

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F 880	Continued From page 11 an increased risk for contact transmission by: 1) Using PPE appropriately, including gloves and gown. Staff (and visitors) were to "wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment. Donning [putting on] PPE upon room entry and properly discarding before exiting the patient room is done to contain pathogens". Review of the 3/5/24, CDC: C. Diff: Facts for Clinicians guidelines, located at https://www.cdc.gov/c-diff/hcp/clinical-overview/index.html#:~:text=If%20a%20patient%20has%20had%20three%20or%20more,Reassess%20appropriateness%20of%20antibiotics%20in%20C.%20diff%20patients, identified: 1) "C. diff sheds in feces. Any surface, device or material that becomes contaminated with feces could serve as a reservoir for the C. diff spores. C. diff spores can transfer to patients by the hands of healthcare personnel who have touched a contaminated surface or item". 2) Staff were to "wear gloves and a gown when treating residents with C. diff, even during short visits. Gloves are important because hand sanitizer doesn't kill C. diff". R12's quarterly Minimum Data Set (MDS) dated 8/7/24, indicated R12 had moderate cognitive impairment and required extensive assistance with toileting hygiene. R12's Hospital Discharge Summary dated 9/30/24, identified R12 was hospitalized from 9/27/24 to 9/30/24, for sepsis (life threatening infection) secondary to C. difficile colitis (inflammation in the intestines). R12 presented from the facility with 1 to 2 weeks of diarrhea, and hospital stool studies were positive for C. difficile.	F 880	The DON/Designee will complete 5 observations a week for 4 consecutive weeks on Donning and Doffing Personal Protective Equipment when at 100 % Observations will transition to 5 a month for 2 months. Results of audits completed will be reviewed at the facility QAPI meeting to review results and develop actions plan as needed. failure to ensure clean gloves with administration of eye ointment. all licensed nursing staff and Trained Medication aides will complete competency on eye medication administration that include proper hand hygiene and glove use November 21st, November 22nd, or November 25th, 2024. The DON/Designee will complete 5 observations a week for 4 consecutive weeks on proper use of gloves with administration of eye medication when at 100 % Observations will transition to 5 a month for 2 months. Results of audits completed will be reviewed at the facility QAPI meeting to review results and develop actions plan as needed. Appropriate DONN PPE with enhanced barrier precaution All LTC staff will complete Avera learning module on Enhanced Barrier Precautions-Avera1758 by November 25th ,2024 and completed annually. LTC Certified Nursing Assistants, Trained Medication Aides, Licenses Nursing Staff, and Activities will complete education proper donning and doffing of Personal Protective Equipment on Enhanced	

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F 880	Continued From page 12 Observation on 10/28/24 at 12:47 p.m., a "Contact Enteric Precautions" sign was posted on the outside of R12's door. Also outside R12's door was a container for PPE and a waste bin. Observation and interview on 10/28/24 at 12:54 p.m., with nursing assistant (NA)-C exiting R12's room identified NA-C removed their gloves and gown in the hallway outside R12's room into a waste bin. Without removing her PPE inside the room as appropriate or washing her hands, NA-C gathered the full bag of trash from the trash bin with her bare hands and disposed of it in the soiled utility room. NA-C exited the soiled utility room and used alcohol-based hand rub (ABHR) from the touch-less wall unit on her hands. When NA-C was asked if soap and water had been used after caring for R12, NA-C stated, "No, I used sanitizer". NA-C further stated staff only needed to wash their hands with soap and water after hand sanitizer had been used 3 times. It was facility practice to have all PPE discarded outside a resident's room. Interview on 10/28/24 at 3:11 p.m., infection preventionist (IP) identified staff were expected to use soap and water for hand hygiene after caring for a resident with C. difficile, and because C. difficile was a spore releasing bacteria. Hand sanitizer would not kill the microbes completely as it does not kill the bacteria. Soap and water was most effective at prevention of transmission. Review of the 3/14/23, Nurse-driven Protocol for Screening Hospitalized Patients for Clostridium Difficile Infections policy identified C. difficile spores could survive for long periods of time in the environment, and the bacteria could be	F 880	Barrier Precaution education November 21st, November 22nd, or November 25th of 2024. The DON/Designee will complete 5 observations a week for 4 consecutive weeks on Donning and Doffing Personal Protective Equipment when at 100 % Observations will transition to 5 a month for 2 months. Results of audits completed will be reviewed at the facility QAPI meeting to review results and develop actions plan as needed. Results of audits completed will be reviewed at the facility QAPI meeting and regularly scheduled nurse and aide meetings to review results and develop action plans as needed. Date of Correction: 11/25/24 Responsible for correction: Director of Nursing	

