Electronically delivered
February 8, 2021

Administrator
Knute Nelson
420 12th Avenue East
Alexandria, MN 56308

RE: CCN: 245435
Cycle Start Date: January 21, 2021

Dear Administrator:

On January 21, 2021, a survey was completed at your facility by the Minnesota Department of Health 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) , as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 25, 2021.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 25, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 25, 2021.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by March 25, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Knute Nelson will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 25, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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

Sarah Grebenc, Unit Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: sarah.grebenc@state.mn.us
Office: (651) 201-3792

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 21, 2021 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, 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:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DIRECTED PLAN OF CORRECTION

A Directed Plan of Correction (DPOC) is imposed in accordance with 42 CFR § 488.424. Your facility must include the following in their POC for the deficient practice cited at F880:

Hand Hygiene

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

POLICIES/PROCEDURES/SYSTEM CHANGES:

- The facility's Quality Assurance and Performance Improvement Committee must conduct a root cause analysis (RCA) to identify the problem(s) that resulted in this deficiency and develop intervention or corrective action plan to prevent recurrence.

The Infection Preventionist and Director of Nursing, shall complete the following:

- Review hand hygiene policies and procedures to ensure they meet CDC guidance, and revise as needed.

TRAINING/EDUCATION:

- As a part of corrective action plan, the facility must provide training for the Infection Preventionist, the Director of Nursing, all staff providing direct care to residents, and all staff entering resident's rooms, whether it be for residents' dietary needs or cleaning and maintenance services. The training must cover standard infection control practices, including but not limited to, transmission-based precautions and adequately caring for and disinfecting shared medical equipment. Findings of the RCA should also be incorporated into staff training.
- The Infection Preventionist, Director of Nursing and Clinical Education Coordinator must implement competency assessments for staff on proper hand hygiene and develop a system to ensure all staff have received the training and are competency
- Online infection prevention training courses may be utilized. The CDC and MDH websites have several infection control training modules and materials.

https://www.health.state.mn.us/people/handhygiene/ (MDH)
Hand Hygiene (MDH) https://www.health.state.mn.us/people/handhygiene/index.html
Hand Hygiene for Health Professionals (MDH)
https://www.health.state.mn.us/people/handhygiene/index.html
Cleaning Hands with Hand Sanitizer (MDH)
https://www.health.state.mn.us/people/handhygiene/clean/index.html
CDC: Guideline for Hand Hygiene in Health-Care Settings (CDC)
https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5116a1.htm
WHO Guidelines on Hand Hygiene in Health Care (WHO)
https://apps.who.int/iris/bitstream/handle/10665/44102/9789241597906_eng.pdf;jsessionid=A770590E49844880F6F3E1D8F22F0841?sequence=1

Hand Hygiene in Outpatient and Home-based Care and Long-term Care Facilities (WHO)
https://www.who.int/gpsc/5may/hh_guide.pdf

CDC RESOURCES:

Infection Control Guidance: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html
CDC: Isolation Precautions Guideline:
https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007): https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Personal Protective Equipment: https://www.cdc.gov/niosh/ppe/
Healthcare Infection Prevention and Control FAQs for COVID-19:
https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control-faq.html

MDH RESOURCES:

Personal Protective Equipment (PPE) for Infection Control:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/ppe/index.html
MDH Contingency Standards of Care for COVID-19: Personal Protective Equipment for Congregate Care Settings (PDF): https://www.health.state.mn.us/communities/ep/surge/crisis/ppegrid.pdf
Interim Guidance on Facemasks as a Source Control Measure (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/maskssource.pdf
Interim Guidance on Alternative Facemasks (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/masksalt.pdf
Aerosol-Generating Procedures and Patients with Suspected or Confirmed COVID-19 (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/aerosol.pdf
Droplet Precautions:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html
Airborne Precautions:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html

MONITORING/AUDITING:

- The Director of Nursing, the Infection Preventionist and other facility leadership will conduct audits on all shifts, every day for one week, then may decrease the frequency based upon compliance. Audits should continue until 100% compliance is met.
- The Director of Nursing, Infection Preventionist or designee will review the results of audits and monitoring with the Quality Assurance Program Improvement (QAPI) program.

