Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 1, 2024

Administrator
Aitkin Health Services
301 Minnesota Avenue South
Aitkin, MN 56431

RE: CCN: 245119
Cycle Start Date: December 21, 2023

Dear Administrator:

On January 19, 2024, we notified you a remedy was imposed. On February 26, 2024 the Minnesota Department of Health 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 16, 2024.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective March 21, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of January 19, 2024, 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 21, 2024 due to denial of payment for new admissions. Since your facility attained substantial compliance on February 16, 2024, 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 Therefore, the NATCEP prohibition is rescinded.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
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 5, 2024

Administrator
Aitkin Health Services
301 Minnesota Avenue South
Aitkin, MN 56431

RE: CCN: 245119
Cycle Start Date: December 21, 2023

Dear Administrator:

On December 21, 2023, 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by March 21, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by June 21, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR) / 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,

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

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January 5, 2024

Administrator
Aitkin Health Services
301 Minnesota Avenue South
Aitkin, MN 56431

Re: Event ID: LEGB11

Dear Administrator:

The above facility survey was completed on December 21, 2023 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,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245119	A. BUILDING _____ B. WING _____	C 12/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AITKIN HEALTH SERVICES	301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 12/19/23 through 12/21/23, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H51197941C (MN99225); H51197727C (MN92037); H51197619C (MN92795). As a result of the investigation, additional deficiencies were cited at F684 and F880. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to	F 684		2/2/24

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

Electronically Signed | 01/14/2024

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

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F 684	Continued From page 1 facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure coordination of care upon discharge from the hospital for 1 of 3 residents (R1) reviewed for change in condition. In addition, the facility failed to monitor a newly identified bruise for 1 of 3 residents (R1) reviewed. Findings include: R1's significant change minimal data set (MDS) dated 12/6/23, indicated R1 had diagnoses of dementia, anxiety and severe cognitive impairment. R1's care plan printed 12/19/23, identified R1 required assistance with activities of daily living (ADLs) such as dressing, toileting, grooming, transferring, and ambulating. R1's Emergency Department (ED) Provider Notes dated 11/26/23, revealed R1 was noted to have a closed fracture of multiple pubic rami with no restrictions, course of action recommended was weight bear as tolerated with walker. Further review of ED note indicated R1 had a urinalysis completed, which did not reveal any concern for a urinary tract infection (UTI). At the time of discharge from the ED, there were no urine culture (UC) results. Nurse practitioner (NP)-A signed and acknowledged she reviewed the document on 11/28/23.	F 684	AHS will ensure that the resident's right to Quality of Care by having assessments when their condition changes and have their needs addressed and provided. Residents are to be given appropriate treatment and services in accordance with professional standards of practice and person-centered care. AHS failed to provide Quality of Care an assessment for a change of condition and no monitoring initiated for an unidentified bruise for resident R1. AHS staff did not provide timely assessment for R1 and did not read hospital summary identifying fracture and did not follow up on UC results. When results were obtained, AHS did not follow up in a timely manner. Education was provided to Licensed Nursing staff by 2/2/2024 on the process for the resident's aftercare summary findings, recommendations, orders and needed results follow-up. The policy for Accident/Incident were reviewed and a new process document, Resident Aftercare Summary Process to be followed for the reviewing and documentation of aftercare summary findings, recommendations, orders and needed results follow-up. The DON or designee will monitor	

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F 684	Continued From page 2 R1's UC Results dated 11/28/23, revealed culture contained Escherichia coli (E.Coli) and antibiotic recommended was Cefazolin. Further, document revealed fax with UC results was sent to facility on 12/7/23 at 4:09 p.m. However, facility signed and dated document on 12/9/23 as reviewed (2 days later). R1's Physician Orders dated 12/8/23, indicated NP-A ordered Cephalexin 500 mg by mouth every 8 hours for 7 days for a UTI with symptoms of urinary frequency, urgency, and confusion. In addition, an order to obtain the UC results from 11/26/23 ED visit. On 12/13/23, Cephalexin was discontinued. R1's progress notes revealed: - On 11/26/23 noted at 1:01 a.m., R1 was found on the floor on right side with her walker tipped over and yelling out help. R1's daughter was notified of fall and in agreement to have R1 sent into the ED for further evaluation to rule out any fractures. - On 11/26/23 noted at 7:33 a.m., R1 returned to the facility from the ED and no fracture was noted from the fall. R1 was noted to have pain to hip and needs assistance with transfers and walking. - On 11/27/23 noted at 3:39 a.m. R1 does have hip pain related to recent fall however no fractures noted. - On 11/28/23 noted at 10:14 a.m., R1 was scheduled a significant change assessment for next week related to new diagnosis of fracture from fall and increase in assistance from staff. On 12/21/23 at 10:00 a.m., licensed practical nurse (LPN)-B confirmed she was the floor nurse	F 684	residents post visit summary after return from outside visits for medical care, orders, for assessments, progress notes, provider/family notifications, and interventions. Results will be brought to IDT and QAPI for recommendations for ongoing monitoring. Audits will be completed with 2 random residents weekly for 6 weeks and then 1 resident randomly for 6 weeks.	

