Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 15, 2025

Administrator
Pelican Valley Health Center
211 East Mill Avenue
Pelican Rapids, MN 56572-0645

RE: CCN: 245373
Cycle Start Date: January 8, 2025

Dear Administrator:

On January 8, 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 widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), 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:

LeAnn Huseth, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, MN 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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 April 8, 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 July 8, 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

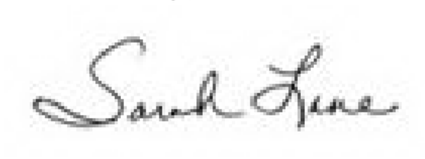
A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process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



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING _____ B. WING _____	01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(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 1/6/25 to 1/8/25, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) 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 1/6/25 to 1/8/25, 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 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements.	F 812		1/29/25

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

Electronically Signed | 01/23/2025

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 812	Continued From page 1 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 maintain the ice machines located in the kitchen and on the 300 wing in a sanitary manner to prevent potential illness. This deficient practice had the potential to affect all 32 residents who received water from the ice machines. Findings include: During an observation on 1/6/25 at 10:13 a.m., the ice machine in the dining room had a thick white hard powder substance approximately one-fourth of an inch in height around the entire inside and outside of the ice spout. During an observation on 1/6/25 at 11:33 a.m., the ice machine on the 300 wing had a thick white hard powder substance approximately one-fourth	F 812	No residents were identified with adverse effects as a result of this deficient practice. All residents residing in the facility have the potential to be affected. All ice machines in the facility have been cleaned and maintained in a sanitary manner. Facility staff have developed and implemented procedures to clean and maintain ice machines in a sanitary manner. All staff responsible will be educated on the procedures for cleaning and maintaining ice machines on 1/28/25. Maintenance Director or designee will audit that ice machines are maintained in a sanitary manner. Audits will be done weekly for 4 weeks, then done randomly for 3 months. Results of these audits will be taken to the QAPI committee for further recommendations.	

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F 812	Continued From page 2	F 812		

of an inch in height around the entire inside and outside of the ice spout. The drip pan drain below the ice and water spouts had a thick white hard powder substance.

During an observation on 1/7/25 at 4:15 p.m., the ice machine on 300 wing continued to have the white hard powder substance around the ice spout and drain. The ice machine in the dining room appears to have been cleaned and no longer had a thick white hard powder build-up.

During an observation on 1/8/25 at 7:20 a.m., the ice machine on the 300 wing continued to have the white hard powder substance around the ice spout and drain.

During an interview on 1/6/25 at 11:47 a.m., the dining director confirmed the build-up on the ice machine in the dining room had a thick hard white powered substance buildup. The dining director indicated the kitchen staff were not responsible for the cleaning of the ice machines.

During an interview on 1/6/25 at 4:41 p.m., the environmental services director (ESD) verified a thick, white, hard, powder substance was present on the outside and inside of the ice machine in the dining room. The ESD verified there was a thick, white, hard, powder substance present on the outside and inside of the ice machine on the 300 wing. The ESD indicated the ice machine on the 300 wing had a continuous water drip. The ESD stated the water spouts were removed and cleaned monthly. The ESD indicated the water spouts would still have build-up even after being cleaned. The ESD printed out an ice machine cleaning log identifying the spouts that were cleaned monthly and the entire ice machines that

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F 812	Continued From page 3 were cleaned inside and out every three months. ESD verified keeping the waterspouts clean was important since residents drank the water that came out of the machines. During an interview on 1/8/25 at 12:11 p.m., the infection preventionist (IP) indicated he expected staff to clean the ice machines more frequently when needed. IP verified maintenance was responsible for the cleaning of the ice machines. Keeping the ice machines clean was important as it is was the source of drinking water for the residents. IP indicated a resident could become ill if there was a build-up as it could cause food-borne illness. During an interview on 1/8/25 at 12:11 p.m., the director of nursing (DON) indicated housekeeping was responsible for cleaning the ice machines. DON indicated her expectation was the ice machines would have been kept clean and sanitary, as that was where the residents obtained their drinking water from. DON indicated a resident could become ill if there was a build-up present as it could be a source for food-borne illness. Review of the ice machines cleaning and service spreadsheet titled 2024 ice machine cleaning and service, recorded the ice machines had been fully cleaned every three months. The exterior of the ice machines had been cleaned monthly along with the shower head and faucets. Review of the ice machine manual titled Scotsman ice systems installation and user's manual for meridian ice maker dispenser's models HID312, HID625, and HID 540 dated 2015, revealed steps to clean the ice machine,	F 812		

