DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 3, 2023

Administrator
Milaca Elim Meadows Health Care Center
730 Second Street Southeast
Milaca, MN 56353

RE: CCN: 245422
Cycle Start Date: December 22, 2022

Dear Administrator:

On January 10, 2023, we notified you a remedy was imposed. On February 9, 2023 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of February 7, 2023.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective March 22, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of January 10, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 22, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on February 7, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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Electronically delivered

March 3, 2023

Administrator
Milaca Elim Meadows Health Care Center
730 Second Street Southeast
Milaca, MN 56353

Re: Reinspection Results
Event ID: ZB6312

Dear Administrator:

On February 7, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 22, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 10, 2023

Administrator
Milaca Elim Meadows Health Care Center
730 Second Street Southeast
Milaca, MN 56353

RE: CCN: 245422
Cycle Start Date: December 22, 2022

Dear Administrator:

On December 22, 2022, a survey was completed at your facility by the Minnesota Department(s) 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 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:

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

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 22, 2023.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 22, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 22, 2023.

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.

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 $11,292; 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 22, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Milaca Elim Meadows Health Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 22, 2023. 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" and/or an "E" tag), i.e., the plan of correction should be directed to:

Karen Aldinger, Unit Supervisor
St. Cloud A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: karen.aldinger@state.mn.us
Office: (651) 201-3794 Mobile: (320) 249-2805

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 June 22, 2023 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:

Steven.Delich@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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@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.

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245422	A. BUILDING _____ B. WING _____	C 12/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILACA ELIM MEADOWS HEALTH CARE CENTER	730 SECOND STREET SOUTHEAST MILACA, MN 56353

(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 December 19, 2022 through December 22, 2022, 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 the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On December 19, 2022 through December 22, 2022, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT IN compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED, however NO deficiencies were cited due to actions implemented by the facility prior to survey: H5422033C (MN00081993) The following complaints were found to be UNSUBSTANTIATED: H54226796C (MN00088235) The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/18/2023

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 000	Continued From page 1 page of the CMS-2567 form. Although no plan of correction is required, the facility must acknowledge receipt of the electronic documents.	F 000		
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 §483.70(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	F 880		2/7/23

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F 880	Continued From page 2 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 ensure handwashing was performed during medication pass for 1 of 8 residents (R57) observed for medications. In addition, the facility failed to follow manufacturer instructions to discard opened tube feeding	F 880	It is the policy of Cassia Milaca Elim Meadows to comply with F880 To assure continued compliance, the following plan has been put into place; Regarding cited resident:	

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F 880	Continued From page 3 formula at least every 12 hours, for 1 of 1 residents (R33) reviewed for tube feeding. Also, the facility failed to disinfect a mechanical lift between use for 3 of 7 residents (R9, R3, and R24) observed for transfers with a mechanical lift. Findings include: R57's admission Minimum Data Set (MDS) dated 11/11/22, identified cognitively intact and diagnoses with right ankle surgery and was receiving intravenous (IV) antibiotics and wound vacuum. R57 was dependent upon staff for transfers and personal hygiene. During medication pass observation on 12/20/22, at 4:45 p.m. licensed practical nurse (LPN)-A began setting up evening medication for R57 which consisted of Eliquis (anticoagulant) and a of normal saline 0.9% in a 10 milliliter (ml) commercially filled syringe. Upon entering R57's room, LPN-A provided resident water and the dose of Eliquis, the donned disposable gloves to flush R57's PICC line (peripherally inserted central catheter) located on resident's left arm. LPN-A removed the end cap for the PICC line, and using a alcohol prep pad disinfected the needle-less connector. After aspirating for blood, to check for patency, LPN-A flushed the PICC and placed a new sterile end cap on. LPN-A then placed the empty syringe on one gloved hand doffing the syringe inside, then doffed the other glove around it as well. LPN-A then exited the room without any form of hand hygiene, walked to the medication cart disposing of the used gloves and syringe. LPN then pulled keys out of her pocket , opening the medication storage room quickly returning unused end caps then returned to the medication cart, signing off on the	F 880	R57- Actions taken to identify other potential residents having similar occurrences: All clinical staff will be trained on moments for hand hygiene. Measures put in place to ensure deficient practice does not recur: Clinical staff will be educated on moments for hand hygiene. Effective implementation of actions will be monitored by: The clinical managers will audit clinical staff for weekly x1 month alternating shifts, then monthly for 3 months. Results of these audits will be reviewed by the facility QAPI committee and they will make the decision if further monitoring/audits are recommended. Those responsible to maintain compliance will be: The Director of Nursing, ADON, and Infection Preventionist, or designee is responsible for maintain compliance. Completion date for certification purposes only is: February 7th, 2023 Regarding cited resident: R9, R3, & R24 Actions taken to identify other potential residents having similar occurrences:	