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F 880	Continued From page 13 transmitted to others through contact with the contaminated environment and equipment or indirectly on unwashed hands of health care workers. Review of the 11/21/23, Hand Hygiene policy identified staff were to complete hand hygiene with soap and water, not alcohol-based hand rub (ABHR), after caring for a resident with known C. difficile. R19 R19's 8/21/24, Significant change Minimum Data Set (MDS) assessment identified R19 had severe cognitive impairment, She required total assistance with activities of daily living (ADLS), and was transferred with a sling type lift. R19's printed diagnosis list identified aphasia (a language disorder that affects communication), a surgical wound (complex wound of head with avulsive loss of part of skull and cranial contents-non healing), osteomyelitis (bone infection) of the skull, hemiplegia (paralysis of one side of the body), diabetes, bowel and bladder incontinence, and had been admitted to Hospice services with a terminal diagnosis of respiratory failure with hypoxia. Observation on 10/28/24 at 3:15 p.m. of R19's door identified a bright green sign posted which identified she was on EBP. Staff and visitors must clean their hands before entering and when leaving the room. Providers and staff must also wear gloves and a gown for all the following high-contact resident care activities such as dressing, bathing/showering, transferring, changing linens, providing hygiene, changing	F 880		

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F 880	Continued From page 14 briefs or assisting with toileting, device care/use, wound care-any skin opening requiring a dressing, or therapy involving high-contact. Observation on 10/29/24 at 12:31 p.m. when trained medication aide (TMA)-A and nursing assistant (NA)-B retrieved the sling lift and prepared to transfer R19 from her recliner to her bed and then to check and change her incontinent brief. Both TMA-A and NA-B entered the room wearing gloves but no gowns, as indicated by the precautions listed on the door. NA-B retrieved the lift sling and with TMA-A's assistance, shifted R19 forward to place the sling behind her and then beneath her legs. R19 was resting her body against NA-B as she was shifted forward. TMA-A had visible contact against her uniform as she positioned the sling around R19. R19 was then transferred onto her bed. The sling was removed by turning R19 from side to side. NA-A removed R19's pants and change her wet brief . Both NA-A and TMA-A changed their gloves and R19 was redressed. Staff then left R19's room and performed hand hygiene. Interview on 10/29/24 at 12:41 p.m. with NA-B and TMA-A reported R19 was on EBP due to her open head wound and when asked about the sign posted on the door, both NA-B and TMA-A reported they should have been wearing gowns when they provided R19's personal care, but stated they had forgotten. Observation and interview on 10/29/24 at 12:51 p.m. with registered nurse (RN)-A identified staff should have been wearing a gown when transferring and performing brief changes. She reported the sign posted on the door identified both gown and gloves were to be used while	F 880		

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F 880	Continued From page 15 providing cares. Interview on 10/29/24 at 1:35 p.m. with the infection preventionist reported EBP was to be in place for residents with any open wounds, lines, drains, with a history of a multi-resistant organisms (MDRO). Staff were expected to use appropriate PPE as indicated on the signage. She reported education on EBP's had been included in the May 24 annual in-service, and reviewed recently. Interview on 10/29/24 at 1:50 p.m. with the director or nursing (DON) confirmed her expectation was for staff to comply with use of PPE when performing personal care for a resident on EBP and that all staff had received training on infection prevention and EBP. Review of the November 2023, LTC-Transmission Based precautions (TBP) and enhanced barrier precautions (EBP) policy identified EBP was utilized when staff were providing high-contact resident care. EBP precautions were to be utilized when a resident had an MDRO with wounds that require dressings, indwelling medical devices such as a central line, a urinary catheter, a feeding tube or a tracheostomy (tube in throat used for breathing). A gown and gloves were indicated when assisting with dressing, bathing/showering, transferring, providing hygiene activities, changing linens, changing briefs or toileting, device care, wound care and therapy services. EBP were indicated to be used throughout a resident's stay in the facility unless the wound heals, the device is no longer used, and the IP had been consulted.	F 880		

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F 880	Continued From page 16 R32 R32's October 2024, Medication Administration Record (MAR) identified R32 was to be administered erythromycin 0.5% ophthalmic eye ointment. Observation and interview on 10/30/24 at 8:12 a.m., with licensed practical nurse (LPN)-A during medication administration identified she put on gloves (donned) gloves, opened the drawer of the medication cart, removed R32's blister packs of medication, and placed them into a medication cup. With her gloved hands, LPN-A placed the blister packs into the drawer, opened another drawer and took out a tube that contained erythromycin (antibiotic) eye ointment. LPN-A then closed the drawer, locked the medication cart, and walked down to R32's room. LPN-A knocked on the door, opened it, sat the medication on the overbed table, and administered the eye ointment. LPN-A did not wash hands or change gloves prior to administering eye ointment after touching other surfaces. LPN-A agreed with the above findings and identified she should have removed her old gloves, washed her hands and donned clean gloves prior to administering R32's eye ointment. Interview on 10/30/24 at 4:54 p.m., with the director of nursing (DON) identified she would expect staff to follow infection control practices by donning clean gloves just prior to administering eye ointments. A policy related to administration of eye medication was requested, nothing was provided by the end of the survey.	F 880		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 10/28/24 through 10/30/24, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed during the survey: H52289821C (MN107372), and H52289822C (MN106935). NO licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000		