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F 684	Continued From page 3 upon R1 returning to the facility from the ED on 11/26/23. LPN-B stated LPN-A took verbal report from the hospital which the hospital failed to report R1's fracture at that time. LPN-B was not aware of R1 returning to the facility with any paperwork other than a script with an order for pain medication. Further, LPN-B stated the nurse managers on the unit were expected to review the hospital paperwork upon a resident returning to the facility and the floor nurses were not responsible as they don't have access to records that come through to the electronic system, Epic. LPN-B confirmed she did not review the paperwork from R1's ED visit upon R1 returning to the facility. On 12/21/23 at 10:57 a.m., LPN-A stated he transported R1 from the ED back to the facility on 11/26/23, and the hospital did not report R1 had a fracture at that time. LPN-A stated he was not aware of R1's fracture until NP-A reviewed the hospital paperwork a couple days later and notified him. Further, LPN-A stated the facility process for collaborating with the hospital following a resident's return was the floor nurse or charge nurse on duty would be expected to review the hospital paperwork the resident returns with. LPN-A confirmed he did not review the paperwork upon R1 returning. LPN-A was not sure if there was a UA and UC obtained while R1 was in the ED on 11/26/23. Reviewing R1's records in paper chart, LPN-A stated a UC was completed on 11/26/23 and results were completed on 11/28/23 and faxed to the facility on 12/7/23 at 4:05 p.m. but was unsure where the results went on 12/7/23 since NP-A wrote an order to obtain the results the following day on 12/8/23, so the staff must not have seen or reviewed the results sitting on the fax machine.	F 684		

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F 684	Continued From page 4 LPN-A stated the facility typically receives UC results sooner and "it shouldn't take that long to fax the results", had the facility received these results sooner, NP-A would have been updated and R1 would have received antibiotics sooner. However, LPN-A stated the delay in starting antibiotics was not a factor in R1's urinary retention or catheter placement. On 12/21/23 at 11:33 a.m., NP-A stated communication with the facility staff had been a challenge as information was not getting communicated that should be. NP-A stated she was reviewing R1's medical chart and had read the ED paperwork that was in R1's book, when she noted R1 had a fracture. NP-A was not aware of R1's fracture and no facility staff had reported it because no one read the paperwork upon R1's return from the ED on 11/26/23. NP-A expressed frustration as the paperwork clearly identified R1 had a fracture and stated thankfully there were no restrictions related to the fracture as R1 was weight bearing as tolerated. Further, NP-A stated typically a UC would not be completed if a UA came back clear, which was the case for R1. NP-A stated if she would have been notified of the UC results sooner she would not have changed the course of treatment for R1 since R1's UA was clear, and NP-A did not feel the delay in antibiotic treatment caused the urinary retention as it could have been caused by R1's decreased mobility that changed dramatically following the fall on 11/26/23. Director of Nursing was unavailable for interview during survey. On 12/21/23 at 12:07 p.m., administrator was unsure of the process for collaborating with the	F 684		

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F 684	Continued From page 5 hospital to ensure effective communication following a resident's return to the facility. Facility failed to provide a copy of policy related to collaborating efforts with hospital following a resident's return to the facility. R1's significant change minimal data set (MDS) dated 12/6/23, indicated R1 had diagnoses of dementia, anxiety and had severe cognitive impairment. R1's care plan printed 12/19/23, identified R1 required assistance with activities of daily living (ADLs) such as dressing, toileting, grooming, transferring, and ambulating. R1's Healed Wounds assessment dated 11/25/23, identified a bump on upper left back of head. Review of R1's medical record at start of survey on 12/19/23, lacked evidence of a bruise being identified. R1's progress note added on 12/21/23 at 9:22 a.m. revealed on 12/14/23, family had noted a bruise to be on the left side of neck, behind lower portion of R1's ear. Bruise was noted to be light purple color in center of bruise and the rest of bruise was yellowing in color (appeared to be an aging bruise). This area was approximately the size of a quarter. Bruise was suspected injury from one of the recent falls that were unwitnessed. R1 denied pain or discomfort, nor exhibited discomfort when this area was touched. Nurse manager aware of bruise and stated after skin check completed after bath and did not note this area during that time, nor did nursing assistant report prior to this day.	F 684		

