Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 30, 2023

Administrator
Regina Senior Living
1175 Nininger Road
Hastings, MN 55033

RE: CCN: 245254
Cycle Start Date: August 22, 2023

Dear Administrator:

On August 22, 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:

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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 November 22, 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 February 22, 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,

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

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August 30, 2023

Administrator
Regina Senior Living
1175 Nininger Road
Hastings, MN 55033

Re: Event ID: 13R311

Dear Administrator:

The above facility survey was completed on August 22, 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,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245254	A. BUILDING _____ B. WING _____	C 08/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA SENIOR LIVING	1175 NININGER ROAD HASTINGS, MN 55033

(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 8/21/23 - 8/22/23, 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. H52544689C MN96104 H52544712C MN95918 The following complaints were reviewed. H52544628C (MN95981) with a deficiency issued at 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 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.	F 880		10/21/23

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

Electronically Signed | 09/08/2023

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 880	Continued From page 1 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a 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	F 880		

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F 880	Continued From page 2 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 record review the facility failed to ensure staff maintained infection control prevention with the proper use of gloves, hand hygiene, and handling of wound supplies during a dressing change for 1 of 3 residents (R1) reviewed with an infection present. Findings include: CDC: Healthcare Providers | Hand Hygiene, www.cdc.gov/handhygiene/providers/index.html indicated to perform hand hygiene prior to starting wound care for each resident: This includes before retrieving wound care supplies, before donning gloves, and after doffing gloves. Wound care prevention recommendations for long term care facilities. Alcohol-based hand rub (ABHR) should be readily accessible throughout the wound care process. Unless hands are visibly soiled, alcohol-based hand rub is preferred over	F 880	Plan for Compliance 1) The staff person/RN A is an agency nurse with Grapetree Staffing. The expectation of that organization is that we go through them for any challenges in care with their staff. RN DON immediately followed up with Grapetree HR letting them know the concerns and also that they would need to complete mitigation. Last point to Grapetree is that we have an expectation that their staff can demonstrate expected nursing competencies in our facility. 2) Currently all staff employed at facility are being audited for hand hygiene compliance randomly and incognito to assure compliance in daily care. 3) Currently we are performing two	

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F 880	Continued From page 3 soap and water. Health care workers should not touch items in the resident care environment while performing wound care as this will contaminate gloves, supplies, and/or the environment. Hand hygiene must be performed by use of ABHR or soap and water immediately after removing gloves and upon exiting resident room. CDC: Guideline for Disinfection and Sterilization in Healthcare Facilities, www.cdc.gov/infectioncontrol/pdf/guidelines/disinfection-guidelines-H.pdf indicated any reusable equipment (e.g., bandage scissor, flashlight, mirror) and supplies that come in contact with non-intact skin, mucous membranes, or any bodily fluids or drainage, including fluids on bedding or gloved health care workers hands, are considered semi-critical instruments. Either: 1. Perform high-level disinfection (HLD) before use on another resident OR 2. Discard wound care equipment or products when no longer needed for an individual resident. When HLD (or sterilization) is not available and dedicated equipment is used for each resident, it is important to clean and disinfect each piece of equipment after each use on the same resident to reduce bio load per manufacturer's instructions for use (IFU). Dispose of dedicated equipment (if disposable equipment is used) or arrange to have dedicated equipment appropriately processed after no longer needed for care of the designated resident. Dedicate tape, sprays, creams, and all wound care products to an individual resident and do not store used sprays with clean wound care supplies. If fresh bandages are cut for the resident, it should be done with clean scissors, not with scissors used to cut off soiled bandages. Wound care dressings can be disposed of in the	F 880	Wound Care Competency audit tool observations per week and will continue that for 4 weeks. Then 1 per week for 4 weeks. These results will be presented to quality team at facility. 4) Hand Hygiene Competency will continue to be completed in facility orientation/annually and as needed	

