Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
February 7, 2024

Administrator
Meadow Manor
210 East Grand Avenue
Grand Meadow, MN 55936

RE: CCN: 245367
Cycle Start Date: January 22, 2024

Dear Administrator:

On February 6, 2024, 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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 7, 2024

Administrator
Meadow Manor
210 East Grand Avenue
Grand Meadow, MN 55936

Re: Reinspection Results
Event ID: GCGT12

Dear Administrator:

On February 6, 2024 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 January 22, 2024. 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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 24, 2024

Administrator
Meadow Manor
210 East Grand Avenue
Grand Meadow, MN 55936

RE: CCN: 245367
Cycle Start Date: January 22, 2024

Dear Administrator:

On January 22, 2024, 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:

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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 April 22, 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 July 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,

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
	245367	A. BUILDING _____ B. WING _____	C 01/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW MANOR	210 EAST GRAND AVENUE GRAND MEADOW, MN 55936

(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 1/18/24 and 1/22/24, 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: H53678922C (MN00099796), H53679022C (MN00100095), with a deficiency cited 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		2/2/24

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

Electronically Signed | 02/01/2024

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 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	F 880		

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F 880	Continued From page 2 disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper hand hygiene and glove use practices were maintained for 1 of 3 residents (R3) observed during incontinence cares. Findings include: R3's quarterly Minimum Data Set (MDS) dated 12/12/23 identified R3's diagnoses included medically complex conditions, dementia, and was currently on hospice. In addition, R3's MDS identified R3 was unable to understand or be understood, and was dependent with activities of daily living (ADLs). R3's care plan revised on 4/17/23 indicated R3 had bladder and bowel incontinence related to	F 880	F 880 PLAN OF CORRECTION denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the	

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F 880	Continued From page 3 advanced dementia, functional decline, and impaired mobility. Staff were to check and change every two hours. During an observation on 1/18/24 at 12:18 p.m., nursing assistant (NA)-A and NA-B entered R3's room NA-A proceeded to wash her hands at the sink in the room. NA-B did not perform hand hygiene upon entering the room, and grabbed gloves and put them in her scrub pocket. NA-A and NA-B put the transfer sling around R3. Both donned gloves after the transfer sling was placed, and transferred R3 from the wheelchair to the bed. NA-A and NA-B removed the transfer sling and began to remove R3's clothing to change the soiled incontinent brief. NA-B began using wipes and removing bowel movement from R3. NA-B removed her soiled gloves and without performing hand hygiene, donned clean gloves. NA-A continued to assist with cares, positioning R3 and holding legs apart for NA-B to continue to cleanse R3. NA-B wiped more bowel movement from R3, discarded her gloves, and without performing hand hygiene, donned clean gloves. NA-A and NA-B both positioned R3 with pillows and pulled up her bedding to tuck her into bed, put the call light in place and adjusted the bed to lower position, using soiled gloves. NA-A and NA-B removed their gloves, completed hand hygiene and left the room. During interview on 1/18/24, at 12:33 p.m., NA-B stated she should have performed hand hygiene during cares and whenever she changed her gloves. NA-B verified she had not appropriately performed hand hygiene during R3's cares and stated she hadn't because NA-A was holding R3, and she wanted to get the cares done without	F 880	requirements of participation, or that corrective action was necessary. 1. In continuing compliance with F 880, infection Prevention and Control. Grand Meadow Senior Living corrected the deficiency by adding hand hygiene & glove us education to our agency checklist/training packet. 2. To correct the deficiency and to ensure the problem does not recur all staff were educated on proper hand hygiene & glove use by DNS on 2/2/2024 or prior to their next shift. The DNS and/or designee will audit handwashing of staff 3x/week for 4 weeks, 2x/week for 4 weeks, weekly for 4 weeks, and then randomly to ensure continued compliance. 3. As part of Grand Meadows ongoing commitment to quality assurance, the DNS and/or designee will report identified concerns through the community's QA Process.	

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F 880	Continued From page 4 leaving NA-B hanging on to R3 while she left her to wash her hands. During an interview on 1/22/24 at 11:53 a.m., the director of nursing (DON) stated it was an expectation staff should perform hand hygiene when entering and exiting residents' rooms and each time they moved from a dirty area to a clean area. The DON further stated staff were expected to perform hand hygiene with each glove change. The DON expressed all staff were expected to follow facility policy when it came to hand hygiene and infection control. The facility policy Handwashing/Hand Hygiene updated 10/5/23, directed proper hand washing techniques should be used to protect the spread of infection. Hand hygiene may occur multiple times during a single care episode. Use an alcohol-based hand sanitizer: -before coming in direct contact with a resident -before performing aseptic techniques (indwelling device) or handling an invasive medical device -immediately before putting on gloves and after glove removal -after touching a resident or the resident's immediate environment -after contact with blood, body fluids or contaminated surfaces. Wash with soap and water: -when hands are visible soiled -after caring for a resident with known or suspected diarrhea -after known or suspected exposure to communicable infectious disease	F 880		