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F 684	Continued From page 6 R1's medical record lacked any evidence of monitoring following identification of newly identified bruise. On 12/21/23 at 10:00 a.m., licensed practical nurse (LPN)-B stated she observed the bruise on 12/14/23, when family reported they took a picture of the "massive bruise". LPN-B stated she assumed the bruise appeared from one of R1's falls and staff didn't see it until R1 had got a haircut. LPN-B stated she was directed to add a late entry note because on 12/14/23 she was not the nurse on the floor but was working on paperwork, so management directed her to add in a late note. LPN-B stated staff were expected to add a treatment into the resident's record upon discovery of a newly identified bruise to monitor, which included description of bruise and if there was pain or swelling noted, until resolved. LPN-B confirmed she did not add any additional monitoring to R1's record after becoming aware of the bruise on 12/14/23. On 12/21/23 at 10:57 a.m., LPN-A stated he was aware of a bruise on R1's left side under her ear which appeared to be about a quarter size. LPN-A stated he assumed the bruise was from her first fall that occurred on 11/21/23 which resulted in a head strike. There was no pain for swelling when LPN-A palpated the area. Further, LPN-A stated staff were expected to document newly identified skin concerns under wound assessments and add a treatment to monitor the bruise, which typically was once daily to include color, size, and stage of healing, to ensure the bruise is healing and not getting worse or any other underlying issues. LPN-A confirmed R1's bruise that was identified on 12/14/23, was not monitored.	F 684		

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F 684	Continued From page 7 On 12/21/23 at 12:07 p.m., administrator stated staff were expected to document any newly identified skin concerns in the resident's record, however, was not sure if additional monitoring was expected. Facility failed to provide a copy of policy related to skin and monitoring following a newly identified bruise.	F 684		
F 880 SS=D	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,	F 880		2/2/24

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F 880	Continued From page 8 but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.	F 880		

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	245119	A. BUILDING _____ B. WING _____	C 12/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AITKIN HEALTH SERVICES	301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431

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F 880	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate personal protective equipment (PPE) was worn for 1 of 2 residents (R1) reviewed who was diagnosed with Coronavirus disease (COVID)-19. In addition, the facility failed to ensure visitors were educated on appropriate PPE while visiting a resident who was positive for COVID-19. Findings include: R1's significant change minimal data set (MDS) dated 12/6/23, indicated R1 had diagnoses of dementia, anxiety and had severe cognitive impairment. R1's care plan printed 12/19/23, identified R1 required assistance with activities of daily living (ADLs) such as dressing, toileting, grooming, transferring, and ambulating. Review of untitled document dated 12/15/23, identified a rapid swab was performed on R1 and returned with a positive COVID-19 result. R1 was immediately placed on isolation precautions per CDC regulations. Resident had staff that wear PPE for airborne precautions and don/doff PPE (gown, gloves, face shield, N95 face mask). R1's isolation period will end on 12/26/23. On 12/19/23 at 1:16 p.m., R1's door was closed, and isolation precaution signs were observed to be posted on the door and on the wall directing staff and visitors of appropriate PPE required upon entering R1's room. There was an isolation cart with PPE and a garbage bin with lid located outside the resident's door.	F 880	AHS will ensure that the proper eye protection is used by staff to prevent the spread of Covid-19. All staff and residents have the potential to be affected by not utilizing the proper eye protection and required PPE. Education will be provided to visitors, all residents, and staff by 2/2/2024 on proper PPE, including eye protection to use, and when to wear them. Education for visitors on what they need to know and do during a COVID 19 outbreak. The policies for Covid-19 Prevention, Screening and Identification, Care Center Visitation during a Covid-19 Outbreak and Covid 19 suspected or confirmed were reviewed/revised. Educare education training Infection Prevention & Control – PPE The DON or designee will do random audits 4x/week x 1 week, 2x/ week x1 week and weekly for 6 months. Audit results will be brought to the QAPI meeting for review and further recommendations.	