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F 812	Continued From page 4 along with time to clean was when the clean light was on when unit had not been cleaned for at least six months. Water drips from spout may be normal, a few drops per minute is normal. Maintenance and cleaning..wash out the drip tray and dispense chutes. Use ice machine scale remover if needed to dissolve scale.	F 812		
F 880 SS=E	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 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	F 880		1/29/25

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F 880	Continued From page 5 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 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 maintain sanitary	F 880	No residents were identified with adverse effects as a result of this deficient	

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F 880	Continued From page 6 conditions for mechanical lifts for four (R2, R25, R7, R15) out of five residents observed who used a mechanical lift. Finding include: During an observation on 1/6/25 at 6:59 p.m., nursing assistant (NA)-A assisted R7 into bed with a mechanical lift. NA-A placed the mechanical lift away in the nook without sanitizing the mechanical lift. No sanitizing wipes were in the nook where the lifts were stored. During an observation on 1/7/25 at 8:48 a.m., NA-B took the mechanical lift out of R2's room and placed the mechanical lift in the nook without sanitizing the machine. During an observation on 1/7/25 at 9:15 a.m., NA-C took the mechanical lift out of R25's room, placed it in the corner of the living room, and did not sanitize the mechanical lift. During an observation on 1/7/25 at 9:31 a.m., NA-D took the mechanical lift without sanitizing it before bringing it into R7's room. NA-D and NA-C hooked R7's lift pad to the lift and lifted R7 out of the wheelchair. R7's arms came into contact with the mechanical lift during the transfer. NA-D took the mechanical lift out of the room along with a bag of garbage. The garbage bag touched the mechanical lift as NA-D pushed the mechanical lift to the corner of the living room. NA-D did not sanitize the mechanical lift. During an observation on 1/7/25 at 10:00 a.m., NA-D took the mechanical lift to R25's room. NA-D hooked R25 up to the mechanical lift and lifted R25 out of the wheelchair. R25 grabbed	F 880	practice. Any residents utilizing the mechanical lifts have the potential to be affected by this. All mechanical lifts are in a sanitary condition. Facility staff has developed and implemented procedures to ensure mechanical lifts are maintained in a sanitary condition to prevent the potential spread of infection or illness. All nursing staff will be educated on the procedure for ensuring mechanical lifts are maintained in a sanitary condition on 1/28/25. DON or designee will audit that mechanical lifts are maintained in a sanitary condition. Audits will be done weekly for 4 weeks, then done randomly for 3 months. Results of these audits will be taken to the QAPI committee for further recommendations.	

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F 880	Continued From page 7 onto the mechanical lift. NA-D laid R25 into bed. NA-D placed the mechanical lift in the living room corner, without sanitizing the mechanical lift. During an observation on 1/7/25 at 3:55 p.m., licensed practical nurse (LPN)-A took the mechanical lift into R15's room. At 4:02 p.m., LPN-A took the mechanical lift out of R15's room and placed it in the nook without sanitizing the lift. After continuous observations at 4:20 p.m., NA-A brought the lift into room R2's room without being sanitized. During an observation on 1/8/25 at 8:10 a.m., LPN-B brought a mechanical lift into R25's room without sanitizing the lift first. At 8:14 a.m., LPN-B brought the mechanical lift to the living room corner and walked away without sanitizing the mechanical lift. During an observation on 1/8/25 at 8:36 a.m., NA-E took the mechanical lift into R7's room without sanitizing the lift. At 8:45 a.m., NA-E brought the mechanical lift out of R7's room and placed the lift in the corner of the living room without sanitizing the lift. During an interview on 1/6/25 at 7:39 p.m., NA-A verified the mechanical lift was not sanitized after use. NA-A's normal practice was not to sanitize mechanical lifts. NA-A believed night shift sanitized and cleaned the mechanical lifts. During an interview on 1/7/25 at 10:16 a.m., NA-B verified the mechanical lift was not sanitized after use in R2's room. NA-B did not sanitize the lift after using it as there were not any sanitizing wipes nearby.	F 880		

