DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
June 20, 2024

Administrator
Langton Shores
1900 West County Road D
Roseville, MN 55112

RE: CCN: 245389
Cycle Start Date: May 23, 2024

Dear Administrator:

On June 17, 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

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Electronically delivered

June 20, 2024

Administrator
Langton Shores
1900 West County Road D
Roseville, MN 55112

Re: Reinspection Results
Event ID: B7KV12

Dear Administrator:

On June 17, 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 May 23, 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

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Electronically delivered
June 5, 2024

Administrator
Langton Shores
1900 West County Road D
Roseville, MN 55112

RE: CCN: 245389
Cycle Start Date: May 23, 2024

Dear Administrator:

On May 23, 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:

Lisa Krebs, Rapid Response Supervisor
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 August 23, 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 November 23, 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

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June 5, 2024

Administrator
Langton Shores
1900 West County Road D
Roseville, MN 55112

Re: State Nursing Home Licensing Orders
Event ID: B7KV11

Dear Administrator:

The above facility was surveyed on May 22, 2024 through May 23, 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:

Lisa Krebs, Rapid Response Supervisor
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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00284	A. BUILDING: _____ B. WING _____	C 05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANGTON SHORES	1900 WEST COUNTY ROAD D ROSEVILLE, MN 55112

(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 5/22/24 and 5/23/24, 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 issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed: H53893948C (MN103449 and MN103445) with a licensing order issued at 1375. 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 enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		

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2 000	Continued From page 2 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		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure enhanced barrier precautions (EBP)-(an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities.) were implemented for management of a surgical wound to reduce the risk of infection to others for 1 of 1 resident (R2) reviewed for transfers. Findings include: R2's face sheet identified diagnoses of age-related osteoporosis with current pathological fracture of left lower leg and need of assistance with personal cares. R2's order summary dated 5/14/24, identified R2's incision was located on the left tibia was covered with dry dressings including	21375	POC F880 Resident R2 was reviewed and care plan, care strip and door all stated Enhanced Barrier Precautions (EBP) were required. Resident R2 was assessed and did not have any negative outcomes. NA-A and NA-B were re-educated on 5/22/24 regarding the expectation of EBP compliance. All residents meeting criteria for use of EBP are at risk with this citation. All residents on EBP were audited on 5/22/24 to ensure compliance with EBP indicated on care plan, care card and posted outside door and staff were immediately educated on EBP compliance expectations starting on 5/22/24. EBP Policy was reviewed, and no changes	6/14/24

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21375	Continued From page 3 xeroform/Adaptec, gauze fluffs, ABD, and ACE wrap. Keep dressing in place, clean and dry for two weeks. Change dressing only PRN (as needed) saturation greater than 60% every day shift. Incisions evaluated in clinic in 2-3 weeks and remove any staples or sutures as indicated. R2's Nurse Practioner (NP) visit note dated 5/15/24, identified R2 was hospitalized for Trauma Surgery with a closed fracture of left tibia and fibula due to a fall, R2 proceeded with an insertion of intramedullary rod left tibia and removal of hardware left tibia on 5/11/2024 and admitted to the facility for a short term stay on 5/14/24. R2's care plan dated 5/15/24, identified a focus, "I require enhanced barrier precautions due to a surgical incision." Intervention indicated to follow enhanced barrier precautions in addition to standard precautions: wear gown and gloves during high-contact resident care activities. An additional focus dated 5/14/24 identified, "I have limited physical mobility." Intervention included transfers, "I require assist of two with a full lift and medium universal sling." During an observation on 5/22/24 at 5:08 p.m., upon entrance to R2's room an orange paper sign was hung on the wall to the right side of R2's door. Two red colored, "STOP" signs noted at the top on either side. Signage read: "ENHANCED BARRIER PRECAUTIONS EVERYONE MUST: clean their hands, including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: Wear gloves and a gown for the following activities. Dressing, Bathing/Showering, Transferring, changing linens, Providing Hygiene, Changing briefs or assisting with toileting. Device care or	21375	were made. All nursing staff were re-educated on EBP compliance expectations including hand hygiene before and after transfers/cares on 6/11/24 and 6/13/24. Enhanced Barrier Precaution Observation Tool Audits will be conducted by Clinical Administrator or designee on 10% of residents currently on EBP every week x 4 weeks and then monthly for 2 months. Clinical Administrator is responsible and will bring the results of the audits to the Quarterly Quality Assurance Meeting for review and recommendations by the Interdisciplinary Team.	