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F 880	Continued From page 10 Observation and interview on 12/20/23 at 10:49 a.m., visitor (V)-A opens R1's door from the inside of R1's room and was observed to be wearing a blue surgical mask, no other PPE that was identified on the signs posted to R1's door was worn by V-A. Nursing assistant (NA)-A and NA-B were observed to be outside of R1's door donning PPE which included gown, gloves, a blue surgical mask with a N95 over the surgical mask. NA-A and NA-B knocked on R1's door and entered R1's room with a mechanical lift and neither NA's were wearing eye protection. Surveyor looked in the isolation cart for a supply of eye protection available to the staff and none were noted to be in the cart. Surveyor knocked on R1's door and V-A opened the door and NA-A and NA-B were observed assisting R1 out of her recliner chair with the mechanical lift. NA-B came to the door, when asked where her eye protection was, NA-B stated "I don't know. I don't know if we need them." Surveyor notified social services who brought a supply of eye protection to NA-A and NA-B at 10:56 a.m. Observation and interview on 12/20/23 at approximately 11:00 a.m., NA-A exits R1's room and doffs PPE into the garbage outside of R1's door. NA-A stated this was her first day back to work after some time off (casual staff) and was not aware eye protection was needed in COVID positive resident rooms. Further, NA-A confirmed she had been in COVID-19 positive resident rooms earlier in her shift as well and did not don eye protection. On 11/20/23 at 11:35 a.m., NA-B stated she was a contracted agency staff member and had only been working at the facility for "a couple days".	F 880		

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F 880	Continued From page 11 NA-B stated since working at the facility, with COVID positive residents, she had not been wearing eye protection and stated, "I just forgot" and "I just didn't think about it". When asked about wearing an N95 over a surgical mask, NA-B stated, "I was doing it because everyone else was doing it this way". On 11/20/23 at 1:31 p.m., V-A was observed to exit R1's room with a surgical mask on, does not use hand sanitizer, and exits the building. An unidentified male visitor, V-B, exits R1's room wearing a surgical mask and no additional PPE as well, stating he with an audiology company. VA-B stated he was aware R1 was positive for COVID but was unsure what PPE was required to be worn into R1's room as he did not alert staff of his visit. V-B stated, "now I will just pray". On 12/20/23 at 1:31 p.m., licensed practical nurse (LPN)-C stated staff were required to wear gown, gloves, N95 mask, as well as eye protection into COVID positive resident rooms. Further, LPN-C stated she had observed staff not wearing eye protection for a "few days" despite the facility having a supply available for all staff. LPN-B stated eye protection would be important PPE to wear into COVID positive rooms due to eyes being an open membrane and keeps bodily fluids out. In addition, LPN-C stated visitors, who are going into COVID positive rooms, have been directed to wear a mask but no additional PPE. On 12/20/23 at 2:07 p.m., registered nurse (RN)-A stated staff were required to wear gown, gloves, N95 mask and eye protection. RN-A stated she had concerns regarding staff not wearing eye protection into COVID positive rooms and had been reminding staff to wear them. RN-A	F 880		

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F 880	Continued From page 12 stated visitors were expected to wear a mask but no other PPE while visiting a COVID positive resident. On 12/20/23 at 3:54 p.m., LPN-A stated staff were required to wear gown, gloves, mask, and eye protection into COVID positive resident rooms. There are isolation carts with PPE supplies outside each quarantine room. In addition, LPN-A stated visitors were expected to wear the same PPE as staff were required to wear into a COVID positive resident room and are asked to stay in the room. DON was unavailable to interview during survey. On 12/21/23 at 12:07 p.m., administrator stated staff were required to follow facility policy regarding PPE use in COVID positive resident rooms, which included wearing eye protection. Further, administrator stated visitors were expected to follow PPE protocol as well while visiting a COVID positive resident, however visitors have the option to decline. Review of facility policy titled Suspected (or Confirmed) Coronavirus (COVID-19) Outbreak revised 7/25/23, directed staff to limit only essential personnel to enter the room of an isolated resident with appropriate PPE and respiratory protection as follows: gloves, gown, masks, eye protection, face shield. Further policy revealed eye protection should cover both the front and sides of the face. Review of facility policy titled Care Center Visitation during a COVID-19 Outbreak revised 12/3/23, identified all visitors to those who are in quarantine or in a designated COVID unit will use	F 880		

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F 880	Continued From page 13 the same PPE as required by staff (with the exception of an N95 respirator).	F 880		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 12/19/23 through 12/21/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure The following complaints were reviewed:	2 000		

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2 000	Continued From page 1 H51197941C (MN99225); H51197727C (MN92037); H51197619C (MN92795). Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		