Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
May 18, 2023

Administrator
Rochester East Health Services
501 Eighth Avenue Southeast
Rochester, MN 55904

RE: CCN: 245184
Cycle Start Date: April 20, 2023

Dear Administrator:

On May 18, 2023, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 18, 2023

Administrator
Rochester East Health Services
501 Eighth Avenue Southeast
Rochester, MN 55904

Re: Reinspection Results
Event ID: K9FY12

Dear Administrator:

On May 18, 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 April 20, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

DEPARTMENT OF HEALTH

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April 28, 2023

Administrator
Rochester East Health Services
501 Eighth Avenue Southeast
Rochester, MN 55904

RE: CCN: 245184
Cycle Start Date: April 20, 2023

Dear Administrator:

On April 20, 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:

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 July 20, 2023 (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 October 20, 2023 (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,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING _____ B. WING _____	C 04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHESTER EAST HEALTH SERVICES	501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904

(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 4/20/23, 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 complaint was reviewed with no deficiencies issued, H51841455C (MN000991568). The following complaint was reviewed, H51841450C (MN00092751) with a deficiencies issued at F609 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 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property,	F 609		5/15/23

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

Electronically Signed | 05/05/2023

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 609	Continued From page 1 are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure an incident of serious bodily injury was reported to the state agency (SA) immediately, but no later than 2 hours for 1 of 3 residents (R1) reviewed for allegations of abuse. Findings include: A facility reported incident was submitted to the state agency (SA) on 4/13/23, at 6:15 p.m. The incident report identified an allegation of physical abuse resulting in skin tear and bruise to R1's right arm. The report indicated the allegation was reported to facility staff on 4/13/23 at 3:15 p.m. during a care conference. The injuries had initially been identified by staff on 4/10/23, when R1 had	F 609	R1 has not voiced further allegations of mistreatment. Residents who report allegations of mistreatment have the potential to be impacted by the alleged practice. The nurse manager was educated during survey regarding timeframes for reporting allegations and verbalized understanding. The Executive Director or designee provided education to the interdisciplinary team on timeframes for reporting allegations of abuse beginning May 4, 2023. Education was presented to the management team, nursing, therapy and ancillary departments.	

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F 609	Continued From page 2 reported she bumped her arm on the side rail. However, on 4/13/23, during her care conference, R1 reported the injuries were the result of a staff member striking R1's arm with a fist. R1's admission Minimum Data Set (MDS) dated 3/15/23, included diagnoses of cognitive communication deficit and aphasia (difficulty with speech) following a cerebral infarct (stroke). MDS indicated R1 had moderate cognitive impairment with behaviors directed toward others and rejection of cares behaviors. R1 required extensive assist of two staff with bed mobility, transfers, dressing, toilet use, personal hygiene and bathing. R1's progress note dated 4/10/23, at 10:30 p.m. indicated R1 had a skin tear. Progress note dated 4/11/23, identified R1 had two skin tears on right arm, one measured 1.5 centimeters (cm) and the other one measured 4.0 cm. R1's late entry progress note dated for 4/13/23 at 1:48 p.m. indicated during care conference R1 reported that the skin tear on her forearm was from R1 swinging out at staff on 4/10/23, and then staff swung back at her causing the skin tears. During an interview on 4/20/23, at 12:22 p.m. nurse manager (NM)-B indicated she was present during R1's care conference on 4/13/23. During the care conference R1 reported staff had caused the skin tears by hitting her. NM-B stated she reported R1's allegation to the director of nursing (DON) after all of her scheduled care conferences were completed. NM-B stated she was not aware of the time frame for reporting allegations of abuse.	F 609	Audits of understanding of abuse reporting timelines will be completed three times weekly for four weeks through interviews of management, nursing, therapy or ancillary departments. Audits will be completed by the Executive Director or designee. Results of audits will be forwarded to the Quality Assurance committee for review and recommendations.	

