



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
April 15, 2025

Administrator
Paynesville Health Care Center
200 First Street West
Paynesville, MN 56362

RE: CCN: 245253
Cycle Start Date: March 19, 2025

Dear Administrator:

On April 10, 2025, the Minnesota Departments of Health 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.

A handwritten signature in black ink, appearing to read 'M. Poepping'.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

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April 1, 2025

Administrator
Paynesville Health Care Center
200 First Street West
Paynesville, MN 56362

RE: CCN: 245253
Cycle Start Date: March 19, 2025

Dear Administrator:

On March 19, 2025, 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:

Nikki Harvey, Regional Operations Supervisor
St. Cloud A District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: nikki.harvey@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

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 June 19, 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 September 19, 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>

Paynesville Health Care Center

April 1, 2025

Page 4

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
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/08/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245253	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/19/2025
NAME OF PROVIDER OR SUPPLIER PAYNESVILLE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 FIRST STREET WEST PAYNESVILLE, MN 56362		
(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 3-17-25 to 3-19-25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities 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 3/17/25 to 3/19/25, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880			3/31/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/04/2025

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 880	Continued From page 1 §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 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,	F 880			

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F 880	Continued From page 2 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 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 record review, the facility failed to ensure proper use of personal protective equipment (PPE) for 1 of 2 residents (R249) during high contact cares. In addition, the facility failed to ensure PPE use while providing wound care for 1 of 2 residents (R249) reviewed for enhanced barrier precautions (EBP). Findings include: R249's quarterly Minimum Data Set (MDS) dated	F 880	Plan of Correction Survey Dates March 17-19, 2025 F880 -Corrective action for those residents found to have been affected by the deficient practice: Upon notification that the facility failed to ensure proper use of personal protective equipment (PPE) for 1 of 2 residents during high contact cares as well as while providing wound care for 1 of 2 residents, nursing staff was		

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F 880	Continued From page 3 3/3/25, indicated R249 was cognitively intact and had acute osteomyelitis (bone infection) on the right ankle and foot and had recently undergone orthopedic surgery for right below the knee amputation, phantom limb syndrome with pain (real pain in a missing limb after amputation), peripheral vascular disease (PVD) (narrowed arteries reduce blood flow to the arms and/or legs), type II diabetes mellitus (DM), hypertension (elevated blood pressure), hyperlipidemia (high cholesterol), neuropathy (nerve pain, tingling, or numbness), and was a carrier or suspected carrier of Methicillin-susceptible Staphylococcus aureus (MSSA) (type of staph bacteria that can cause infections on the skin or other parts of the body). R249's care plan dated 2/26/25, indicated R249 was on EBP due to MSSA, PICC line with six weeks of antibiotics, and chemotherapy medication. Interventions included posting clear signage on the exterior of resident's door with the required PPE, provide education to residents and visitors, PPE available outside of the room, use gown and gloves with high-contact resident care activities. During observation on 3/17/25 at 3:26 p.m., registered nurse (RN)-A along with an unidentified nursing assistant (NA) assisted R249 from his manual wheelchair into his recliner to perform wound care. Neither NA or RN-A wore gown or gloves while assisting R249 with transfer. NA exited the room after assisting with the transfer. R249's legs were elevated using the recliner. RN-A gather the supplies to complete dressing changes then sat in R249's wheelchair to perform R249's wound care. RN-A donned gloves to both hands, but failed to don a gown	F 880	provided an Educare Module on PPE for reeducation purposes. This online education training module is to be completed by all nursing staff no later than 3/31/25. Corrective action was taken by DON against the RN staff member involved. Staff were also responsible for reviewing our Enhanced Barrier Precaution Policy, which defines EBP, gives examples of MDROs, and outlines specific situations requiring enhanced barrier precautions and the required PPE to be worn. Also reviewed was a summary of PPE use and room restrictions when caring for residents in nursing homes, including standard precautions, enhanced barrier precautions, and contact precautions. -Identification of other residents having the potential to be affected by the deficient practice: Audit was conducted of staff compliance to proper usage of personal protective equipment. Audit completed to ensure thorough identification of those who qualify for EBP and proper notification of PPE requirements. -Measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur: Infection prevention and control PPE education module added to mandatory yearly education requirements for staff. PPE education and EBP education to be included in yearly facility skills fair and competencies reviewed with new nursing staff. Staff reeducated on the various resources available that outline those		

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F 880	Continued From page 4 prior to procedure. RN-A then removed Prevalon boot (heel protectant boot) from R249's left heel wound. RN-A noted there was no dressing in place, she then lifted R249's left leg and foot and placed R249's ankle on her right leg above the knee to provide support while painting the wound with betadine per the provider order. After bandaging the left heel RN-A removed her gloves and discarded the used supplies. RN-A returned to sit in the wheelchair and applied a glove to her right hand. She removed the dressing from R249's right below the knee surgical wound with gloved hand, noted there was no drainage and was seen painting the site with a betadine swab. RN-A redressed, dated and initialed the tape used to secure the gauze wrap, and applied the limb protector with gloved hand. RN-A removed her glove and discarded the used supplies. Signage, PPE supply cart and disposal bin were observed on resident's door and just inside of the door. RN-A was not wearing a gown to protect R249 nor herself from pathogens during this procedure. Interview on 3/17/25 at 3:46 p.m., RN-A stated that she had worn gloves. RN-A confirmed she had not worn a gown during resident high contact cares, she stated "I forgot." Unable to complete interview at this time. Interview on 3/17/25 at 3:48 p.m., R249 stated she [RN-A] never wears a gown. Interview on 3/19/25 at 3:02 p.m., RN-A stated when a resident required EBP there should be a sign on the resident's door to alert them. In the resident's plan of care there is a stop sign that indicated the precaution, and if hovered over, it showed the type of precaution specifically. RN-A	F 880	residents on enhanced barrier precautions, including the resident Electronic Health Record (MAR and POC), flagged on the resident Face Page, included in the Care Plan and on the Kardex, signage posted on the resident door, as well as communicated on the huddle board in the staff breakroom. -Facility monitoring of its performance to make sure that solutions are maintained: Immediate implementation of EBH policy and auditing of staff compliance. Regular review with interdisciplinary team and infection preventionist of resident condition and assessment of qualifications for EBP during weekly IDT and monthly/quarterly QAPI meetings. -Date Completed Immediate implementation of PPE education for all nursing staff, audits conducted on an ongoing basis and will be reviewed at weekly IDT, monthly & quarterly QAPI meetings.		