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F 880	Continued From page 8 During an interview on 1/7/25 at 10:35 a.m., NA-D verified the mechanical lift was not sanitized after being in R25's and R7's rooms. NA-D was not certain when a mechanical lift should have been sanitized. During an interview on 1/7/25 at 4:26 p.m., LPN-A verified the mechanical lift had not been sanitized after being used in R15's room. LPN-A verified mechanical lifts were to be sanitized between each resident. During an interview on 1/8/25 at 11:33 a.m., LPN-B verified she did not sanitize the mechanical lift before or after use in R25's room. LPN-B verified lifts were to be sanitized between residents. During an interview on 1/8/25 at 11:37 a.m., NA-E indicated her normal process was to sanitize the mechanical lifts before use and not after use to ensure the lifts were clean. During an interview on 1/7/25 at 12:20 p.m., infection preventionist (IP) indicated his expectation would be for staff to sanitize mechanical lifts between residents to prevent cross-contamination between residents. During an interview on 1/8/25 at 12:11 p.m., director of nursing (DON) verified mechanical lifts were to be sanitized between residents. The DON's expectation was that sanitizing wipes were to be kept in the cubby next to the lifts. DON verified sanitizing lifts was important to prevent cross contamination. Review of policy titled Cleaning and disinfecting mechanical lifts policy dated 10/27/23, revealed it	F 880		

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(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
F 880	Continued From page 9 was the policy of the facility to clean and disinfect mechanical lifts that were shared between residents. Indirect contact transmission-Mechanical lifts may transmit pathogens if devices contaminated with blood or body fluids were shared between residents without cleaning and disinfecting between residents. If a mechanical lift had been used for one resident and must be reused for another resident, the device must be cleaned and disinfected before it can be used for another resident.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING _____ B. WING _____	01/08/2025

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E 000	Initial Comments On 1/6/25 to 1/8/25, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) 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 1/6/25 to 1/8/25, 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 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements.	F 812		1/29/25

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

Electronically Signed | 01/23/2025

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 812	Continued From page 1 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 maintain the ice machines located in the kitchen and on the 300 wing in a sanitary manner to prevent potential illness. This deficient practice had the potential to affect all 32 residents who received water from the ice machines. Findings include: During an observation on 1/6/25 at 10:13 a.m., the ice machine in the dining room had a thick white hard powder substance approximately one-fourth of an inch in height around the entire inside and outside of the ice spout. During an observation on 1/6/25 at 11:33 a.m., the ice machine on the 300 wing had a thick white hard powder substance approximately one-fourth	F 812	No residents were identified with adverse effects as a result of this deficient practice. All residents residing in the facility have the potential to be affected. All ice machines in the facility have been cleaned and maintained in a sanitary manner. Facility staff have developed and implemented procedures to clean and maintain ice machines in a sanitary manner. All staff responsible will be educated on the procedures for cleaning and maintaining ice machines on 1/28/25. Maintenance Director or designee will audit that ice machines are maintained in a sanitary manner. Audits will be done weekly for 4 weeks, then done randomly for 3 months. Results of these audits will be taken to the QAPI committee for further recommendations.	

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F 812	Continued From page 2	F 812		

of an inch in height around the entire inside and outside of the ice spout. The drip pan drain below the ice and water spouts had a thick white hard powder substance.

During an observation on 1/7/25 at 4:15 p.m., the ice machine on 300 wing continued to have the white hard powder substance around the ice spout and drain. The ice machine in the dining room appears to have been cleaned and no longer had a thick white hard powder build-up.

During an observation on 1/8/25 at 7:20 a.m., the ice machine on the 300 wing continued to have the white hard powder substance around the ice spout and drain.