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F 880	Continued From page 4 medication and PICC line flush all without any form of hand hygiene. When interviewed on 12/20/22, at 5:00 p.m. LPN-A stated she had forgotten to wash or disinfect her hands before leaving the R57's room and should have. During an interview on 12/21/22, at 10:09 a.m. the infection preventionist nurse (IP) stated it would be the expectation to perform hand hygiene before LPN-A left the room, especially while R57 was on precautions. The facility policy titled, Hand Hygiene (revised date of 8/12/22) indicated the following: "Hand washing / sanitizing is necessary: 1. Before and after providing care to resident 2. before and between passing meal trays. 3. before eating or handling food. 4. Before and after using the bathroom. 5. After coughing/sneezing, blowing nose, or combing to touching your hair. 6. After removing gloves. 7. After each resident contact. 8. After touching environmental surfaces or equipment near residents. 9. After contact with your own face or mask. 10. Before and after smoking. 11. After handling dressings, catheters, bed pans, specimen or urine. 12. Before any invasive procedure such as administering injections. 13. When hands are visibly soiled. 14. After removing personal protective equipment (PPE)."	F 880	All Cleaning wipe canisters stored on lifts used for residents were checked to make sure they were not dry. Measures put in place to ensure deficient practice does not recur: Clinical staff will be educated on when to clean the lifts. Effective implementation of actions will be monitored by: The clinical managers will audit clinical staff for weekly x1 month alternating shifts, then monthly for 3 months. Results of these audits will be reviewed by the facility QAPI committee and they will make the decision if further monitoring/audits are recommended. Those responsible to maintain compliance will be: The Director of Nursing, ADON, and Infection Preventionist, or designee is responsible for maintain compliance. Completion date for certification purposes only is: February 7th, 2023 Regarding cited resident: R33 Actions taken to identify other potential residents having similar occurrences: The facility will identify all other resident who require enteral feedings, check formula type and ensure proper storage.	

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F 880	Continued From page 5 R33's quarterly MDS dated 10/28/22, identified a traumatic brain injury and received nourishment via parenteral/intravenous feeding and was dependent upon staff for feeding. R33's diagnosis list printed on 12/21/22, included diagnoses of traumatic brain injury with loss of consciousness, hydrocephalus-swelling of the brain, encounter for attention to tracheostomy and encounter for attention to gastrostomy-tube (G-tube) in the stomach to assist in feeding. R33's care plan printed 12/21/22, indicated a concern with nutrition related to tube feedings. Interventions included if cans were used for feeding all equipment had to be changed every twenty-four (24) hours (HRS) and if the prepackaged bottles were used the bottle had to be changed every forty-eight (48) hours. R33's Physician Order Report printed 12/21/22, indicated R33 had order started on 11/22/22, for enteral feeding: Jevity 1.5 bolus, 6 ounce per "G-Tube" four times a day. During observation on 12/19/22, 03:03 p.m. a 1000 milliliter (ML) bottle of Jevity 1.5 cal tube feeding solution was noted on R33's bedside table along side other tube feeding equipment. The bottle was noted to have the date 12/17/22 written on the side of the bottle in large letters. The bottle was noted to have approximately 50-75 ML of tan solution in the bottle. The cap had the same tan solution on top of the cap and	F 880	Nurses were educated on proper handling and storage of enteral feeding. Measures put in place to ensure deficient practice does not recur: On 12/19/2022, Open bottle labeled 12/17/2022 was removed from room and discarded. Nurses educated on Closed feeding systems and open feeding systems, as well as manufacturers feeding guidelines. R33 was changed from 1000ml bottles of feeding to smaller cans to prevent occurrence of leftover formula therefore preventing contamination of bacterial growth in feeding supplies. If ordered amount is less than total amount provided in can, leftovers are closed, dated, timed and placed in refrigerator or discarded. Left over feedings will be discarded per manufacturers guidelines. Effective implementation of actions will be monitored by: The clinical managers will audit clinical staff for weekly x1 month alternating shifts, then monthly for 3 months. Results of these audits will be reviewed by the facility QAPI committee and they will make the decision if further monitoring/audits are recommended. Those responsible to maintain compliance will be: The Director of Nursing, ADON, and Infection Preventionist, or designee is responsible for maintain compliance.	