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2 000	Continued From page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure hand hygiene was provided to 1 of 1 resident (R21) prior to mealtime and during morning cares and required staff assistance. Findings include: R21's quarterly Minimum Data Set (MDS) identified R21's cognition was severely impaired, she had continuous inattention and disorganized thinking present. She required set up assistance with eating and was dependent on staff for all other cares. R21 was incontinent of bowel and bladder. R21 had diagnoses of Alzheimer's disease, dementia, anxiety, and depression.	2 920	Hand Hygiene not provided to resident prior to eating meal Direct education on resident hand hygiene given to staff working on unit on 10/29/24 by nurse manger. LTC Certified Nursing Assistants, Trained Medication Aides, Licenses Nursing Staff, and Activities will complete resident hand hygiene education on November 21st, November 22nd, or November 25th of 2024. The DON/Designee will complete 5 observations a week for 4 consecutive weeks on resident hand hygiene when at 100 % Observations will transition to 5 a month for 2 months. Results of audits completed will be	11/25/24

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	00343	A. BUILDING: _____ B. WING _____	C 10/30/2024

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2 920	Continued From page 3 R21's 5/10/24, care plan identified she had difficulty making needs known and she was rarely understood. She has a diagnosis of Alzheimer's disease and and Vascular dementia. R21 required her food to be cut up and she needed staff assistance. The nurtion assessment noted resident should not have silverware. Interview on 10/28/24 at 4:21 p.m., with family member (FM)-D identified there were concerns R21 was not getting her fingernails trimmed. FM-D states that R21 ate with her hands and at times had been known to put her hands down her pants. Observation on 10/28/24 at 5:28 p.m., of staff assisting R21 identified R21 had come from the common area where she had been seated in the recliner. Her hands were on the recliner and then placed on the EZ stand by staff as they moved her to the wheelchair. R21 placed her hands on the wheelchair arms and was wheeled to the dining room table. There was no observation of hand hygiene assistance despite R21 touching the recliner, wheelchair, and table area. R21 was provided with a grilled cheese "ripped" into pieces along with a bowl of grapes. R21 used both hands to feed herself the sandwich pieces and eat the grapes. Intermittently, R21 was observed touching her wheelchair, pushing herself away from the table with her hands, then pushed back in by staff, where she resumed eating. While she ate, R21would set one hand on the tabe to rest and then would use that same hand again to feed herself. R21 alternates using each hand. R21 nails were observed to be longer that the finger and had some darker debris under the nails. It is unclear the dark debris was food particles or other contaminants.	2 920	reviewed at the facility QAPI meeting and regularly scheduled nurse and aide meetings to review results and develop action plans as needed. Date of Correction: 11/25/24 Responsible for correction: Director of Nursing	

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2 920	Continued From page 4 Observation on 10/29/24 at 12:58 p.m., R21 during meal service identified she was at the table using her hands to eat a take-out meal the facility ordered-in for residents. She had orange chicken and noodles. There were chunks of chicken all over her bib and it appeared she struggled to pick up the noodles as they were hard to pick up with her hands. There was no silverware there and no staff assisting. During an interivew with (NA)B 10/29/24 at 1:27 p.m., she shared that R21 is only allowed one dish as she will get confused and she is not provided with silverware.She is set up with the dish and R21 eats with her hands. Observation on 10/30/24 at 9:52 a.m., of nursing assistant (NA)-A completing morning cares with R21 in the bathroom where NA-A washed R21's face, her back, under her arms, and lastly her personal area. NA-A did not wash R21's hands during morning cares before leaving R21's bathroom and room. NA-A then proceeded to take R21 to the dining room for breakfast. NA-A obtained R21's breakfast and placed it in front of her at the table. She was provided scrammbled eggs, bacon, and a pastry with a glass of juice. R21 was encouraged to start to eat. No staff provided hand hygiene to R21 prior to her eating her meal. R21 was placed in her wheelchair and NA-A proceeded to assist with dressing, pulling her arms through the holes, but grabbing her hands. Once dressed, NA-A pushed R21 to dining room as R21 placed hands on the wheelchair arm rests. NA-A stated they wash wheelchairs once a week. Interview on 10/30/24 at 10:20 a.m., with NA-A revealed she normally only washed R21's hands with a wipe or washcloth after she eats as that is	2 920		