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F 880	Continued From page 5 confirmed R249 did have EBP signage posted on exterior of his door and that there was a PPE cart and disposal bin located inside his doorway. RN-A did not recall receiving any specific EBP training, and stated she "may not have been there for it". RN-A stated gown and gloves should be worn for, "anything up close and personal where concerns for infection are possible, like peri cares, all personal cares and wound care". RN-A was not aware high contact care included transfers. RN-A stated PPE use was important "to prevent infection for the resident with whatever I could be carrying, to keep as clean as possible and not introduce anything new to him". Interview on 3/19/25 at 3:20 p.m., with case manager (CM) and director of nursing (DON). DON stated staff were able to tell which residents were on EBP in the residents EHR, it was flagged on their face page, on the care plan, signage on their door, as well as on the huddle board (white board) in the breakroom that lists all residents on precautions. CM stated they also had supply bins and disposal containers in the residents' rooms. CM also stated they go through the residents on EBP in their morning huddle daily, during shift reports and pass on. DON stated precautions were put into PCC like a medication order, when it was time for wound care to be completed, it alerted the nurse. CM stated training on EBP was provided to care staff at their annual skills fair. DON stated many different audits had been completed, and gown and gloves were expected for all wound care. Both CM and DON agreed they would expect orders to be followed, infection control practices followed, and if there was a question, staff would ask for clarification as they had many tools and resources available to them. DON and CM were not specific on the	F 880			

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F 880	Continued From page 6 expectation of staff to wear PPE during high contact cares, including transfers. A policy effective 3/2025, titled "Enhanced Barrier Precautions" indicated the policy is in place to reduce the transmission of multidrug-resistant organisms (MDROs). Enhanced barrier precautions is defined as "an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities". PPE used for these high-contact resident care activities as dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, and wound care of any skin opening requiring a dressing.	F 880			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 1, 2025

Administrator
Paynesville Health Care Center
200 First Street West
Paynesville, MN 56362

Re: Event ID: D8VK11

Dear Administrator:

The above facility survey was completed on March 19, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00636	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/19/2025
NAME OF PROVIDER OR SUPPLIER PAYNESVILLE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 FIRST STREET WEST PAYNESVILLE, MN 56362		
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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 3-17-25 to 3-19-25, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure and the following correction orders are issued.	2 000			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

04/04/25

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00636	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/19/2025
NAME OF PROVIDER OR SUPPLIER PAYNESVILLE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 FIRST STREET WEST PAYNESVILLE, MN 56362		
(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) COMPLETE DATE	
2 000	Continued From page 1 Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000			

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs		PROVIDER # 245253	MULTIPLE CONSTRUCTION A. BUILDING: 03 - PAYNESVILLE HEALTH CENTER B. WING _____	DATE SURVEY COMPLETE: 3/18/2025
NAME OF PROVIDER OR SUPPLIER PAYNESVILLE HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 FIRST STREET WEST PAYNESVILLE, MN		
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES			
K 363	Corridor - Doors CFR(s): NFPA 101 Doors protecting corridor openings shall be constructed to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have self-latching and positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 18.3.6.3.6 are permitted. 18.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatic closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 18.3.6.3.5. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 03/18/2025 between 9:00 and 10:30 AM, it was revealed by observation that the door to Room 227 did not positively latch when it was closed. Violation was corrected at the time of discovery. An interview with the Administrator and Maintenance Director verified this deficient finding at the time of discovery.			

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

The above isolated deficiencies pose no actual harm to the residents

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/08/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245253		(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - PAYNESVILLE HEALTH CENTER B. WING _____		(X3) DATE SURVEY COMPLETED 03/18/2025	
NAME OF PROVIDER OR SUPPLIER PAYNESVILLE HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 200 FIRST STREET WEST PAYNESVILLE, MN 56362			
(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
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 03/18/2025. At the time of this survey, Paynesville Health 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 18 New Health Care Occupancy 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 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. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO:			K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/04/2025

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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NAME OF PROVIDER OR SUPPLIER PAYNESVILLE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 FIRST STREET WEST PAYNESVILLE, MN 56362		
(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
K 000	Continued From page 1 HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail 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. The Paynesville Health Care Center is a 1-story building with no basement and was constructed in 2024. The building is separated from an assisted living building by a 2-hour fire barrier. The construction type was determined to be Type V (111). The facility is fully protected by a fire sprinkler system. The facility has a fire alarm system with smoke detection in the corridors and spaces	K 000			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245253	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - PAYNESVILLE HEALTH CENTER B. WING _____		(X3) DATE SURVEY COMPLETED 03/18/2025
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K 000	Continued From page 2 open to the corridors and is monitored for automatic fire department notification. The facility has a capacity of 51 beds and had a census of 46 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is not MET.	K 000			