In accordance with 42 CFR § 488.402(f), the DPOC remedy is effective 15 calendar days from the date of the enforcement letter. The DPOC may be completed before or after that date. A revisit will not be approved prior to receipt of documentation confirming the DPOC was completed. To successfully complete the DPOC, the facility must provide all of the following documentation identified in the chart below.

Documentation must be uploaded as attachments through ePOC to ensure you have completed this remedy.

Imposition of this DPOC does not replace the requirement that the facility must submit a complete POC for all cited deficiencies (including F880) within 10 days after receipt of the Form CMS 2567.

Item	Checklist: Documents Required for Successful Completion of the Directed Plan
1	Documentation of the RCA and intervention or corrective action plan based on the results with signatures of the QAA Committee members and members of the Governing Body
2	Documentation that the interventions or corrective action plan that resulted from the RCA was fully implemented
3	Content of the training provided to staff, including a syllabus, outline, or agenda, as well as any other materials used or provided to staff for the training
4	Names and positions of all staff that attended and took the trainings
5	Staff training sign-in sheets
6	Summary of staff training post-test results, to include facility actions in response to any failed post-tests
7	Documentation of efforts to monitor and track progress of the interventions or corrective action plan

In order to speed up our review, identify all submitted documents with the number in the "Item" column

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 8, 2021

Administrator
Knute Nelson
420 12th Avenue East
Alexandria, MN 56308

Re: Event ID: IQRY11

Dear Administrator:

The above facility survey was completed on January 21, 2021 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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245435	A. BUILDING _____ B. WING _____	C 01/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNUTE NELSON	**420 12TH AVENUE EAST ALEXANDRIA, MN 56308**

(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 A COVID-19 Focused Infection Control survey was conducted on 1/19/21 to 1/21/21, at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.73(b)(6). The facility was in full compliance. Because you are enrolled in ePOC, your 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 1/19/21 to 1/21/21, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found to be IN compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be UNSUBSTANTIATED: H5435028C A COVID-19 Focused Infection Control survey was also conducted, at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was determined NOT to be 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.	F 000		
F 880	Infection Prevention & Control	F 880		2/17/21

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

Electronically Signed | 02/17/2021

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 SS=E	Continued From page 1 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 §483.70(e) 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	F 880		

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F 880	Continued From page 2 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 ensure appropriate hand hygiene and personal protective equipment (PPE) practices were performed while providing meal service to 7 of 7 residents (R1, R2, R3, R4, R5, R6, R7) in the dining room. The facility also failed to ensure staff removed potentially infectious PPE in a manor to reduce risk of cross contamination to others in 1 of 1 resident (R8) in droplet precautions during a COVID-19 focus	F 880	F 880 How corrective action will be accomplished for those residents found to have been affected by this deficient practice. The facility will have an infection control prevention and control program which it investigates, controls, and monitors that proper procedures are used to prevent infections within the facility. For resident	