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F 609	Continued From page 3 Review of the facility's abuse, neglect and exploitation policy dated 3/2018, indicated: VII. Reporting/Response, A 1. Reporting of all alleged violations to the Administrator, SA, adult protective services and to all other required agencies (e.g. law enforcement when applicable) within specified timeframes: a. Immediately, but no later then 2 hours after the allegation is made, if the events that caused the allegation involve abuse or result in serious bodily injury, or b. no later than 24 hours if the event that caused the allegation do not involve abuse and do not result in serious bodily injury.	F 609		
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	F 880		5/15/23

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F 880	Continued From page 4 accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, 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.	F 880		

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F 880	Continued From page 5 §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 and interview the facility failed to perform appropriate hand hygiene during a clean dressing change to prevent or mitigate risk of wound infection for 1 of 1 resident (R1) observed who had skin impairment. Finding include: R1's admission Minimum Data Set (MDS) dated 3/15/23, R1 had moderate cognitive impairment and required extensive assist of two staff with bed mobility, transfers, and personal hygiene. During an observation on 4/20/23, at 12:15 p.m. licensed practical nurse (LPN)-A took R1 to her room and explained to R1 he was going to change her dressing. LPN-A washed his hands, applied gloves, removed the old dressing, dated 4/19/23, and placed in trash can. There was a milky whitish/yellowish drainage over the top of the wound. LPN-A with the same gloves on, cleaned wound with 4 x 4 gauze and saline. LPN-A then opened the Mepilex dressing and applied it to R1's wound without removing gloves and performing hand hygiene. LPN-A indicated he was going to inform the physician of the discolored drainage could be a sign the wound was infected. During an interview on 4/20/23, at 12:20 p.m. LPN-A, stated he followed the facility's policy/procedure for clean dressing changes.	F 880	R1□s wound is monitored daily and has not developed any signs or symptoms of infection. Residents who require wound care have the potential to be impacted by the alleged practice. The nurse who provided wound care on 4/20/23 was immediately educated and observed completing a return demonstration of a dressing change. The Infection Preventionist or designee began education on 4/20/23 with licensed nurses on the policy and procedure and infection control principles for dressing changes. Review of the dressing change competency and simulated return demonstration were completed with Infection Preventionist or designee observation. The Infection Preventionist or designee will observe three dressing changes per week using the dressing change competency tool and will submit these to the Quality Assurance committee for review and recommendations. Audits will begin the week of 05/08/2023.	

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F 880	Continued From page 6 During an interview on 4/20/23, at 12:22 p.m. nurse manager (NM)-B stated she did not know what or where to find the policy/procedure for clean dressing changes. NM-B was unable to articulate the dressing change procedure according to facility policy. NA-B did not articulate gloves needed to be removed and hand hygiene completed after the removal of the old dressing and before cleaning the wound, and then again after the wound was cleaned. During an interview on 4/20/23, at 12:52 p.m. NM-C indicated during wound care anytime gloves were removed, hand hygiene needed to be completed. NM-C explained to start a dressing change nurses would wash hands, put cloves on, remove the dressing, remove gloves, perform hand hygiene, apply new gloves, clean wound, remove gloves/hand hygiene, new gloves to put dressing on. During an interview on 4/20/23, at 1:20 p.m. NM-A stated an expectation nurses follow the policy/procedure when completing wound dressing changes. Facility Clean Dressing Change policy dated 7/2022, included: 7. Wash hands and put on clean gloves. 9. Loosen the tape and remove the existing dressing. If needed to minimize skin stripping or pain, moisten with prescribed cleansing solution or use adhesive remover to remove tape. 10. Remove gloves, pulling inside out over the dressing. Discard into appropriate receptacle. 11. Wash hands and put on clean gloves. 12. Cleanse the wound as ordered 14. Wash hands and put on clean gloves. 15. Apply topical ointments or creams and dress	F 880		

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F 880	Continued From page 7 the wound as ordered. 16. Secure dressing. 17. Discard disposable items and gloves into appropriate trash receptacle and wash hands	F 880		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 28, 2023

Administrator
Rochester East Health Services
501 Eighth Avenue Southeast
Rochester, MN 55904

Re: State Nursing Home Licensing Orders
Event ID: K9FY11

Dear Administrator:

The above facility was surveyed on April 20, 2023 through April 20, 2023 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:

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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.

