DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
August 26, 2022

Administrator
Centracare Health System - Melrose Pine Villa C C
525 West Main Street
Melrose, MN 56352

RE: CCN: 245396
Cycle Start Date: August 2, 2022

Dear Administrator:

On August 22, 2022, 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.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Electronically delivered
July 11, 2022

Administrator
Centracare Health System - Melrose Pine Villa C C
525 West Main Street
Melrose, MN 56352

RE: CCN: 245396
Cycle Start Date: June 28, 2022

Dear Administrator:

On June 28, 2022, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, 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 widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

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

If substantial compliance with the regulations is not verified by September 28, 2022 (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 December 28, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245396	A. BUILDING _____ B. WING _____	C 06/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE HEALTH SYSTEM - MELROSE PINE VILLA C C	525 WEST MAIN STREET MELROSE, MN 56352

(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 6/24/22 - 6/28/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be IN compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition, a COVID-19 Focused Infection Control survey was conducted at your facility by the Minnesota Department of Health to determine compliance with §483.73 Infection Control. The facility was determined to be NOT in compliance. The following complaints were found to be SUBSTANTIATED: H53962659C (MN00084438) and H53962790C (MN00084422); however NO deficiences were cited due to actions implemented by the facility prior to survey. The following complaint was found to be UNSUBSTANTIATED: H53962807C (MN00084439). 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 886 SS=F	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility	F 886		8/2/22

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

Electronically Signed | 07/20/2022

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 886	Continued From page 1 must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of	F 886		

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F 886	Continued From page 2 each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure routine COVID-19 testing occurred for all exempted (not COVID-19 vaccinated) and not up-to-date (not vaccinated with all recommended COVID-19 vaccination(s)) staff according to the community transmission rates identified in CMS (Centers for Medicare and Medicaid) guidelines. In addition, the facility failed to ensure COVID-19 testing occurred for all impacted staff during an outbreak according to CMS guidelines for outbreak testing. This had the potential to affect all 69 residents who resided in the facility at the time of the survey. CMS Memorandum QSO-20-29-NH, revised 3/10/22, identified "Routine testing of staff, who are not up-to-date, should be based on the extent	F 886	COVID-19 Testing frequencies will follow CMS guidelines based on facility outbreak status, county transmission rates, and individual vaccine status. All staff education focused on the importance of testing, the requirements of testing and the responsibility of each staff person to complete the required testing and is to be completed by 8/2/2022. A new process was initiated 7/20/2022 for signing out testing weekly for tracking purposes due to the delay from test date to result date utilizing Vault Testing. Department Supervisors will audit staff test collection weekly beginning 7/25/2022 and the Infection Preventionist or RN designee will audit testing compliance	

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F 886	Continued From page 3 of the virus in the community. Facilities should use their community transmission level as the trigger for staff testing frequency." The memo identified Routine Testing Intervals were to be twice a week for staff who were not up-to-date with recommended vaccinations when the county COVID-19 level was "High (red)." In addition, the memo identified any nursing home-onset COVID-19 infection in a resident triggered an outbreak investigation in which "testing should begin immediately" for all staff regardless of vaccination status. Facilities were provided two options for outbreak testing: contact tracing or broad-based (facility-wide) which also included an option for group-level testing. CDC (Center for Disease Control and Prevention) guidance Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 (COVID-19) Spread in Nursing Homes, updated 2/2/22, identified if a health care worker was not -up-to-date with recommended vaccinations and worked infrequently at a facility, "they should ideally be tested within the 3 days before their shift (including the day of the shift)" when the county transmission rate was high. Review of the facility's community transmission rates from 5/23/22 to 6/20/22, indicated the facility was in the red (high) level which required COVID-19 testing two times a week for not up-to-date staff. A facility Positives in the Past Four Weeks list identified the following number of Pine Haven (secured memory care unit) residents who tested positive for COVID-19 on the associated dates: 6/13/22: two residents 6/15/22: eight residents	F 886	based on results weekly beginning 7/18/22. Infection Preventionist will review weekly testing requirements for the facility based on county transmission and outbreak status and the DON will include this data in the weekly staff update beginning 7/18/2022.	