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MILACA ELIM MEADOWS HEALTH CARE CENTER	730 SECOND STREET SOUTHEAST MILACA, MN 56353

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F 880	Continued From page 6 the seal protecting the solution had been punctured. There was no Tubing attached to the bottle. During interview on 12/19/22, at 03:15 p.m. Registered nurse (RN)-A stated she had performed R33's scheduled tube feeding bolus at noon that day. RN-A stated she had used a 1000 ML closed system bottle to perform the scheduled feeding. RN-A entered R33's room and acknowledged the bottle dated 12/17/22, was the bottle use for the feeding that day. RN-stated nursing would open a new bottle and leave it at bedside so all nurses could use it for bolus feeding, and the bottle would get changed about every 2 days, maybe a little longer. RN-A stated that procedure had been done since R33's order had changed in November. RN-A stated she believed it would be ok to change the large tube feeding bottles every 48 HRS. During interview on 12/19/22, at 03:21 p.m. the registered dietician (RD) stated if a 1000 cc bottle of tube feeding was used as an enclosed system, where there was no break between the bottle, tubing and the resident, then everything would be changed every 48 HRS. If there was an opening in the bottle that did not have tubing attached to it, then the tube feeding bottle would need to be changed every 24 HRS. RD entered R33's room and acknowledge the current bottle was not considered an enclosed system and was not safe to use past 48 HRS. The RD stated the current bottle had not been safe to use for the last 24 HRS. The RD stated it would be important to change out bottles of tube feeding every 24 HRS so the increased risk of infection would be prevented.	F 880	Completion date for certification purposes only is: February 7th, 2023 Regarding cited resident: R9, R3, & R24 Actions taken to identify other potential residents having similar occurrences: All Cleaning wipe canisters stored on lifts used for residents were checked to make sure they were not dry. Measures put in place to ensure deficient practice does not recur: Clinical staff will be educated on when to clean the lifts. Effective implementation of actions will be monitored by: The clinical managers will audit clinical staff for weekly x1 month alternating shifts, then monthly for 3 months. Results of these audits will be reviewed by the facility QAPI committee and they will make the decision if further monitoring/audits are recommended. Those responsible to maintain compliance will be: The Director of Nursing, ADON, and Infection Preventionist, or designee is responsible for maintain compliance. Completion date for certification purposes only is: February 7th, 2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245422	A. BUILDING _____ B. WING _____	C 12/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILACA ELIM MEADOWS HEALTH CARE CENTER	730 SECOND STREET SOUTHEAST MILACA, MN 56353

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F 880	Continued From page 7 During interview on 12/21/22, at 1:03 p.m. the director of nursing (DON) stated she expected staff would follow the protocol and would use tube feeding in the appropriate timeframe and get a new bottle when time. Jevity Enteral Nutrition Formula information sheet, undated, identified the solution could only be open and at room temperature for a maximum of 12 hours to prevent from bacteria growth. The facility policy Tube Feeding/enteral feeding-Gravity or Bolus Feeding last revised 5/17/21 indicated formula should have been discarded eight HRS after opened. On 12/20/22, at 4:49 p.m. nursing assistant (NA)-B stated she had education on personal protective equipment (PPE) and infection prevention. NA-B stated when she sanitizes equipment she looks at facility signs posted if she is not sure what wipes to use or how long stuff should be wet to for proper sanitization. On 12/21/22, at 8:42 a.m. NA-A came out of R9's room and placed a hoyer lift in the south hallway. Shortly after, NA-A returned and took the hoyer lift into R3's room. On 12/21/22, at 08:50 AM NA-A brought hoyer lift out of R3's room and did not wipe lift down. NA-A then grabbed the same lift and entered R24's room with the lift. NA-A was asked to step out of the room and share process for cleaning equipment between residents. NA-A pointed at the wipe container stored on the hoyer lift, and stated, "we use these wipes, and we usually wipe	F 880		