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F 880	Continued From page 3 survey. Findings include: R1's annual Minimum Set Data (MDS) dated 1/13/21, identified R1 required supervision/set up for meals and extensive assistance for personal hygiene. R2's admission MDS dated 12/27/20, identified R2 required extensive assistance for eating and personal hygiene. R3's quarterly MDS dated 11/18/20, identified R3 required supervision for meals and extensive assistance for personal hygiene. R4's quarterly MDS dated 12/2/20, identified R4 required total assistance on staff for eating and personal hygiene. R5's quarterly MDS dated 1/13/21, identified R10 required extensive assistance with meals and personal hygiene. R6's annual MDS dated 11/4/20, identified R6 required supervision/set up for meals and extensive assistance with personal hygiene. R7's significant change MDS dated 1/9/21, identified R7 required extensive assistance with meals and total assistance with personal hygiene. HAND HYGIENE AND PPE During an ongoing observation on 1/19/21, at 12:06 p.m. dining attendant (DA)-A pushed R1 in a wheel chair (wc) into the dining room. R1 and DA-A did not sanitize her hands. DA-A removed	F 880	1,2,3,4,5,6,7, we have identified areas of concern as noted with the survey. We have corrected these areas by implementing additional training on hand hygiene and personal protective equipment (PPE) practices while providing meal services and removing PPE. Competencies have been developed with the Infection Control Practitioner and the Director of Nursing, we have initiated these competencies and audits to ensure that there is compliance in these areas that were found deficient. We have developed education materials on hand hygiene and PPE, for staff educating them on when it is necessary to do hand hygiene and when/what proper PPE needs to be worn in different situations. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the risk for potential cross contamination to others by these deficient practices. Staff have completed audits to ensure proper hand washing with the removal of PPE and proper PPE are worn during meal services. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. The staff will be educated on following the hand washing and the proper PPE procedures during cares and at meal service. Education included that dietary staff follow the COVID precaution policy all dining staff will wear masks (surgical or KN 95) and will wear eye protection (shield or goggles) when in direct contact	

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F 880	Continued From page 4 an plate of food from the food cart, dessert, a glass of liquid, and placed it on the table in front of R1. DA-A sat down next to the R1 visited, touched her shoulder and arm then walked away. At 12:10 p.m. DA-A did not sanitize her hands and reached into the food cart and removed a plate of food, a dessert and placed on the table in front of R2. DA-A picked up R2's hand, placed the fork in her hand, and encouraged her to eat. DA-A did not sanitize her hands and walked back to the food cart, removed a plate of food, dessert, a glass of liquid, and placed it on the table in front of R5 and then adjusted his wc. DA-A did not sanitize her hands. At 12:15 p.m. DA-A reached into the food cart and removed a plate of food, dessert, a glass of liquid and placed it on the table in front of R3. DA-A removed R3's mask, touched her hair and face, and placed the mask on the table. DA-A touched R3's shoulder and asked her if she wanted butter on her bun. DA-A put on gloves, buttered the bun and removed the gloves. At 12:20 p.m. DA-A held R3's hand then stood up, removed her goggles, touched her face, adjusted her mask, and hung the goggles on the front of her shirt. At 12:25 p.m. DA-A did not sanitize her hands and walked over to R2's table and rubbed her shoulder and asked if she was ok. DA-A closed the doors to the food cart, pushed it into the kitchen and loaded up the automatic dish washer with dirty plates. At 12:45 p.m. 6 residents (R1, R2, R3, R4, R5, R6) and 3 staff remained in the dining room. DA-A did not sanitize her hands applied gloves, removed dirty dishes from R4's and R6's table, sanitized the tables, and visited with residents. DA-A failed to wear her goggles and sanitize her hands during meal service. During an interview on 1/19/21, at 12:50 p.m. with	F 880	with residents. Dietary staff have been educated on proper hand sanitizing after they have assisted a resident to the table (by pushing wheelchairs into the dining room), after they have removed a tray from the food cart, between each table of service when they are assisting residents with tray set up , after they have touched a residents body (shoulder, arm, hand, face, hair, etc.) , after they have assisted a resident with removing their mask, and sanitize hands when they are changing tasks. As well at any time that the staff have touched their eye protection or masks, and anytime that the staff remove their gloves. Dietary staff have been educated on the need to wear proper PPE which always includes eye protection and facial masks. Nursing staff educated on the need to follow facility Infection control policy that staff are to require to perform hand hygiene before and after all patient contact, contact with infectious material and before and after removal of PPE, including gloves. Nursing staff have been educated that all PPE is kept in the nursing office and not on the railings by resident rooms. Education will take place on 2/15-2/17/21 at varying times to capture all staff. How the facility will monitor its corrective actions to ensure that the deficient practice is being correct and recur. QAPI (Quality Assurance and Performance Improvement) audits will be conducted to ensure that all staff are following facility Infection control policies	