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

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	00953	A. BUILDING: _____ B. WING _____	C 04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHESTER EAST HEALTH SERVICES	501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	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 4/20/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1 identify the date when they will be completed. The following complaint was reviewed with no orders issued, H51841455C (MN00091568). The following complaint was reviewed, H51841450C (MN00092751) with a licensing order issued at 1390. 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html 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	2 000		

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2 000	Continued From page 2 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		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of	21390		5/15/23

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21390	Continued From page 3 current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation and interview the facility failed to perform appropriate hand hygiene during a clean dressing change to prevent or mitigate risk of wound infection for 1 of 3 residents (R1) who had skin impairment that was reviewed for abuse. Finding include: R1's admission Minimum Data Set (MDS) dated 3/15/23, R1 had moderate cognitive impairment and required extensive assist of two staff with bed mobility, transfers, and personal hygiene. During an observation on 4/20/23, at 12:15 p.m. licensed practical nurse (LPN)-A took R1 to her room and explained to R1 he was going to change her dressing. LPN-A washed his hands, applied gloves, removed the old dressing, dated 4/19/23, and placed in trash can. There was a milk white/yellow drainage over the top of the wound. LPN-A with the same gloves on, cleaned wound with 4 x 4 gauze and saline. LPN-A then opened the Mepilex dressing and applied it to R1's wound without removing gloves and performing hand hygiene. LPN-A indicated he was going to inform the physician because the discolored drainage could be a sign the wound was infected. During an interview on 4/20/23, at 12:20 p.m. LPN-A, stated he followed the facility's policy/procedure for clean dressing changes. During an interview on 4/20/23, at 12:22 p.m.	21390	R1□s wound is monitored daily and has not developed any signs or symptoms of infection. Residents who require wound care have the potential to be impacted by the alleged practice. The nurse who provided wound care on 4/20/23 was immediately educated and observed completing a return demonstration of a dressing change. The Infection Preventionist or designee began education on 4/20/23 with licensed nurses on the policy and procedure and infection control principles for dressing changes. Review of the dressing change competency and simulated return demonstration were completed with Infection Preventionist or designee observation. The Infection Preventionist or designee will observe three dressing changes per week using the dressing change competency tool and will submit these to the Quality Assurance committee for review and recommendations. Audits will begin the week of 05/08/2023.	

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21390	Continued From page 4 nurse manager (NM)-B stated she did not know what or where to find the policy/procedure for clean dressing changes. NM-B was unable to articulate the dressing change procedure according to facility policy. NA-B did not articulate gloves needed to be removed and hand hygiene completed after the removal of the old dressing and before cleaning the wound, and then again after the wound was cleaned. During an interview on 4/20/23, at 12:52 p.m. NM-C indicated during wound care anytime gloves were removed, hand hygiene hand hygiene needed to be completed. NM-C explained to start dressing change nurses would wash hands, put cloves on, remove the dressing, remove gloves, perform hand hygiene, apply new gloves, clean wound, remove gloves/hand hygiene, new gloves to put dressing on. During an interview on 4/20/23, at 1:20 p.m. NM-A stated an expectation nurses follow the policy/procedure when completing wound dressing changes. Facility Clean Dressing Change policy dated 7/2022, included: 7. Wash hands and put on clean gloves. 9. Loosen the tape and remove the existing dressing. If needed to minimize skin stripping or pain, moisten with prescribed cleansing solution or use adhesive remover to remove tape. 10. Remove gloves, pulling inside out over the dressing. Discard into appropriate receptacle. 11. Wash hands and put on clean gloves. 12. Cleanse the wound as ordered 14. Wash hands and put on clean gloves. 15. Apply topical ointments or creams and dress the wound as ordered. 16. Secure dressing.	21390		

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21390	Continued From page 5 17. Discard disposable items and gloves into appropriate trash receptacle and wash hands SUGGESTED METHOD OF CORRECTION: The ICP or designee could review facility policies/procedures regarding appropriate infection control technique during dressing changes. The ICP or designee could provide staff education regarding the policies and educate staff on appropriate IC technique while performing dressing changes. The ICP or designee should complete timely audits to ensure policies are being followed to ensure on-going competence. The ICP, or designee should take education verifications and the audits to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for continued monitoring. TIME PERIOD FOR CORRECTION: 21 (twenty-one) DAYS	21390		