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F 886	Continued From page 4 6/16/22: one resident 6/17/22: seven residents 6/18/22: one resident In addition, the facility list identified one Mallard unit resident on 6/21/22 who tested positive for COVID-19. A provided Weekly Situation Update - Positive Resident email, dated 6/13/22, identified the facility experienced a "HIGH" COVID-19 transmission level and that day a resident on Pine Haven tested positive for COVID-19. The email directed "Anyone who worked in Pine Haven starting Saturday June 11th needs to test: On Wednesday June 15th. Further direction on testing to come." In addition, the email directed not up-to-date and unvaccinated staff with a current exemption they needed to test twice weekly. A provided subsequent Weekly Situation Update - Positive Resident email, dated 6/21/22 at 7:57 a.m., identified the facility experienced a "HIGH" COVID-19 transmission level and there were 19 COVID-19 positive residents on Pine Haven. The email indicated the facility was in outbreak status in Pine Haven and again directed anyone who worked in Pine Haven starting 6/11/22 needed to test twice weekly, along with all staff who were not up-to-date and unvaccinated with exemption. Review of the facility's COVID-19 staff testing log spreadsheet revealed the following facility determined testing time-frames and adjustments: -6/3/22, 6/6/22, and 6/9/22 not up-to-date staff were to test two times a week. -6/14/22, 6/16/22, and 6/20/22 not up-to-date staff and Pine Haven staff were to test two times a	F 886		

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F 886	Continued From page 5 week. -6/21/22 and 6/24/22 all staff were to test two times a week due to "outbreak" facility status. The spreadsheet, and facility provided working schedules, dated 6/3/22 through 6/24/22, indicated the following staff members who lacked identified evidence they performed twice a week and/or immediate COVID-19 testing per CMS guidelines in relation to their COVID-19 vaccination status and/or frequency of scheduled work and/or where they worked during the facility outbreak status when 20 of the residents tested positive for COVID-19 from 6/13/22 through 6/21/22. In addition, the staff data reflects information related to the day(s) worked and testing dates identified as completed. Exempted (non-vaccinated) staff (6/3/22 - 6/24/22): -Registered nurse (RN)-A worked five days with two of those on Pine Haven prior to testing on 6/16/22. -Nursing assistant (NA)-A worked five days on Lilac and Mallard. No testing identified. -NA-B worked nine days with one of those days on Pine Haven. NA-B tested on 6/15/22 and 6/22/22. Not up-to-date (lacked recommended booster doses) staff (6/3/22 - 6/24/22): -Licensed practical nurse (LPN)-A worked on 6/7/22 and started twice weekly testing on 6/9/22. -Housekeeper (H)-A worked one day on 6/7/22 on Pine Haven. No testing identified. -H-B worked nine days before she tested on 6/24/22. -Trained medication aide (TMA)-B worked six days before she tested on 6/15/22. Five of those	F 886		

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F 886	Continued From page 6 days were on Pine Haven. -TMA-D worked six days before she tested on 6/24/22. -NA-C worked 12 days with four of those on Pine Haven. She tested on 6/21/22 and 6/24/22. -NA-E worked one day (6/7/22) before she tested on 6/10/22 and then worked two days after before she again tested on 6/22/22. -NA-G worked seven days before she tested on 6/15/22. -NA-L worked six days before she tested on 6/22/22. -NA-N worked six days before she tested on 6/22/22. -NA-O worked ten days before she tested on 6/22/22. -Dietary aide (DA)-D worked 6/14/22, 6/15/22, 6/17/22, and 6/21/22. She tested on 6/10/22 and 6/18/22. The spreadsheet identified she worked every other weekend and lacked evidence she tested within three days of her shift. Pine Haven staff (Pine Haven outbreak) (6/13/22 - 6/24/22): -LPN-B worked three days beginning 6/13/22 before she tested on 6/20/22. -TMA-C worked 6/17/22 before she tested on 6/20/22. -NA-D worked two days (6/13/22, 6/15/22). No testing identified. -NA-F worked two days (6/14/22, 6/20/22). In addition, she worked on 6/24/22 on another unit. She tested on 6/17/22. -NA-H worked five days beginning 6/18/22 before she tested on 6/23/22. -NA-I worked four days beginning on 6/17/22. No testing identified. -NA-J worked five days beginning on 6/18/22. No testing identified.	F 886		

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F 886	Continued From page 7 -NA-K worked 6/15/22 and tested on 6/24/22. -NA-M worked nine days beginning on 6/14/22. No testing identified. -NA-S worked on 6/16/22. No testing identified. -NA-T worked five days beginning 6/13/22 before she tested on 6/22/22. -NA-Q worked four days beginning 6/15/22. No testing identified. -H-C worked three days beginning 6/13/22 before she tested on 6/17/22. -DA-E worked three days beginning 6/13/22. No testing identified. Facility staff (all facility outbreak) (6/21/22-6/24/22): -DA-A worked two days (6/22/22 and 6/24/22). No testing identified. -DA-B worked two days (6/21/22 and 6/22/22). No testing identified. -DA-C worked two days (6/21/22 and 6/24/22). No testing identified. -DA-F worked three days beginning 6/22/22. No testing identified. -DA-G worked three days beginning 6/21/22. No testing identified. -TMA-A worked four days (6/21/22 through 6/24/22). No testing identified. -NA-P worked on 6/21/22. No testing identified. -NA-R worked three days beginning 6/21/22. No testing identified. -H-D worked two days (6/21/22 and 6/22/22) prior to testing on 6/24/22. During interview on 6/27/22, at 1:25 p.m. the administrator stated COVID-19 staff testing was based off of vaccination status and county transmission rates. She explained COVID-19 testing for staff not up-to-date was expected to be completed twice a week. For staff who worked	F 886		