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2 920	Continued From page 5 when R21 has dirty hands. NA-A confirmed she had not washed R21's hands during morning cares or prior to her being served her breakfast. Therefore, R21 went from bed, hands in sheets (which were changed while R21 was in bathroom), to dining room, to eating with her hands withouth having any hand hygiene. Interview on 10/30/24 at 3:21 p.m., with nurse supervisor (NS)-A identified her expectation was that staff would provide hand hygiene to residents who are dependent for cares, prior to meals, after toileting, and as needed throughout the day. Review of 11/21/23, Hand Hygiene policy identified staff were to encourage residents to perform hand hygiene before activities, before eating, and after using the rest room. R21 is dependent on staff for all ADL's. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could educate responsible staff to provide care to residents' dependant on facility staff, based on residents' comprehensively assessed needs. The DON or designee could conduct audits of dependent resident cares to ensure their personal hygiene needs are met consistently. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all	21015		11/25/24

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21015	Continued From page 6 times. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure appropriate infection control technique was followed during 1 of 1 meal service. This had the potential to affect all 20 residents residing on the Gardens unit. Findings include: Observation on 10/28/24 of the supper meal served on the Gardens unit identified at: 1) 5:30 p.m., it was noted The meal being served by cook-A. During serving of the meal, cook-A demonstrated multiple incidents of potential cross-contamination and lack of appropriate hand hygiene as he plated the meal for residents. Cook-A was noted to have facial hair that was uncovered as he was dishing food items from the steam table and moving about the kitchenette, obtaining various food items and placing them onto plates. 2) 5:32 p.m., cook-A returned to the steam table wearing the same gloves with which he had opened cabinets to retrieve serving items, and opened the refrigerator and freezer doors to obtain items to place onto trays. Upon returning to the steam table, cook-A placed a plate on the counter in front of the steam table, picked up a grilled cheese sandwich with his same gloved hands, place it onto the plate, used a knife to cut the sandwich, and separated the half's with his gloved hands. He then picked up a bowl and ladled soup into the bowl and placed it onto the plate between the sandwich halves. He then turned to a counter behind him and dished up coleslaw into a cup and placed it onto the tray.	21015	Gloves not changed cross-contamination. Facial Hair uncovered Direct education of proper hand hygiene, glove use, and facial hair education give to staff working on 10/29/24. Dietary aids will be educated on proper hand hygiene, glove use, and facial hair covering through the AveraLearn Hand Hygiene Education Module. The Dietary Manager/Designee will complete 5 observations a week for 4 consecutive weeks on staff hand hygiene/glove use. when at 100 % Observations will transition to 5 a month for 2 months. The Dietary Manager/Designee will complete 5 observations a week for 4 consecutive weeks on proper facial coverings. when at 100 % Observations will transition to 5 a month for 2 months. Results of audits completed will be reviewed at the facility QAPI meeting and regularly scheduled nurse and aide meetings to review results and develop action plans as needed. Date of Correction: 11/25/24 Responsible for correction: Director of Nursing	

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21015	Continued From page 7 While still wearing the same gloves, cook-A opened the freezer, and moved a cardboard box with his gloved hand to obtain an ice cream sandwich. He then brought the sandwich to the serving line and placed it on the tray. The meal was then delivered to the resident by dietary staff. 3) 5:33 p.m., cook-A was still wearing his same contaminated gloves. Cook-A went to a cabinet, opened the cabinet, obtained a divided plate, placed it on the steam table and continued the same process. 4) 5:34 p.m., still wearing his unchanged gloves, he moved to a clipboard lying on the counter, and picked up a pen and made a notation. Still with no glove change or hand hygiene cook-A repeated the same process of handling sandwich's with his gloved hands, and then touching cabinets, the refrigerator and various other items on the counter. 6) 5:38 p.m. cook-A continued serving wearing his unchanged gloves, as he dished a bowl with Cole slaw with his thumb inside the dish coming in contact with the with Cole slaw, he wiped his hand on a napkin and turned to write a note on the clip board. 7) 5:40 p.m. cook-A picked up a small bowl, that had a black mark on the inside, he touched the black area, which did not rub off and stated it looked like ink, he set the bowl aside and continued to serve food , no hand hygiene or glove change. Cook A was also observed to be a wearing a braided bracelet on his right wrist, (uncovered by his glove), as he reached into the steam table to pick up sandwich's. 8) 5:48 p.m. cook-A continued serving the supper meal continuing the same repeated process with no glove change or hand hygiene performed. 9) 5:55 p.m. a resident indicated she did not want the meal being served and indicated she would like a cheese burger and chips. Cook-A removed	21015		