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F 880	Continued From page 5 DA-A indicated R1 had sat in her wc in the hallway prior to the meal. DA-A wheeled R1 into the dining room and failed to sanitize her hands and R1's hands. DA-A also indicated she did not sanitize her hands after she assisted R1. DA-A verified it is an expectation of staff to encourage and assist residents with sanitization of their hands prior to when they enter and exit the dining room. DA-A indicated it is an expectation of staff to sanitize their hands prior to putting on gloves, after the removal of gloves, and after touching a resident. During the interview DA-A failed to wear eye protection. During an ongoing observation on 1/20/21, at 11:48 a.m. DA-A pushed a food cart in to the dining room. She did not have eye protection on. DA-A walked into the kitchen and grabbed a box of plate covers. DA-A placed them over each plate of food, added drinks, and dessert to each tray, and then wheeled the food cart to the doorway to hand off to another staff member to deliver to resident's rooms. At 12:00 p.m. DA-A remained in the dining room and placed a plate of uncovered food on the table in front of R4. Without sanitizing her hands DA-A placed a plate of uncovered food, a glass of liquid, and dessert on the table in front of R1. R1 indicated she needed to go to the bathroom. DA-A removed the plate from her table, patted R1 on the back, repositioned the wc, placed her plate back into food cart, and did not sanitize her hands. DA-A removed a plate of food, a glass of liquid, and placed it on the table in front of R7. DA-A removed a plate of food from the food cart, added dessert, and glass of liquid, and placed it on the table in front of R5. DA-A patted R5 on his back, bent over and talked to him, then walked back to the food cart and removed another uncovered	F 880	on handwashing and proper PPE. Audits will include observation of facility staff and interviewing staff putting on and removing PPE, and proper hand hygiene before/after cares, and when providing meal service. Audits will be completed to ensure proper procedure of hand hygiene is occurring when staff are entering/leaving isolation rooms, when they are removing their PPE. These audits will be done weekly to reach 100% compliance and as needed to ensure compliance rates., then randomly by Director of Nursing and/or designee. Results of the audits will be taken to the QAPI committee for further recommendations. The date that that each deficiency will be covered. Completion date: 2/17/21 DIRECTED PLAN OF CORRECTION HAND HYGIENE " Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. The facility will have an infection control prevention and control program which it investigates, controls, and monitors that proper procedures are used to prevent infections within the facility. For resident 1,2,3,4,5,6,7, we have identified areas of concern as noted with the survey. We have corrected these areas by implementing additional training on hand hygiene and personal protective equipment (PPE) practices while providing	

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F 880	Continued From page 6 plate of food, added a glass of liquid, dessert, and placed in on the table in front of R6. DA-A failed to sanitize her hands and wear eye protection during meal service in the dining room. During an interview on 1/20/21, at 12:55 p.m. Infection Preventionist (IFP) indicated staff were expected to sanitize their hands before and after glove use, from resident to resident, and after touching anything that is contaminated. IFP indicated all residents are expected to sanitize hands before and after entering the dining room for meals. IFP indicated hand hygiene would help prevent the spread of infection. IFP also indicated staff were expected to wear eye protection during resident cares, walking down the hall, anytime they have resident contact, and in the dining room while meals were served and residents were assisted. During an interview on 1/20/21, at 1:35 p.m. director of nursing (DON) indicated residents were expected to sanitize their hands prior to entering the dining room. Staff were expected to sanitize their hands every time they touched something, left a room, and before and after they assisted a resident in the dining room. DON also indicated staff were expected to wear eye protection during meal service and during contact with a resident. During an interview on 1/21/21, at 7:50 a.m. culinary supervisor (CS)-A indicated staff were expected to sanitize their hands when they prepared food, go from one task to another, during food service to each table, and after removal of gloves to help prevent the spread of germs. CS-A also indicated all staff were expected to wear eye protection during meal	F 880	meal services. Competencies have been developed with the Infection Control Practitioner and the Director of Nursing, we have initiated these competencies and audits to ensure that there is compliance in these areas that were found deficient. We have developed education materials on hand hygiene and PPE, for staff educating them on when it is necessary to do hand hygiene and when/what proper PPE needs to be worn in different situations. " Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the risk for potential cross contamination to others by these deficient practices. Staff have completed audits to ensure proper hand washing with the removal of PPE and proper PPE are worn during meal services. POLICIES/PROCEDURES/SYSTEM CHANGES: " The facility□s Quality Assurance and Performance Improvement Committee must conduct a root cause analysis (RCA) to identify the problem(s) that resulted in this deficiency and develop intervention or corrective action plan to prevent recurrence. Hand hygiene Root Cause Analysis The root cause analysis was completed by the DON, Infection Preventionist and other facility Nurse managers. The deficient practice found was hand hygiene not being completed at all appropriate times during donning and doffing procedures of PPE and during meal service. Staff were observed to fail	