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21375	Continued From page 4 use: central line, urinary catheter, feeding tube, tracheostomy. Wound care: any skin opening requiring a dressing. Do not wear the same gown and gloves for the care of more than one person." The sign also had color pictures of hand cleanser, gloves, and gown. Nursing assistant (NA)-A and NA-B walked into R2's room without doing hand hygiene, did not utilize gloves or a gown. NA-A and NA-B transferred R2 from the bed to the recliner using a Hoyer lift. NA-A and NA-B did not perform hand hygiene after the transfer. During an interview on 5/22/24 at 5:16 p.m., NA-A and NA-B indicated an unawareness that EBP was to be used for high contact resident activities including transfers with R2. NA-B stated, I will go ask the nurse if we need to use EBP with R2. NA-B came back and stated, yes, we were supposed to use gown and gloves with the transfer for R2 due to R2 having a surgical wound to her left leg and indicated they should be using hand hygiene before and after cares with each resident and utilize gown and gloves with residents who are on EBP precautions to help prevent the spread of infection. During an interview on 5/22/24 at 5:23 p.m., interim clinical administrator stated, staff should be using EBP's with transfers for R2 due to a surgical wound on her left leg to help prevent the spread of infection. All residents with EBP have a sign clearly posted outside their room and staff should be looking for that and following our policy for EBP to help prevent the spread of infection. Facility policy, "enhance Barrier Precautions Policy and Procedure," modified April 2024, identified a Purpose: PHS recognizes that our care center residents are at a higher risk of	21375		

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21375	Continued From page 5 becoming colonized and infected with multidrug-resistant organisms (MDROs) as the prevalence of MDROs is higher in this care setting. As such, enhanced barrier precautions (EBP) which are a preventative approach to the use of personal protective equipment (PPE) to reduce opportunities of MDRO transmission during high-contact resident care activities will be implemented. Policy: 1. EBP (targeted gowns and gloves) are used in conjunction with standard precautions and will be implemented during high contact resident care activities for residents who: a. are known to be colonized or infected with CDC-targeted MDROs when Contact Precautions do not otherwise apply; and b. when caring for residents with wounds or indwelling medical devices even if the resident is not known to be colonized or infected with a MDRO. 2. EBP will be in place for the duration of a residents stay in the site or until resolution of the wound or discontinuation of the indwelling medical device for residents who are not colonized. 3. EBP is not intended to be a form of isolation and residents are not restricted to their rooms or limited from participation in group activities. 4. EBP should be followed when transferring residents in shared/common shower rooms and when working with residents in the therapy gym, specifically when anticipating close physical contact while assisting with transfers and mobility. 5. EBP does not need to be followed when transferring residents in the dining or activity rooms where contact is anticipated to be shorter in duration. Definitions: Wounds generally include chronic wounds and longer lasting wounds. This includes pressure injuries, venous stasis and diabetic ulcers, and unhealed surgical wounds, including new ostomies. This does not include short lasting wounds (e.g., skin tears). High-contact resident care activities include	21375		

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21375	Continued From page 6	21375		

dressing, bathing/showering, transferring, providing hygiene, changing briefs, or assisting with toileting, changing linens, and indwelling medical device care or use (e.g., central line, dialysis port, urinary catheter, feeding tube, tracheostomy). Procedure:
1. Identify residents requiring EBP during the admission screening process and as needed. Specifically, review available key documents (e.g., H&P, discharge summary, physician progress notes, laboratory testing results) for documentation of known colonization of CDC-targeted MDROs, wounds or indwelling medical devices. 2. Review new notation of resident colonization of CDC-targeted MDROs, wounds or indwelling medical devices during the IDT process. 3. Upon identification of a resident with a known colonization of a CDC-targeted MDRO, wounds or indwelling medical devices: a. Notify and educate the resident or resident representative, IDT and QST, direct care staff. Provide re-education as needed. i. Resident and resident representative notification and education should be documented in the resident's record. The Enhanced Barrier Precautions Notification Letter may be used, however, should still be documented as given. b. Place an EBP sign on the resident's door. c. Ensure adequate supply of gowns and gloves are available in the resident's room. Note: This does not require an isolation cart to be placed outside the resident's room as this is a preventative measure that should have as little impact as possible on the resident's homelike environment. d. Ensure there is a trash can and hand hygiene supplies placed near the exit of the resident's room to discard the gloves and gowns prior to exiting the room. If the resident has a roommate, ensure staff are discarding the gloves and gowns, and performing hand hygiene before providing care to the second