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21015	Continued From page 8 his gloves, left the kitchenette and went to the main kitchen where he obtained a burger patty in a container. He returned to the kitchenette, put on new gloves without performing hand hygiene. He placed the burger patty to the microwave, reporting the temperature needed to be at 150 F for beef. Cook-A removed gloves while microwave the patty for the second time. When the microwave sounded he removed the burger from the microwave and checked the temperature which was at 145 F, cook-A again returned the burger to the microwave and heated again. On the third time microwave the burger the temperature was at 160 F, and cook-A applied gloves, retrieved a bun from a plastic package, opened the refrigerator and obtained a package of cheese slices, which he separated with his gloved hands and placed a slice on the burger patty. Cook-A again opened the refrigerator, picked up a bottle of catsup with his same gloved hands, squirted some on the burger and replaced the bottle in the the refrigerator and closed the door. Throughout the process of preparing the burger cook-A neither changed his gloves or performed any hand hygiene. Cook-A set the plate on the counter, opened a cabinet, and reached into a box to retrieve a package of potato chips which he opened and placed on the plate with the burger and served to the waiting resident. Cook-A then removed his gloves and indicated he was finished serving. Interview on 10/28/24 at 6:04 p.m. with cook-A identified he did not think he needed to use a facial hair covering because he kept his facial hair cut short. When asked about glove changing and hand hygiene he reported he did not realize he had not changed his gloves between tasks during the meal service when he needed to retrieve items not at the serving line. Cook-A reported he	21015		

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21015	Continued From page 9 had received education on infection control practices, and reported he should have been changing his gloves and washing his hands between touching surfaces and food items. Interview on 10/29/24 at 8:32 a.m. with the dietary manager (DM) reported her expectation for a person serving food, to change gloves and perform hand hygiene when they touched food and then touched other items in the kitchen or area, and returned to touching food items. She also reported she was not aware of the need to cover facial hair. Review of the October 2024 LTC Food Safety and Sanitation Policy identified gloves were to be worn when handling ready to eat foods. Gloves were to be changed anytime a contaminated surface was touched with handwashing performed after removing the soiled gloves and prior to applying a new pair. Hair was to be restrained with hairnets, hats and/or beard restraints. Hair restraints were to be worn when preparing or serving of food items. SUGGESTED METHOD OF CORRECTION: The dietary manager, registered dietician, or administrator, could ensure appropriate security and sanitation of food items and or equipment in the kitchen and dining areas. The facility should also ensure appropriate hand hygiene, glove use and hair containment is practiced. The facility could update or create policies and procedures and educate staff on these changes and perform competencies. The dietary manager, registered dietician, or administrator could perform audits and report audit findings to the Quality Assurance Performance Improvement (QAPI) for further recommendations or to determine compliance.	21015		

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21015	Continued From page 10 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to appropriately discard	21390	Infection preventionist provided verbal real time education on hand hygiene with	11/25/24

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21390	Continued From page 11 personal protective equipment (PPE) after use inside the resident's room and perform appropriate hand hygiene with soap and water, and put on new gloves when carrying infection waste to the soiled utility room for 1 of 2 residents (R12) with a highly infectious disease (Clostridium Difficile (C-Difficile)). This practice had the potential to affect 8 of 73 residents who resided on the wing. Furthermore, the facility failed to ensure Enhanced Barrier Precautions (EBP) PPE use was followed for 1 of 1 resident (R19), who had an open scalp wound due to a drug resistent bacteria. That had the potential to affect 18 of 19 other residents who resided on that wing. The facility also failed to ensure gloves were discarded and hand hygiene occured after touching multiple surfaces and before administration of an eye ointment for 1 of 1 resident (R32) during medication pass observation. R12 Review of the 4/3/24, US Centers for Disease Control and Prevention (CDC) Transmission-Based Precautions guidelines, located at https://www.cdc.gov/infection-control/hcp/basics/transmission-based-precautions.html, identified staff were to use Contact Precautions for patients with known or suspected infections that represent an increased risk for contact transmission by: 1) Using PPE appropriately, including gloves and gown. Staff (and visitors) were to "wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment. Donning [putting on] PPE upon room entry and properly discarding before exiting the patient room is done to contain pathogens". Review of the 3/5/24, CDC: C. Diff: Facts for	21390	C-Diff to staff working on 10/29/2024, and 10/30/2024. Avera C. Difficle Education module number- Avera286 via the Avera Learning Center deployed to all LTC Certified Nursing Assistants, Trained Medication Aides, Licensed Nursing Staff, and Activities on with completion date by November 25th. Avera C. Difficle Education module number- Avera286 via the Avera Learning Center added to annual education training schedule for LTC Certified Nursing Assistants, Trained Medication Aides, Licensed Nursing Staff, Activities by their leader, to be completed by 11/25/2024. LTC Certified Nursing Assistants, Trained Medication Aides, Licenses Nursing Staff, and Activities will complete hand hygiene and proper donning and doffing of Personal Protective Equipment on Transmission Based Precaution education on November 21st, November 22nd, or November 25th of 2024. The Infection Preventionist/Designee will complete 5 hand hygiene knowledge checks a week for 4 weeks on use of soap and water on white contact precautions. Once at 100% will transition to 5 a month for 2 months. The DON/Designee will complete 5 observations a week for 4 consecutive weeks on Donning and Doffing Personal Protective Equipment when at 100 % Observations will transition to 5 a month for 2 months. Results of audits completed will be reviewed at the facility QAPI meeting to review results and develop actions plan as needed.	