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F 880	Continued From page 5 -before moving from a soiled body site to a clean body site on the same resident	F 880		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 24, 2024

Administrator
Meadow Manor
210 East Grand Avenue
Grand Meadow, MN 55936

Re: State Nursing Home Licensing Orders
Event ID: GCGT11

Dear Administrator:

The above facility was surveyed on January 18, 2024 through January 22, 2024 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:

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00390	A. BUILDING: _____ B. WING _____	C 01/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW MANOR	210 EAST GRAND AVENUE GRAND MEADOW, MN 55936

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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 1/18/24 and 1/22/24 , 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 was	2 000		

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2 000	Continued From page 1 issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed. H53678922C (MN00099796), H53679022C (MN00100095), 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 is	2 000		

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2 000	Continued From page 2 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	21390		2/2/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00390	A. BUILDING: _____ B. WING _____	C 01/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21390	Continued From page 3 incontinence products; and l. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper hand hygiene and glove use practices were maintained for 1 of 3 residents (R3) observed during incontinence cares. Findings include: R3's quarterly Minimum Data Set (MDS) dated 12/12/23 identified R3's diagnoses included medically complex conditions, dementia, and was currently on hospice. In addition, R3's MDS identified R3 was unable to understand or be understood, and was dependent with activities of daily living (ADLs). R3's care plan revised on 4/17/23 indicated R3 had bladder and bowel incontinence related to advanced dementia, functional decline, and impaired mobility. Staff were to check and change every two hours. During an observation on 1/18/24 at 12:18 p.m., nursing assistant (NA)-A and NA-B entered R3's room NA-A proceeded to wash her hands at the sink in the room. NA-B did not perform hand hygiene upon entering the room, and grabbed gloves and put them in her scrub pocket. NA-A and NA-B put the transfer sling around R3. Both donned gloves after the transfer sling was placed, and transferred R3 from the wheelchair to the bed. NA-A and NA-B removed the transfer sling and	21390	Corrected	

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21390	Continued From page 4 began to remove R3's clothing to change the soiled incontinent brief. NA-B began using wipes and removing bowel movement from R3. NA-B removed her soiled gloves and without performing hand hygiene, donned clean gloves. NA-A continued to assist with cares, positioning R3 and holding legs apart for NA-B to continue to cleanse R3. NA-B wiped more bowel movement from R3, discarded her gloves, and without performing hand hygiene, donned clean gloves. NA-A and NA-B both positioned R3 with pillows and pulled up her bedding to tuck her into bed, put the call light in place and adjusted the bed to lower position, using soiled gloves. NA-A and NA-B removed their gloves, completed hand hygiene and left the room. During interview on 1/18/24, at 12:33 p.m., NA-B stated she should have performed hand hygiene during cares and whenever she changed her gloves. NA-B verified she had not appropriately performed hand hygiene during R3's cares and stated she hadn't because NA-A was holding R3, and she wanted to get the cares done without leaving NA-B hanging on to R3 while she left her to wash her hands. During an interview on 1/22/24 at 11:53 a.m., the director of nursing (DON) stated it was an expectation staff should perform hand hygiene when entering and exiting residents' rooms and each time they moved from a dirty area to a clean area. The DON further stated staff were expected to perform hand hygiene with each glove change. The DON expressed all staff were expected to follow facility policy when it came to hand hygiene and infection control. The facility policy Handwashing/Hand Hygiene	21390		

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21390	Continued From page 5 updated 10/5/23, directed proper hand washing techniques should be used to protect the spread of infection. Hand hygiene may occur multiple times during a single care episode. Use an alcohol-based hand sanitizer: -before coming in direct contact with a resident -before performing aseptic techniques (indwelling device) or handling an invasive medical device -immediately before putting on gloves and after glove removal -after touching a resident or the resident's immediate environment -after contact with blood, body fluids or contaminated surfaces. Wash with soap and water: -when hands are visible soiled -after caring for a resident with known or suspected diarrhea -after known or suspected exposure to communicable infectious disease -before moving from a soiled body site to a clean body site on the same resident SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should review/revise facility policies to ensure they contain all components of an infection control program to mitigate transmission of potential infections including hand hygiene. The DON or designee could educate all staff on existing or revised policies and perform audits to ensure the policies are being followed. The results of those audits should be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring.	21390		

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21390	Continued From page 6 Time Period for Correction: Twenty-one (21) days.	21390		