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21375	Continued From page 7 resident. e. Update the resident's care plan and care/team sheets. f. Update the infection control log and document the type of CDC-targeted MDRO the resident is known to be colonized with. 4. When performing high-contact resident care activities staff should: a. Perform hand hygiene. b. Don gloves and a gown c. Complete the high contact activity d. Remove gloves and gown and dispose of in a trash can in the resident's room or if outside of the resident's room (e.g., shower/tub room or therapy gym) in a trash can contained within the area. e. Perform hand hygiene 5. If at any time a resident is requiring EBP they require additional precautions or isolation protocol, the more stringent precautions/protocol will apply.6. The Clinical Administrator, IP, or designee should audit staff adherence to this policy at random intervals using the Enhanced Barrier Precautions Observation Form. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON), ICP, or designee could review facility policies/procedures regarding Enhanced Barrier Precautions (EBP) for the resident and provide staff education regarding the policies and educate staff on appropriate PPE wear. They could also do environmental rounds, audits, and re-educatioon anytime EBP are placed. The ICP, DON and/or designee could take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time, until the QAPI committee determines successful compliance or the need for ongoing monitoring. Time Period for Correction: Twenty-one (21) days.	21375		

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F 000	INITIAL COMMENTS On 5/22/24 and 5/23/24, 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: H53893948C (MN103449 and MN103445) 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. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F 880		6/14/24

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

Electronically Signed | 06/10/2024

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 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 contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed	F 880		

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F 880	Continued From page 2 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 enhanced barrier precautions (EBP)-(an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities.) were implemented for management of a surgical wound to reduce the risk of infection to others for 1 of 1 resident (R2) reviewed for transfers. Findings include: R2's face sheet identified diagnoses of age-related osteoporosis with current pathological fracture of left lower leg and need of assistance with personal cares. R2's order summary dated 5/14/24, identified R2's incision was located on the left tibia was covered with dry dressings including xeroform/Adaptec, gauze fluffs, ABD, and ACE wrap. Keep dressing in place, clean and dry for	F 880	POC F880 Resident R2 was reviewed and care plan, care strip and door all stated Enhanced Barrier Precautions (EBP) were required. Resident R2 was assessed and did not have any negative outcomes. NA-A and NA-B were re-educated on 5/22/24 regarding the expectation of EBP compliance. All residents meeting criteria for use of EBP are at risk with this citation. All residents on EBP were audited on 5/22/24 to ensure compliance with EBP indicated on care plan, care card and posted outside door and staff were immediately educated on EBP compliance expectations starting on 5/22/24. EBP Policy was reviewed, and no changes were made.	

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F 880	Continued From page 3 two weeks. Change dressing only PRN (as needed) saturation greater than 60% every day shift. Incisions evaluated in clinic in 2-3 weeks and remove any staples or sutures as indicated. R2's Nurse Practioner (NP) visit note dated 5/15/24, identified R2 was hospitalized for Trauma Surgery with a closed fracture of left tibia and fibula due to a fall, R2 proceeded with an insertion of intramedullary rod left tibia and removal of hardware left tibia on 5/11/2024 and admitted to the facility for a short term stay on 5/14/24. R2's care plan dated 5/15/24, identified a focus, "I require enhanced barrier precautions due to a surgical incision." Intervention indicated to follow enhanced barrier precautions in addition to standard precautions: wear gown and gloves during high-contact resident care activities. An additional focus dated 5/14/24 identified, "I have limited physical mobility." Intervention included transfers, "I require assist of two with a full lift and medium universal sling." During an observation on 5/22/24 at 5:08 p.m., upon entrance to R2's room an orange paper sign was hung on the wall to the right side of R2's door. Two red colored, "STOP" signs noted at the top on either side. Signage read: "ENHANCED BARRIER PRECAUTIONS EVERYONE MUST: clean their hands, including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: Wear gloves and a gown for the following activities. Dressing, Bathing/Showering, Transferring, changing linens, Providing Hygiene, Changing briefs or assisting with toileting. Device care or use: central line, urinary catheter, feeding tube,	F 880	All nursing staff were re-educated on EBP compliance expectations including hand hygiene before and after transfers/cares on 6/11/24 and 6/13/24. Enhanced Barrier Precaution Observation Tool Audits will be conducted by Clinical Administrator or designee on 10% of residents currently on EBP every week x 4 weeks and then monthly for 2 months. Clinical Administrator is responsible and will bring the results of the audits to the Quarterly Quality Assurance Meeting for review and recommendations by the Interdisciplinary Team.	