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21390	Continued From page 12 Clinicians guidelines, located at https://www.cdc.gov/c-diff/hcp/clinical-overview/index.html#:~:text=If%20a%20patient%20has%20had%20three%20or%20more,Reassess%20appropriateness%20of%20antibiotics%20in%20C.%20diff%20patients, identified: 1) "C. diff sheds in feces. Any surface, device or material that becomes contaminated with feces could serve as a reservoir for the C. diff spores. C. diff spores can transfer to patients by the hands of healthcare personnel who have touched a contaminated surface or item". 2) Staff were to "wear gloves and a gown when treating residents with C. diff, even during short visits. Gloves are important because hand sanitizer doesn't kill C. diff". R12's quarterly Minimum Data Set (MDS) dated 8/7/24, indicated R12 had moderate cognitive impairment and required extensive assistance with toileting hygiene. R12's Hospital Discharge Summary dated 9/30/24, identified R12 was hospitalized from 9/27/24 to 9/30/24, for sepsis (life threatening infection) secondary to C. difficile colitis (inflammation in the intestines). R12 presented from the facility with 1 to 2 weeks of diarrhea, and hospital stool studies were positive for C. difficile. Observation on 10/28/24 at 12:47 p.m., a "Contact Enteric Precautions" sign was posted on the outside of R12's door. Also outside R12's door was a container for PPE and a waste bin. Observation and interview on 10/28/24 at 12:54 p.m., with nursing assistant (NA)-C exiting R12's room identified NA-C removed their gloves and gown in the hallway outside R12's room into a waste bin. Without removing her PPE inside the	21390	failure to ensure clean gloves with administration of eye ointment. all licensed nursing staff and Trained Medication aides will complete competency on eye medication administration that include proper hand hygiene and glove use November 21st, November 22nd, or November 25th, 2024. The DON/Designee will complete 5 observations a week for 4 consecutive weeks on proper use of gloves with administration of eye medication when at 100 % Observations will transition to 5 a month for 2 months. Results of audits completed will be reviewed at the facility QAPI meeting to review results and develop actions plan as needed. Appropriate DONN PPE with enhanced barrier precaution All LTC staff will complete Avera learning module on Enhanced Barrier Precautions-Avera1758 by November 25th ,2024 and completed annually. LTC Certified Nursing Assistants, Trained Medication Aides, Licenses Nursing Staff, and Activities will complete education proper donning and doffing of Personal Protective Equipment on Enhanced Barrier Precaution education November 21st, November 22nd, or November 25th of 2024. The DON/Designee will complete 5 observations a week for 4 consecutive weeks on Donning and Doffing Personal Protective Equipment when at 100 % Observations will transition to 5 a month for 2 months. Results of audits completed will be reviewed at the facility QAPI meeting to	

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21390	Continued From page 13 room as appropriate or washing her hands, NA-C gathered the full bag of trash from the trash bin with her bare hands and disposed of it in the soiled utility room. NA-C exited the soiled utility room and used alcohol-based hand rub (ABHR) from the touch-less wall unit on her hands. When NA-C was asked if soap and water had been used after caring for R12, NA-C stated, "No, I used sanitizer". NA-C further stated staff only needed to wash their hands with soap and water after hand sanitizer had been used 3 times. It was facility practice to have all PPE discarded outside a resident's room. Interview on 10/28/24 at 3:11 p.m., infection preventionist (IP) identified staff were expected to use soap and water for hand hygiene after caring for a resident with C. difficile, and because C. difficile was a spore releasing bacteria. Hand sanitizer would not kill the microbes completely as it does not kill the bacteria. Soap and water was most effective at prevention of transmission. Review of the 3/14/23, Nurse-driven Protocol for Screening Hospitalized Patients for Clostridium Difficile Infections policy identified C. difficile spores could survive for long periods of time in the environment, and the bacteria could be transmitted to others through contact with the contaminated environment and equipment or indirectly on unwashed hands of health care workers. Review of the 11/21/23, Hand Hygiene policy identified staff were to complete hand hygiene with soap and water, not alcohol-based hand rub (ABHR), after caring for a resident with known C. difficile. R19	21390	review results and develop actions plan as needed. Results of audits completed will be reviewed at the facility QAPI meeting and regularly scheduled nurse and aide meetings to review results and develop action plans as needed. Date of Correction: 11/25/24 Responsible for correction: Director of Nursing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00343	A. BUILDING: _____ B. WING _____	C 10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MORNINGSIDE HEIGHTS CARE CENTE	300 SOUTH BRUCE STREET MARSHALL, MN 56258