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F 886	Continued From page 8 every other weekend, they were expected to test two to three days before their shift. Staff obtained two to four Vault testing kits from the facility each week in which they were allowed to test "whenever they want" as long as they tested twice a week and at least two days apart from each other. Staff performed the tests either at the facility or at home. She stated Vault testing was initiated approximately three months earlier. Lab results took approximately two days to receive back from Vault and if the result was inconclusive, or the staff was symptomatic, they were required to follow up with employee health for a rapid swab test. She indicated the facility continued to use Vault for testing instead of conducting rapid testing once the outbreak was identified as staff "are very good at wearing all of their PPE (personal protective equipment) and are being good at reporting symptoms." The administrator explained upon COVID-19 being identified on Pine Haven, contact tracing was attempted and inconclusive, thus, all staff who worked on Pine Haven were tested within two to three days. Further, she explained being the initial positive residents were contained within Pine Haven, Pine Haven group-level staff testing was conducted; however, once a positive resident was identified on 6/21/22, facility wide staff testing was initiated and continued. With review of staff testing and vaccination spreadsheet, the administrator confirmed there were staff who lacked the required twice a week testing. She explained she reviewed lab results one or two times a week depending on when the results were received back; however, she denied she performed a formal audit each week which ensured all staff tested as required. The administrator verbalized when staff failed to test as directed it placed the facility at risk for COVID-19: "Unless we know	F 886		

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(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 886	Continued From page 9 they [staff] are negative [for COVID] they are potentially at risk for having COVID even if asymptomatic." When interviewed on 6/28/22, at 12:08 p.m. NA-Q stated she typically worked on Pine Haven and acknowledged she entered COVID-19 positive resident rooms. She acknowledged she was expected to test twice a week and tested, "whenever I get around to it ...usually on my days off." She stated she was "about two weeks behind on testing ...it has been so busy." She stated she was informed to stay out of other "neighborhoods" as much as possible and thus was unable to obtain tests. She did confirm she could have asked another staff to obtain them for her. She verbalized the importance of testing was due to increased number of COVID-19 positive residents within the facility; however, she did not think the residents were at risk due to her lack of expected testing. When interviewed on 6/28/22, at 12:24 p.m. dietary aide (DA)-E acknowledged she primarily worked on Pine Haven and interacted with residents. She stated she knew COVID-19 positive residents resided on that unit. She explained she was first directed to test twice a week on 6/27/22 as no one instructed her to test prior to that. She stated important facility updates were provided by her supervisor or through her email; however, she acknowledged she does not routinely check her email despite her being expected to check her email at least once every day due to lack of time either at home or at work. She reported, "I obviously work in the area where there is COVID and we need to know if we are positive so we do not get residents or other employees sick with COVID."	F 886		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245396	A. BUILDING _____ B. WING _____	C 06/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE HEALTH SYSTEM - MELROSE PINE VILLA C C	525 WEST MAIN STREET MELROSE, MN 56352

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F 886	Continued From page 10 During interview on 6/28/22, at 12:51 p.m. DA-G stated she started testing "maybe eight or ten days ago" and she was expected to test twice a week; however, when questioned when she tested she indicated she "just sent one in today" and could not identify any other specific dates. She stated, "I do not think I got the test results back." DA-G explained she did not like to test and stated, "just seems like everybody is vaccinated anyways ...most everybody. We keep our distance and we wear our masks. "I honestly do not see an issue [risk of not testing as expected]" as she interacted with residents very little" and her only interaction basically was when she brought the residents their plates. When interviewed on 6/28/22, at 1:10 p.m. NA-A stated she tested twice a week as she was unvaccinated which was expected since her hire date "three or four months ago." She indicated she tested twice a week; however, acknowledged she missed some testing and did not always test twice a week. She explained her busy life and work schedules were the reasons for the missed tests. She verbalized expected testing was important in order to make sure she remained healthy, that she did not "cross contaminate" between the two facilities she worked at. When interviewed on 6/28/22, at 1:16 p.m. H-D stated she was not scheduled to work on Pine Haven when residents were identified with COVID-19; however, she worked when other unit residents tested positive for COVID-19. She indicated she was informed of the expected twice weekly testing on 6/24/22. H-D explained if testing was not performed as expected the residents were at risk for COVID-19.	F 886		

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CENTRACARE HEALTH SYSTEM - MELROSE PINE VILLA C C	525 WEST MAIN STREET MELROSE, MN 56352