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F 880	Continued From page 8 stuff down in the room or hall after we leave room." NA-A opened the wipe container to show a couple wipes left in the container. NA-A verified the wipes were mostly dry to touch but stated she would still use the wipes. NA-A stated she did not know about dwell times, or that times were listed on the container for how long equipment needed to remain wet to ensure proper sanitization between residents. NA-A verified the wipe container listed a two-minute dwell time. NA-A verified she did not sanitize the hoyer before entering R9, R3 or R24's room. On 12/21/22, at 10:09 a.m. the infection preventionist (IP) verified staff should be using appropriate wipes between residents to disinfect all high touch surfaces on the hoyer. The wipes should be saturated, they may dry out if the top is left open. On 12/22/22, at 1:10 p.m. the director of nursing (DON) verified that staff should sanitize equipment with appropriate wipes between patient use.	F 880		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245422	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/21/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILACA ELIM MEADOWS HEALTH CARE CENTER	**730 SECOND STREET SOUTHEAST** **MILACA, MN 56353**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 12/21/2022. At the time of this survey, Milaca Elim Meadows Health Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/18/2023

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

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K 000	Continued From page 1	K 000		

Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101-5145, OR

By email to:
FM.HC.Inspections@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A detailed description of the corrective action taken or planned to correct the deficiency.

2. Address the measures that will be put in place to ensure the deficiency does not reoccur.

3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.

4. Identify who is responsible for the corrective actions and monitoring of compliance.

5. The actual or proposed date for completion of the remedy.

The facility was inspected as one facility:
Milaca Elim Meadows Health Care Center is a 1-story building with a small partial basement. The basement is not used by the nursing home residents. The building was constructed in 1963, with additions in 1973 77 & 89. A chapel and connector link to the assisted living unit was constructed in 2006. The original building and the additions are all Type II (111) constr uction.

The building is fully fire sprinkler protected. The

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K 000	Continued From page 2 facility has a complete fire alarm system with smoke detection in spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 70 beds and had a census of 58 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition),	K 353	1 The damaged sprinkler head was replaced on 1-10-23 #2 Educate staff to notify maintenance right away if they damage or notice a	1/19/23

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	245422	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/21/2022**

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K 353	Continued From page 3 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.2.1.1 through 5.2.1.1.2. This deficient finding could have a isolated impact on the residents within the facility. Findings include: On 12/21/2022 at 11:30 AM, observation revealed a sprinkler head on the south wing by room 216 with a damaged deflector. An interview with the Environmental Services Director verified this deficient finding at the time of discovery.	K 353	damaged sprinkler head. #3 We will put a new task on our preventive maintenance care program to inspect all sprinkler heads monthly. #4 the Environmental service director (Patrick Johnson) will be responsible for monitoring of compliance. #5 Date for completion of remedy is 1-19-23	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 10, 2023

Administrator
Milaca Elim Meadows Health Care Center
730 Second Street Southeast
Milaca, MN 56353

Re: State Nursing Home Licensing Orders
Event ID: ZB6311

Dear Administrator:

The above facility was surveyed on December 19, 2022 through December 22, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Karen Aldinger, Unit Supervisor
St. Cloud A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: karen.aldinger@state.mn.us
Office: (651) 201-3794 Mobile: (320) 249-2805

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00376	A. BUILDING: _____ B. WING _____	C 12/22/2022

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On December 19, 2022 through December 22, 2022, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found to be NOT IN compliance with MN State Licensure.	2 000		

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2 000	Continued From page 1 The following complaints were found to be SUBSTANTIATED, however NO Licensing orders were cited due to actions implemented by the facility prior to survey: H5422033C (MN00081993) The following complaints were found to be UNSUBSTANTIATED: H54226796C (MN00088235) Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/inf	2 000		