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21390	Continued From page 14 R19's 8/21/24, Significant change Minimum Data Set (MDS) assessment identified R19 had severe cognitive impairment, She required total assistance with activities of daily living (ADLS), and was transferred with a sling type lift. R19's printed diagnosis list identified aphasia (a language disorder that affects communication), a surgical wound (complex wound of head with avulsive loss of part of skull and cranial contents-non healing), osteomyelitis (bone infection) of the skull, hemiplegia (paralysis of one side of the body), diabetes, bowel and bladder incontinence, and had been admitted to Hospice services with a terminal diagnosis of respiratory failure with hypoxia. Observation on 10/28/24 at 3:15 p.m. of R19's door identified a bright green sign posted which identified she was on EBP. Staff and visitors must clean their hands before entering and when leaving the room. Providers and staff must also wear gloves and a gown for all the following high-contact resident care activities such as dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care/use, wound care-any skin opening requiring a dressing, or therapy involving high-contact. Observation on 10/29/24 at 12:31 p.m. when trained medication aide (TMA)-A and nursing assistant (NA)-B retrieved the sling lift and prepared to transfer R19 from her recliner to her bed and then to check and change her incontinent brief. Both TMA-A and NA-B entered the room wearing gloves but no gowns, as indicated by the precautions listed on the door. NA-B retrieved the lift sling and with TMA-A's assistance, shifted R19 forward to place the sling	21390		

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AVERA MORNINGSIDE HEIGHTS CARE CENTE	300 SOUTH BRUCE STREET MARSHALL, MN 56258

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21390	Continued From page 15 behind her and then beneath her legs. R19 was resting her body against NA-B as she was shifted forward. TMA-A had visible contact against her uniform as she positioned the sling around R19. R19 was then transferred onto her bed. The sling was removed by turning R19 from side to side. NA-A removed R19's pants and change her wet brief . Both NA-A and TMA-A changed their gloves and R19 was redressed. Staff then left R19's room and performed hand hygiene. Interview on 10/29/24 at 12:41 p.m. with NA-B and TMA-A reported R19 was on EBP due to her open head wound and when asked about the sign posted on the door, both NA-B and TMA-A reported they should have been wearing gowns when they provided R19's personal care, but stated they had forgotten. Observation and interview on 10/29/24 at 12:51 p.m. with registered nurse (RN)-A identified staff should have been wearing a gown when transferring and performing brief changes. She reported the sign posted on the door identified both gown and gloves were to be used while providing cares. Interview on 10/29/24 at 1:35 p.m. with the infection preventionist reported EBP was to be in place for residents with any open wounds, lines, drains, with a history of a multi-resistant organisms (MDRO). Staff were expected to use appropriate PPE as indicated on the signage. She reported education on EBP's had been included in the May 24 annual in-service, and reviewed recently. Interview on 10/29/24 at 1:50 p.m. with the director or nursing (DON) confirmed her expectation was for staff to comply with use of	21390		

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21390	Continued From page 16 PPE when performing personal care for a resident on EBP and that all staff had received training on infection prevention and EBP. Review of the November 2023, LTC-Transmission Based precautions (TBP) and enhanced barrier precautions (EBP) policy identified EBP was utilized when staff were providing high-contact resident care. EBP precautions were to be utilized when a resident had an MDRO with wounds that require dressings, indwelling medical devices such as a central line, a urinary catheter, a feeding tube or a tracheostomy (tube in throat used for breathing). A gown and gloves were indicated when assisting with dressing, bathing/showering, transferring, providing hygiene activities, changing linens, changing briefs or toileting, device care, wound care and therapy services. EBP were indicated to be used throughout a resident's stay in the facility unless the wound heals, the device is no longer used, and the IP had been consulted. R32 R32's October 2024, Medication Administration Record (MAR) identified R32 was to be administered erythromycin 0.5% ophthalmic eye ointment. Observation and interview on 10/30/24 at 8:12 a.m., with licensed practical nurse (LPN)-A during medication administration identified she put on gloves (donned) gloves, opened the drawer of the medication cart, removed R32's blister packs of medication, and placed them into a medication cup. With her gloved hands, LPN-A placed the blister packs into the drawer, opened another drawer and took out a tube that contained erythromycin (antibiotic) eye ointment. LPN-A then closed the drawer, locked the medication	21390		