During an interview on 1/6/25 at 11:47 a.m., the dining director confirmed the build-up on the ice machine in the dining room had a thick hard white powered substance buildup. The dining director indicated the kitchen staff were not responsible for the cleaning of the ice machines.

During an interview on 1/6/25 at 4:41 p.m., the environmental services director (ESD) verified a thick, white, hard, powder substance was present on the outside and inside of the ice machine in the dining room. The ESD verified there was a thick, white, hard, powder substance present on the outside and inside of the ice machine on the 300 wing. The ESD indicated the ice machine on the 300 wing had a continuous water drip. The ESD stated the water spouts were removed and cleaned monthly. The ESD indicated the water spouts would still have build-up even after being cleaned. The ESD printed out an ice machine cleaning log identifying the spouts that were cleaned monthly and the entire ice machines that

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F 812	Continued From page 3 were cleaned inside and out every three months. ESD verified keeping the waterspouts clean was important since residents drank the water that came out of the machines. During an interview on 1/8/25 at 12:11 p.m., the infection preventionist (IP) indicated he expected staff to clean the ice machines more frequently when needed. IP verified maintenance was responsible for the cleaning of the ice machines. Keeping the ice machines clean was important as it is was the source of drinking water for the residents. IP indicated a resident could become ill if there was a build-up as it could cause food-borne illness. During an interview on 1/8/25 at 12:11 p.m., the director of nursing (DON) indicated housekeeping was responsible for cleaning the ice machines. DON indicated her expectation was the ice machines would have been kept clean and sanitary, as that was where the residents obtained their drinking water from. DON indicated a resident could become ill if there was a build-up present as it could be a source for food-borne illness. Review of the ice machines cleaning and service spreadsheet titled 2024 ice machine cleaning and service, recorded the ice machines had been fully cleaned every three months. The exterior of the ice machines had been cleaned monthly along with the shower head and faucets. Review of the ice machine manual titled Scotsman ice systems installation and user's manual for meridian ice maker dispenser's models HID312, HID625, and HID 540 dated 2015, revealed steps to clean the ice machine,	F 812		

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F 812	Continued From page 4 along with time to clean was when the clean light was on when unit had not been cleaned for at least six months. Water drips from spout may be normal, a few drops per minute is normal. Maintenance and cleaning..wash out the drip tray and dispense chutes. Use ice machine scale remover if needed to dissolve scale.	F 812		
F 880 SS=E	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 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	F 880		1/29/25

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F 880	Continued From page 5 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 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 maintain sanitary	F 880	No residents were identified with adverse effects as a result of this deficient	

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F 880	Continued From page 6 conditions for mechanical lifts for four (R2, R25, R7, R15) out of five residents observed who used a mechanical lift. Finding include: During an observation on 1/6/25 at 6:59 p.m., nursing assistant (NA)-A assisted R7 into bed with a mechanical lift. NA-A placed the mechanical lift away in the nook without sanitizing the mechanical lift. No sanitizing wipes were in the nook where the lifts were stored. During an observation on 1/7/25 at 8:48 a.m., NA-B took the mechanical lift out of R2's room and placed the mechanical lift in the nook without sanitizing the machine. During an observation on 1/7/25 at 9:15 a.m., NA-C took the mechanical lift out of R25's room, placed it in the corner of the living room, and did not sanitize the mechanical lift. During an observation on 1/7/25 at 9:31 a.m., NA-D took the mechanical lift without sanitizing it before bringing it into R7's room. NA-D and NA-C hooked R7's lift pad to the lift and lifted R7 out of the wheelchair. R7's arms came into contact with the mechanical lift during the transfer. NA-D took the mechanical lift out of the room along with a bag of garbage. The garbage bag touched the mechanical lift as NA-D pushed the mechanical lift to the corner of the living room. NA-D did not sanitize the mechanical lift. During an observation on 1/7/25 at 10:00 a.m., NA-D took the mechanical lift to R25's room. NA-D hooked R25 up to the mechanical lift and lifted R25 out of the wheelchair. R25 grabbed	F 880	practice. Any residents utilizing the mechanical lifts have the potential to be affected by this. All mechanical lifts are in a sanitary condition. Facility staff has developed and implemented procedures to ensure mechanical lifts are maintained in a sanitary condition to prevent the potential spread of infection or illness. All nursing staff will be educated on the procedure for ensuring mechanical lifts are maintained in a sanitary condition on 1/28/25. DON or designee will audit that mechanical lifts are maintained in a sanitary condition. Audits will be done weekly for 4 weeks, then done randomly for 3 months. Results of these audits will be taken to the QAPI committee for further recommendations.	