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F 880	Continued From page 7 service to help provide another barrier to help prevent the spread of COVID-19. HAND HYGIENE R8's quarterly MDS dated 12/24/20, identified extensive assistance needed for bed mobility, personal hygiene, eating, toileting, and transfers. R8's care plan dated 7/1/20, R8 had positive Covid 19 test, droplet precautions. Activities of daily living (ADL) self care deficit required extensive assitance with cares (wash face,/hands, mouth cares, back rub, pericares). During an ongoing observation on 1/20/21, at 9:45 a.m. nursing assistant (NA)-A identified R8 was COVID-19 positive. NA-A indicated she would complete personal morning cares and provide assitance with breakfast. NA-A removed her surgical mask and tossed in into the garbage can. NA-A removed the N95 mask from a paper bag placed on the railing in the hallway. NA-A applied a surgical mask over the N95 mask, booties, hair covering, gown, gloves, and entered R8's isolation room. At 10:49 a.m. NA-A exited R8's room with eye protection and the N95 still on. NA-A removed the N95 mask, placed the mask in the paper bag located on the railing. NA-A did not sanitize her hands opened the isolation care drawer, removed a clean surgical mask and placed one her face. NA-A picked up the paper bag that contained the N95 mask and walked down the hallway. During an interview on 1/20/21, at 10:54 a.m. NA-A verified she exited R8's room, removed the N95 mask and without sanitizing her hands reached into the isolation cart drawer, grabbed a	F 880	to follow proper Infection Control procedures regarding providing meal service in the dining room, dining staff failed to do hand hygiene after passing plates to residents, touching residents, and touching their own masks/eye protection. Staff was also observed when removing potentially infectious PPE, removing a soiled mask, and opening a drawer on infection cart and getting a new mask and applying this with no hand hygiene completed. After investigation, the problem main causes were identified. The limited hands-on education for staff was lacking due to the COVID-19 pandemic and the social distancing guidelines on hands on education was inhibited. This included new staff that were hired during the pandemic. Another cause that was found was the lack of staff□s understanding of the PPE policy including hand hygiene. Changes that will be made to correct this deficient practice will be made to ensure all appropriate hand hygiene and PPE procedures are followed. Further education for all staff including dietary and nursing staff will be completed. ICP and DON will post signage throughout the facility with the proper steps to follow for hand hygiene and donning/doffing PPE. Audits specific to hand hygiene during meal service and donning/doffing PPE will be completed following the guidelines set on the DPOC. To monitor the effectiveness of the changes and audits these will be reviewed, a goal of 100% compliance for proper hand hygiene with meal services	