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21390	Continued From page 17 cart, and walked down to R32's room. LPN-A knocked on the door, opened it, sat the medication on the overbed table, and administered the eye ointment. LPN-A did not wash hands or change gloves prior to administering eye ointment after touching other surfaces. LPN-A agreed with the above findings and identified she should have removed her old gloves, washed her hands and donned clean gloves prior to administering R32's eye ointment. Interview on 10/30/24 at 4:54 p.m., with the director of nursing (DON) identified she would expect staff to follow infection control practices by donning clean gloves just prior to administering eye ointments. A policy related to administration of eye medication was requested, nothing was provided by the end of the survey. SUGGESTED METHO OF CORRECTION: The Director of Nursing (DON), ICP, or designee should review facility policies/procedures regarding isolation precautions for the resident and provide staff education regarding the policies and educate staff on appropriate PPE wear. They should also do environmental rounds, audits, and re-educatioon anytime isolation precautions are placed. The ICP should have formal training to be completed according to regulation and head the above measures. In additon, the DON or designee should review and ensure compliance with g-tube feeding/medication administration with audits to ensure policies are being followed to ensure on-going competence. The ICP, DON and/or designee should take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time, until the QAPI	21390		

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21390	Continued From page 18 committee determines successful compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: 21 (twenty-one) DAYS	21390		

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	245228	A. BUILDING **02 - NEW BUILDING AND RENOVATED EXISTING BLD** B. WING _____	**10/29/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MORNINGSIDE HEIGHTS CARE CENTER	**300 SOUTH BRUCE STREET** **MARSHALL, MN 56258**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 10/29/2024. At the time of this survey, Avera Morningside Heights Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 11/19/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Avera Morningside Heights Care Center was constructed as follows: The original building was constructed in 1963, it is two-stories in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction; The 2004 Addition is two-stories in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction. The facility has a capacity of 76 beds and had a	K 000		

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K 000	Continued From page 2 census of 71 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by:	K 321		11/25/24

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K 321	Continued From page 3 Based on observation and staff interview, the facility failed to maintain Hazardous Areas-Soiled Linen Rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1 and 19.3.5.9. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 10/29/2024 at 10:00 AM, it was revealed by observation that the door on the Soiled Linen Room, Unit 1, would not positively latch when the door closed. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 321	Door on soiled utility room on unit would not positively latch when door was closed on 10/29/24. 1. Vendor was here on 11/11/2024 to adjust the door and correct latching issues on the Soiled Linen Room, First Floor, Unit 1. Work Order 28742 from W.L.Hall Co. 2. Continue with Annual inspections by 3rd party vendor and make repairs if noted from inspection. Continue inspections of latching through semi-annual environmental rounds and make repairs immediately if found deficient. 3. Monitor findings through Environmental Rounds. Report findings from inspections to the safety committee. Educate facilities maintenance staff at the next monthly meeting on 11/26/2024 on the importance of monitoring and compliance of the K-Tag. All nursing staff receiving education regarding appropriate reporting and placing work orders for doors that do not latch properly. 4. Environmental Rounds team will be responsible for the corrective actions and monitoring of compliance through the semi-annual rounds. Facility Maintenance Supervisor will be responsible for making sure corrective actions are repaired from the environmental rounds conducted. Results of audits completed will be reviewed at the facility Safety Meetings. Date of Correction: 11/25/24 Responsible for correction: Director of Nursing	

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K 920	Continued From page 4	K 920		
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: K920 NOT MET: Based on observation and staff interview, the facility failed to conduct a Resident Room inspection which would have discovered an extension cord per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), and TIA 12-5. This deficient finding could have a isolated impact on the residents within the facility.	K 920	An audit was conducted and completed of all resident rooms and care areas to ensure all non-hospital grade extension cords and power strips were removed. All licensed and nursing assistant staff will receive education on extension cord use at the education days on November 21st, November 22nd and November 25th. Orientation checklist/binders will be revised to include education regarding	11/25/24

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K 920	Continued From page 5 Findings include: On 10/29/2024 at 10:20AM, it was revealed by observation that a extension cord was being used in Resident Room 121. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 920	extension cord use. Resident admission packets will be revised to include education regarding extension cord use for residents and families. DON/designee will audit each neighborhood weekly for 4 weeks to ensure no extension cords are utilized in resident rooms and care areas. Once 100% compliance x 4 weeks, will decrease audit auditing to 4 observations (1 per neighborhood) per month x 2 months. Results of audits completed will be reviewed at the facility QAPI meeting and regularly scheduled nurse and aide meetings to review results and develop action plans as needed. Date of Correction: 11/25/24 Responsible for correction: Director of Nursing	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
December 10, 2024

Administrator
Avera Morningside Heights Care Center
300 South Bruce Street
Marshall, MN 56258

RE: CCN: 245228
Cycle Start Date: October 30, 2024

Dear Administrator:

On December 10, 2024, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 10, 2024

Administrator
Avera Morningside Heights Care Center
300 South Bruce Street
Marshall, MN 56258

Re: Reinspection Results
Event ID: 9X4M12

Dear Administrator:

On December 10, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on October 30, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us