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F 880	Continued From page 4 regular trash unless they are dripping or saturated with blood or other regulated body fluids. Clean and disinfect the surface (e.g., over bed table) where wound care supplies will be placed prior to setting down wound care supplies in resident room. Store wound care supplies in a clean area of resident room. R1's Minimal Data Set (MDS) dated 8/8/23 indicated R1 was cognitively intact. R1 required extensive assistance of two staffs for activities of daily living, toileting and transferring. R1's pertinent diagnosis included intervertebral disc disorders with radiculopathy (inflammation or pinching of a spinal nerve in the lower bac), and polyneuropathy (malfunction of multiple nerves throughout the body). R1 was a quadriplegic. R1's progress note dated 8/17/23 at 1:37 p.m. indicated a wound culture was sent to the lab on 8/11/23 and R1 was on an antibiotic for cellulitis. R1's progress note dated 8/17/23 indicated R1 was to be on Levofloxacin 500 mg daily (antibiotic) until 8/24/23 and had a new treatment. 1. Cleanse bilateral leg wounds daily with wound cleanser. 2. Apply Xeroform and secure with tape. Upon observation on 8/21/23 at 12:25 p.m. registered nurse, (RN)-A answered R1's call light and stated she would perform his dressing change. RN-A donned clean gloves and cut the kerlix dressing off R1's right leg. RN-A placed the dirty scissors in the plastic tote with R1's clean dressing supplies. RN-A pulled the old Xeroform petrolatum dressing off two small open skin lesions. RN-A placed the soiled xeroform on R1's tray table. RN-A did not remove soiled gloves or	F 880		

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F 880	Continued From page 5	F 880		

wash her hands. RN-A then placed a disposable absorbent pad under both R1's legs. RN-A then took the wound cleansing bottle and a piece of gauze of R1's supply tote. RN-A sprayed R1's lower extremity and dabbed the area with the gauze. RN-A placed the used gauze and the wound cleanser on R1's tray table. RN-A then took the dirty scissors and cut the new xeroform to place on R1's legs. RN-A wrapped R1's left leg from his ankle to approximately two inches below his left knee with kerlix to cover the Xeroform. RN-A then applied lotion to R1's right foot. RN-A doffed the gloves and placed them on R1's tray table. RN-A donned new gloves and removed the kerlix dressing and xeroform from R1's left leg. RN-A used the same dirty scissors on the left leg to cut off the wrapped kerlix dressing. RN-A did not take off the dirty gloves and was rummaging through R1's dressing supplies to finish the procedure. RN-A took off the of gloves and placed them on the tray table before leaving the room to get more supplies. At 12:48 p.m. RN-A returned to the room and washed her hands. RN-A donned another pair of gloves, cleansed the lower extremity of the leg with the wound cleanser and dabbed the area with gauze. She continued to use the same dirty scissors to cut the new xeroform to cover three small lesions on R1's left lower extremity. The Director of nursing (DON) entered the room and requested RN-A's keys to the medication cart. RN-A placed her right hand in her pocket and handed the DON her keys without changing her gloves. RN-A began to wrap the kerlix around R1's lower extremity and the kerlix unrolled and the end approximately 10 inches of the of the kerlix was touching the floor. RN-A continued to wrap R1's leg with the kerlix that had been on the floor. RN-A then applied lotion to R1's left foot. RN-A

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F 880	Continued From page 6 took all the dirty supplies off R1's tray table and used a Clorox wipe to clean the tray table, RN-A had not changed her gloves prior to cleaning the table. RN-A was leaving the room and the facility wound nurse, LPN-A entered the room to assist RN-A. LPN-A reminded RN-A to wash her hands. RN-A and LPN-A both donned new clean gloves and LPN-A held R1's leg out straight and RN-A wrapped R1's right leg and then did the same with R1's right leg. Upon interview on 8/21/23 at 2:07 p.m. RN-A stated she does not know of all the protocols at the facility as she is an agency nurse, and she is not familiar with R1. In addition, she stated she is aware she should have changed gloves more often during the procedure but was nervous and the day was very busy due to short staffing at the facility. Upon interview on 8/22/23 at 2:20 p.m. the DON stated she expects the staff to follow the standard precautions when completing dressing changes. She expects staff to use clean equipment once it is soiled and change gloves throughout the treatment. An Infection Control policy was requested from the facility, however none received.	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 8/21/23 - 8/22/23, 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 during	2 000		

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2 000	Continued From page 1 the survey. H52544628C MN95981 H52544689C MN96104 H52544712C MN95918 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		