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F 880	Continued From page 8 surgical mask, and applied it to her face. NA-A also stated she did not sanitize her hands after she removed the N95 mask or prior to application of the clean mask. NA-A indicated she should have sanitized her hands after the removal of the N95 mask and prior to application of the clean mask. During an interview on 1/20/21, at 12:55 p.m. IFP identified staff were expected to take off outer mask, sanitize their hands, and leave on the N95 and eye protection prior to leaving COVID positive room. The staff should not have a paper bag on the railing and the N95 mask should not be removed. IFP also indicated staff were expected to sanitize their hands after the removal of the N95 mask prior to reaching into the isolation cart to get a new clean mask, before and after glove use, and before and after resident to resident contact and if they touched anything that's contaminated. During an interview on 1/20/21, at 1:35 p.m. with the director of nursing (DON) identified prior to exiting an isolation room where the resident is on droplet precautions staff were expected to remove all their PPE in the resident's bathroom except their eye protection/faceshield and N95 mask, then sanitize hands and exit room. DON also indicated staff were also expected to sanitize their hands after removal of a N95 mask and prior to application of a clean mask to help protect themselves and others from germs and provide extra protection from infection. Review of a facility policy titled Infection Control Protocol revised 3/25/20, identified it is the policy of Knute Nelson to follow best practice guidelines and protocols as it relates to infection control,	F 880	and donning/doffing PPE will be put into place. The ICP and DON will review these audits weekly and as needed to ensure compliance rates. These audits will be brought to the QAPI committee and reviewed for compliance and any recommendations. The Infection Preventionist and Director of Nursing, shall complete the following: " Review hand hygiene policies and procedures to ensure that they meet CDC guidance, and revise as needed. The Infection Control/Hand Hygiene Policy was reviewed to ensure that it meets the CDC guideline along with the Infection Control/Standard Precautions was reviewed to ensure that it meets the CDC guidance and revise as needed. These policies were reviewed during our training. TAINING/EDUCATION " As part of the corrective action plan, the facility must provide training for the Infection Preventionist, the Director of Nursing, all staff providing care to residents, and all staff entering resident□s rooms, whether it be for resident□s dietary needs or cleaning and maintenance services. The training must cover standard infection control practices, including but not limited to, transmission-based precautions and adequately caring for and disinfecting shared medical equipment. Findings of the RCA should also be incorporated into the staff training. " The Infection Preventionist, Director of Nursing must implement competency	

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F 880	Continued From page 9 cleaning and disinfecting/sanitizing. Staff are required to perform hand hygiene using alcohol based hand sanitizer before and after all patient contact, contact with infectious material and before and after removal of personal protective equipment (PPE), including gloves. Review of facility policy titled Dining and Food Service Policy revised 3/18/20, identified with COVID precautions all dining services staff will wear masks (surgical or KN 95) and will wear eye protection (shield or goggles [sic]) when in direct contact with residents. Review of a facility policy titled Infection Control Contact Precautions Category: Hand Hygiene/Infection Control revised 1/2020, identified hand hygiene continues to be the primary means of preventing the transmission of infection. Perform hand hygiene before and after having direct contact with patients/residents, after contact with patients intact skin, before and after touching food to be given to a resident, before and after providing personal cares for a resident, and after removing gloves.	F 880	assessments for staff on proper hand hygiene and develop a system to ensure all staff have received the training and competency. The following video training was used for education for all staff from the CDC: Demonstrating of Donning (Putting on) PPE and Demonstration of Doffing (Taking off) PPE, a video on hand hygiene Why should I use soap and water with handwashing from CDC and a power point was used that included Hand Sanitizer Out and About from CDC. A post test was completed by all staff attending the training. MONITORING/AUDITING: " The Director of Nursing, the Infection Preventionist and other facility leadership will conduct audits on all shifts, every day for one week, then decrease the frequency based upon compliance. Audits should continue until 100% compliance is met. Competencies on hand hygiene during meal service and donning/doffing PPE have been developed by DON and ICP and each staff member went through the competency with a return demonstration to show their understanding of this competency. A post-test was completed after education. The Director of Nursing, Infection Preventionist or designee will monitor the effectiveness of the changes and audits these will be reviewed, a goal of 100% compliance for proper hand hygiene with meal services and donning/doffing PPE will be put into place. The ICP and DON will review these audits weekly and as	

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F 880	Continued From page 10	F 880	needed to ensure compliance rates. These audits will be brought to the QAPI committee and reviewed for compliance and any recommendations that is held the first Tuesday of every month.	

Minnesota Department of Health

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2 000	Initial Comments	2 000		

*****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 1/19/21 to 1/21/21, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be IN compliance with the MN State Licensure.

The following complaint was found to be UNSUBSTANTIATED: H5435028C

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2 000	Continued From page 1 NO orders were issued. 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		