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2 000	Continued From page 2 obul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure handwashing was performed during medication pass for 1 of 8 residents (R57) observed for medications. In addition, the facility failed to follow manufacturer	21385	Corrected.	2/7/23

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21385	Continued From page 3 instructions to discard opened tube feeding formula at least every 12 hours, for 1 of 1 residents (R33) reviewed for tube feeding. Also, the facility failed to disinfect a mechanical lift between use for 3 of 7 residents (R9, R3, and R24) observed for transfers with a mechanical lift. Findings include: R57's admission Minimum Data Set (MDS) dated 11/11/22, identified cognitively intact and diagnoses with right ankle surgery and was receiving intravenous (IV) antibiotics and wound vacuum. R57 was dependent upon staff for transfers and personal hygiene. During medication pass observation on 12/20/22, at 4:45 p.m. licensed practical nurse (LPN)-A began setting up evening medication for R57 which consisted of Eliquis (anticoagulant) and a of normal saline 0.9% in a 10 milliliter (ml) commercially filled syringe. Upon entering R57's room, LPN-A provided resident water and the dose of Eliquis, the donned disposable gloves to flush R57's PICC line (peripherally inserted central catheter) located on resident's left arm. LPN-A removed the end cap for the PICC line, and using a alcohol prep pad disinfected the needle-less connector. After aspirating for blood, to check for patency, LPN-A flushed the PICC and placed a new sterile end cap on. LPN-A then placed the empty syringe on one gloved hand doffing the syringe inside, then doffed the other glove around it as well. LPN-A then exited the room without any form of hand hygiene, walked to the medication cart disposing of the used gloves and syringe. LPN then pulled keys out of her pocket , opening the medication storage room quickly returning unused end caps then returned to the medication cart, signing off on the	21385		

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MILACA ELIM MEADOWS HEALTH CARE CEN	730 SECOND STREET SOUTHEAST MILACA, MN 56353

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21385	Continued From page 4 medication and PICC line flush all without any form of hand hygiene. When interviewed on 12/20/22, at 5:00 p.m. LPN-A stated she had forgotten to wash or disinfect her hands before leaving the R57's room and should have. During an interview on 12/21/22, at 10:09 a.m. the infection preventionist nurse (IP) stated it would be the expectation to perform hand hygiene before LPN-A left the room, especially while R57 was on precautions. The facility policy titled, Hand Hygiene (revised date of 8/12/22) indicated the following: "Hand washing / sanitizing is necessary: 1. Before and after providing care to resident 2. before and between passing meal trays. 3. before eating or handling food. 4. Before and after using the bathroom. 5. After coughing/sneezing, blowing nose, or combing to touching your hair. 6. After removing gloves. 7. After each resident contact. 8. After touching environmental surfaces or equipment near residents. 9. After contact with your own face or mask. 10. Before and after smoking. 11. After handling dressings, catheters, bed pans, specimen or urine. 12. Before any invasive procedure such as administering injections. 13. When hands are visibly soiled. 14. After removing personal protective equipment (PPE)."	21385		

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	00376	A. BUILDING: _____ B. WING _____	C 12/22/2022

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21385	Continued From page 5 R33's quarterly MDS dated 10/28/22, identified a traumatic brain injury and received nourishment via parenteral/intravenous feeding and was dependent upon staff for feeding. R33's diagnosis list printed on 12/21/22, included diagnoses of traumatic brain injury with loss of consciousness, hydrocephalus-swelling of the brain, encounter for attention to tracheostomy and encounter for attention to gastrostomy-tube (G-tube) in the stomach to assist in feeding. R33's care plan printed 12/21/22, indicated a concern with nutrition related to tube feedings. Interventions included if cans were used for feeding all equipment had to be changed every twenty-four (24) hours (HRS) and if the prepackaged bottles were used the bottle had to be changed every forty-eight (48) hours. R33's Physician Order Report printed 12/21/22, indicated R33 had order started on 11/22/22, for enteral feeding: Jevity 1.5 bolus, 6 ounce per "G-Tube" four times a day. During observation on 12/19/22, 03:03 p.m. a 1000 milliliter (ML) bottle of Jevity 1.5 cal tube feeding solution was noted on R33's bedside table along side other tube feeding equipment. The bottle was noted to have the date 12/17/22 written on the side of the bottle in large letters. The bottle was noted to have approximately 50-75 ML of tan solution in the bottle. The cap had the same tan solution on top of the cap and the seal protecting the solution had been punctured. There was no Tubing attached to the bottle. During interview on 12/19/22, at 03:15 p.m. Registered nurse (RN)-A stated she had	21385		