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F 880	Continued From page 4 tracheostomy. Wound care: any skin opening requiring a dressing. Do not wear the same gown and gloves for the care of more than one person." The sign also had color pictures of hand cleanser, gloves, and gown. Nursing assistant (NA)-A and NA-B walked into R2's room without doing hand hygiene, did not utilize gloves or a gown. NA-A and NA-B transferred R2 from the bed to the recliner using a Hoyer lift. NA-A and NA-B did not perform hand hygiene after the transfer. During an interview on 5/22/24 at 5:16 p.m., NA-A and NA-B indicated an unawareness that EBP was to be used for high contact resident activities including transfers with R2. NA-B stated, I will go ask the nurse if we need to use EBP with R2. NA-B came back and stated, yes, we were supposed to use gown and gloves with the transfer for R2 due to R2 having a surgical wound to her left leg and indicated they should be using hand hygiene before and after cares with each resident and utilize gown and gloves with residents who are on EBP precautions to help prevent the spread of infection. During an interview on 5/22/24 at 5:23 p.m., interim clinical administrator stated, staff should be using EBP's with transfers for R2 due to a surgical wound on her left leg to help prevent the spread of infection. All residents with EBP have a sign clearly posted outside their room and staff should be looking for that and following our policy for EBP to help prevent the spread of infection. Facility policy, "enhance Barrier Precautions Policy and Procedure," modified April 2024, identified a Purpose: PHS recognizes that our care center residents are at a higher risk of	F 880		

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F 880	Continued From page 5 becoming colonized and infected with multidrug-resistant organisms (MDROs) as the prevalence of MDROs is higher in this care setting. As such, enhanced barrier precautions (EBP) which are a preventative approach to the use of personal protective equipment (PPE) to reduce opportunities of MDRO transmission during high-contact resident care activities will be implemented. Policy: 1. EBP (targeted gowns and gloves) are used in conjunction with standard precautions and will be implemented during high contact resident care activities for residents who: a. are known to be colonized or infected with CDC-targeted MDROs when Contact Precautions do not otherwise apply; and b. when caring for residents with wounds or indwelling medical devices even if the resident is not known to be colonized or infected with a MDRO. 2. EBP will be in place for the duration of a residents stay in the site or until resolution of the wound or discontinuation of the indwelling medical device for residents who are not colonized. 3. EBP is not intended to be a form of isolation and residents are not restricted to their rooms or limited from participation in group activities. 4. EBP should be followed when transferring residents in shared/common shower rooms and when working with residents in the therapy gym, specifically when anticipating close physical contact while assisting with transfers and mobility. 5. EBP does not need to be followed when transferring residents in the dining or activity rooms where contact is anticipated to be shorter in duration. Definitions: Wounds generally include chronic wounds and longer lasting wounds. This includes pressure injuries, venous stasis and diabetic ulcers, and unhealed surgical wounds, including new ostomies. This does not include short lasting wounds (e.g., skin tears).	F 880		

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F 880	Continued From page 6 High-contact resident care activities include dressing, bathing/showering, transferring, providing hygiene, changing briefs, or assisting with toileting, changing linens, and indwelling medical device care or use (e.g., central line, dialysis port, urinary catheter, feeding tube, tracheostomy). Procedure: 1. Identify residents requiring EBP during the admission screening process and as needed. Specifically, review available key documents (e.g., H&P, discharge summary, physician progress notes, laboratory testing results) for documentation of known colonization of CDC-targeted MDROs, wounds or indwelling medical devices. 2. Review new notation of resident colonization of CDC-targeted MDROs, wounds or indwelling medical devices during the IDT process. 3. Upon identification of a resident with a known colonization of a CDC-targeted MDRO, wounds or indwelling medical devices: a. Notify and educate the resident or resident representative, IDT and QST, direct care staff. Provide re-education as needed. i. Resident and resident representative notification and education should be documented in the resident's record. The Enhanced Barrier Precautions Notification Letter may be used, however, should still be documented as given. b. Place an EBP sign on the resident's door. c. Ensure adequate supply of gowns and gloves are available in the resident's room. Note: This does not require an isolation cart to be placed outside the resident's room as this is a preventative measure that should have as little impact as possible on the resident's homelike environment. d. Ensure there is a trash can and hand hygiene supplies placed near the exit of the resident's room to discard the gloves and gowns prior to exiting the room. If the resident has a roommate, ensure staff are	F 880		

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F 880	Continued From page 7 discarding the gloves and gowns, and performing hand hygiene before providing care to the second resident. e. Update the resident's care plan and care/team sheets. f. Update the infection control log and document the type of CDC-targeted MDRO the resident is known to be colonized with. 4. When performing high-contact resident care activities staff should: a. Perform hand hygiene. b. Don gloves and a gown c. Complete the high contact activity d. Remove gloves and gown and dispose of in a trash can in the resident's room or if outside of the resident's room (e.g., shower/tub room or therapy gym) in a trash can contained within the area. e. Perform hand hygiene 5. If at any time a resident is requiring EBP they require additional precautions or isolation protocol, the more stringent precautions/protocol will apply.6. The Clinical Administrator, IP, or designee should audit staff adherence to this policy at random intervals using the Enhanced Barrier Precautions Observation Form.	F 880		