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F 880	Continued From page 7 onto the mechanical lift. NA-D laid R25 into bed. NA-D placed the mechanical lift in the living room corner, without sanitizing the mechanical lift. During an observation on 1/7/25 at 3:55 p.m., licensed practical nurse (LPN)-A took the mechanical lift into R15's room. At 4:02 p.m., LPN-A took the mechanical lift out of R15's room and placed it in the nook without sanitizing the lift. After continuous observations at 4:20 p.m., NA-A brought the lift into room R2's room without being sanitized. During an observation on 1/8/25 at 8:10 a.m., LPN-B brought a mechanical lift into R25's room without sanitizing the lift first. At 8:14 a.m., LPN-B brought the mechanical lift to the living room corner and walked away without sanitizing the mechanical lift. During an observation on 1/8/25 at 8:36 a.m., NA-E took the mechanical lift into R7's room without sanitizing the lift. At 8:45 a.m., NA-E brought the mechanical lift out of R7's room and placed the lift in the corner of the living room without sanitizing the lift. During an interview on 1/6/25 at 7:39 p.m., NA-A verified the mechanical lift was not sanitized after use. NA-A's normal practice was not to sanitize mechanical lifts. NA-A believed night shift sanitized and cleaned the mechanical lifts. During an interview on 1/7/25 at 10:16 a.m., NA-B verified the mechanical lift was not sanitized after use in R2's room. NA-B did not sanitize the lift after using it as there were not any sanitizing wipes nearby.	F 880		

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F 880	Continued From page 8 During an interview on 1/7/25 at 10:35 a.m., NA-D verified the mechanical lift was not sanitized after being in R25's and R7's rooms. NA-D was not certain when a mechanical lift should have been sanitized. During an interview on 1/7/25 at 4:26 p.m., LPN-A verified the mechanical lift had not been sanitized after being used in R15's room. LPN-A verified mechanical lifts were to be sanitized between each resident. During an interview on 1/8/25 at 11:33 a.m., LPN-B verified she did not sanitize the mechanical lift before or after use in R25's room. LPN-B verified lifts were to be sanitized between residents. During an interview on 1/8/25 at 11:37 a.m., NA-E indicated her normal process was to sanitize the mechanical lifts before use and not after use to ensure the lifts were clean. During an interview on 1/7/25 at 12:20 p.m., infection preventionist (IP) indicated his expectation would be for staff to sanitize mechanical lifts between residents to prevent cross-contamination between residents. During an interview on 1/8/25 at 12:11 p.m., director of nursing (DON) verified mechanical lifts were to be sanitized between residents. The DON's expectation was that sanitizing wipes were to be kept in the cubby next to the lifts. DON verified sanitizing lifts was important to prevent cross contamination. Review of policy titled Cleaning and disinfecting mechanical lifts policy dated 10/27/23, revealed it	F 880		

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F 880	Continued From page 9 was the policy of the facility to clean and disinfect mechanical lifts that were shared between residents. Indirect contact transmission-Mechanical lifts may transmit pathogens if devices contaminated with blood or body fluids were shared between residents without cleaning and disinfecting between residents. If a mechanical lift had been used for one resident and must be reused for another resident, the device must be cleaned and disinfected before it can be used for another resident.	F 880		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
February 19, 2025

Administrator
Pelican Valley Health Center
211 East Mill Avenue
Pelican Rapids, MN 56572-0645

RE: CCN: 245373
Cycle Start Date: January 8, 2025

Dear Administrator:

On February 11, 2025, the Minnesota Department 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.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us