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21385	Continued From page 6 performed R33's scheduled tube feeding bolus at noon that day. RN-A stated she had used a 1000 ML closed system bottle to perform the scheduled feeding. RN-A entered R33's room and acknowledged the bottle dated 12/17/22, was the bottle use for the feeding that day. RN-stated nursing would open a new bottle and leave it at bedside so all nurses could use it for bolus feeding, and the bottle would get changed about every 2 days, maybe a little longer. RN-A stated that procedure had been done since R33's order had changed in November. RN-A stated she believed it would be ok to change the large tube feeding bottles every 48 HRS. During interview on 12/19/22, at 03:21 p.m. the registered dietician (RD) stated if a 1000 cc bottle of tube feeding was used as an enclosed system, where there was no break between the bottle, tubing and the resident, then everything would be changed every 48 HRS. If there was an opening in the bottle that did not have tubing attached to it, then the tube feeding bottle would need to be changed every 24 HRS. RD entered R33's room and acknowledge the current bottle was not considered an enclosed system and was not safe to use past 48 HRS. The RD stated the current bottle had not been safe to use for the last 24 HRS. The RD stated it would be important to change out bottles of tube feeding every 24 HRS so the increased risk of infection would be prevented. During interview on 12/21/22, at 1:03 p.m. the director of nursing (DON) stated she expected staff would follow the protocol and would use tube feeding in the appropriate timeframe and get a new bottle when time. Jevity Enteral Nutrition Formula information	21385		

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21385	Continued From page 7 sheet, undated, identified the solution could only be open and at room temperature for a maximum of 12 hours to prevent from bacteria growth. The facility policy Tube Feeding/enteral feeding-Gravity or Bolus Feeding last revised 5/17/21 indicated formula should have been discarded eight HRS after opened. On 12/20/22, at 4:49 p.m. nursing assistant (NA)-B stated she had education on personal protective equipment (PPE) and infection prevention. NA-B stated when she sanitizes equipment she looks at facility signs posted if she is not sure what wipes to use or how long stuff should be wet to for proper sanitization. On 12/21/22, at 8:42 a.m. NA-A came out of R9's room and placed a hoyer lift in the south hallway. Shortly after, NA-A returned and took the hoyer lift into R3's room. On 12/21/22, at 08:50 AM NA-A brought hoyer lift out of R3's room and did not wipe lift down. NA-A then grabbed the same lift and entered R24's room with the lift. NA-A was asked to step out of the room and share process for cleaning equipment between residents. NA-A pointed at the wipe container stored on the hoyer lift, and stated, "we use these wipes, and we usually wipe stuff down in the room or hall after we leave room." NA-A opened the wipe container to show a couple wipes left in the container. NA-A verified the wipes were mostly dry to touch but stated she would still use the wipes. NA-A stated she did not know about dwell times, or that times were listed on the container for how long equipment needed to remain wet to ensure proper sanitization between residents. NA-A verified the wipe container listed a two-minute dwell time. NA-A verified she did not sanitize the hoyer before	21385		

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21385	Continued From page 8 entering R9, R3 or R24's room. On 12/21/22, at 10:09 a.m. the infection preventionist (IP) verified staff should be using appropriate wipes between residents to disinfect all high touch surfaces on the hoyer. The wipes should be saturated, they may dry out if the top is left open. On 12/22/22, at 1:10 p.m. the director of nursing (DON) verified that staff should sanitize equipment with appropriate wipes between patient use. Suggested Method of Correction: The DON (Director of Nursing) or designee could review/revise facility policies as needed to ensure they reflect current standards of practice for handwashing, tube feedings, and disinfecting mechanical lifts. In addition, the DON or designee could train staff and conduct audits to ensure compliance. Also, the DON or designee could report the results to quality assurance. Time Period for Correction: Twenty-one (21) days.	21385		