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F 886	Continued From page 11 When interviewed on 6/28/22, at 1:32 p.m. housekeeping director (HD) stated staff were expected to test twice a week "right now." She indicated she sent out an email on 6/23/22 to housekeeping staff which directed twice a week testing. She denied knowledge some of the housekeeping staff lacked expected testing since the facility was determined to be in a facility wide outbreak status on 6/21/22. She acknowledged there was a definite infection control risk if staff lacked required testing as management needed to know if staff brought infection(s) into the building in order for the residents to be kept safe from those potential infections. When interviewed on 6/28/22, at 3:02 p.m. dietary manager (DM) stated "everybody should be testing twice a week with two full days between each test ...regardless of vaccination status." She denied knowledge any of her dietary staff were behind in such testing and she denied she was involved in any auditing to ensure her staff followed the testing requirements. DM explained expected testing was important to see if it [COVID-19] has been transmitted and you have to keep testing as the incubation period is different for each person." In addition, she explained staff could be asymptomatic and spread COVID-19 if they could touched their mask, which was "so easy" and then they touched the residents' silverware or plates. When interviewed on 6/28/22, at 3:21 p.m. nurse manager RN-B stated all staff were testing twice a week due to the facility being in outbreak status. She explained initially "unvaccinated" staff were expected to test twice a week; however, when COVID residents were identified on Pine	F 886		

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F 886	Continued From page 12 Haven, then the staff "exposed" on Pine Haven started to also test twice a week. RN-B stated when a non-Pin Haven resident tested positive then all staff were expected to test twice a week. She explained after she received an email notification on 6/21/22 which identified all staff were to test twice a week she sent a text message to nursing staff which updated staff on the email delivered information. RN-B stated she spoke to the ICP after the initial positive residents were identified and the ICP "encouraged" staff to test at least once that week; however, two times was best and then continue with twice weekly testing after that. RN-B denied involvement in auditing the testing spreadsheet; however, she did acknowledge the administrator had emailed her staff information prior about staff not being up-to-date on testing. Once she received that information, she emailed the staff about the need for testing. She explained if there were no staff response received back, or administrator follow-up response, she assumed they completed the missed test. She expressed surprise at the facility currently having missed tests and explained there was "a lot of transition on status testing needs." RN-B stated lack of required testing placed residents at risk for COVID as the residents could potentially be exposed from asymptomatic staff. During interview on 6/28/22, at 3:56 p.m. the infection control preventionist (RN)-C stated she initially was informed staff were not testing as expected when she was informed of the potential infection control deficiency related to an issue with staff testing. She denied she was allowed access to the testing spreadsheet and she acknowledged she was not involved in any audits to ensure staff tested as expected. RN-C	F 886		

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F 886	Continued From page 13 explained "unvaccinated" staff "no matter what" tested twice a week due to the high county transmission rate. Further, she explained when COVID-19 was identified on Pine Haven, those staff were also expected to test twice a week as "they were able to keep the doors locked and it was contained to just one area." Once COVID-19 was identified on another unit, all staff were then to be tested twice a week. She stated twice a week testing was important to help mitigate the spread of COVID-19 in the facility. During interview on 6/28/22, at 4:27 p.m. the director of nursing (DON) stated the administrator updated her on 6/24/22 staff were behind on the required twice a week testing. Prior to 6/24/22, she denied such knowledge. She stated she was allowed access to the testing spreadsheet; however, she had not reviewed it recently. The DON stated she expected staff to follow the testing requirements as staff could potentially be asymptomatic and spread COVID. A policy COVID-19 Staff and Resident Testing Plan, dated last reviewed 4/2022, indicated COVID-19 testing was a priority to help inform clinical care and infection prevention and control practices in their setting. The policy directed "whole house surveillance testing or targeted surveillance testing of staff when the following situations occurred based on the guidance from Minnesota Department of Health: one or more residents are confirmed to have COVID-19, a cluster (two or more) residents and/or staff develop symptoms consistent with COVID-19.	F 886		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 11, 2022

Administrator
Centracare Health System - Melrose Pine Villa C C
525 West Main Street
Melrose, MN 56352

Re: Event ID: PLT211

Dear Administrator:

The above facility survey was completed on June 28, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00633	A. BUILDING: _____ B. WING _____	C 06/28/2022

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CENTRACARE HEALTH SYSTEM - MELROSE F	525 WEST MAIN STREET MELROSE, MN 56352

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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 6/24/22 - 6/28/22, a complaint survey was conducted at your facility by a surveyor from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. The following complaints were found to be	2 000		

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2 000	Continued From page 1 SUBSTANTIATED: H53962659C (MN00084438) and H53962790C (MN00084422), however NO licensing orders were issued. The following complaint was found to be UNSUBSTANTIATED: H53962807C (MN00084439). The 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		