DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 14, 2023

Administrator
Little Falls Care Center
1200 First Avenue Northeast
Little Falls, MN 56345

RE: CCN: 245399
Cycle Start Date: December 19, 2022

Dear Administrator:

On January 17, 2023, we notified you a remedy was imposed. On February 3, 2023 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of January 20, 2023.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective March 19, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of January 5, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 19, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on January 20, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 14, 2023

Administrator
Little Falls Care Center
1200 First Avenue Northeast
Little Falls, MN 56345

Re: Reinspection Results
Event ID: VIBF12

Dear Administrator:

On February 3, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 19, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

DEPARTMENT OF HEALTH

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Electronically delivered
January 5, 2023

Administrator
Little Falls Care Center
1200 First Avenue Northeast
Little Falls, MN 56345

RE: CCN: 245399
Cycle Start Date: December 19, 2022

Dear Administrator:

On December 19, 2022, 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 19, 2023.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 19, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 19, 2023.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for

new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by March 19, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Little Falls Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 19, 2023. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 19, 2023 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and

1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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

Kamala Fiske-Downing
Minnesota Department of Health
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
	245399	A. BUILDING _____ B. WING _____	12/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE FALLS CARE CENTER	1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345

(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 12/16/22, through 12/19/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirments for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H53996493C (MN00089257 and MN00088947); however, no deficiencies were cited due to actions implemented by the facility prior to survey. A COVID-19 Focused Infection Control survey was also conducted at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was determined to be NOT in compliance. As a result of the investigation, a deficiency was 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.	F 000		
F 880 SS=E	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		1/20/23

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

Electronically Signed | 01/20/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 880	Continued From page 1 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable	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 standards of practice for hand hygiene was completed between residents and residents' rooms, to prevent the spread of infection, and to maintain infection control measures for 10 of 10 residents (R6, R7, R8, R9, R11, R12, R13, R14, R15, and R16) observed during the passing of meal trays and the passing of residents' laundry. In addition, the facility failed to ensure appropriate source control was utilized in accordance with national standards during the provision of care for 1 of 1 residents (R10). Findings include: The CDC (Centers for Disease Control and Prevention) website dated 9/23/22, identified "When SARS-CoV-2 Community Transmission	F 880	Little Falls Health Services was found to have inadequate infection prevention measures in place. Inadequate infection prevent measures were found under the following circumstances; inadequate hand hygiene when entering and exiting rooms to pass meal trays, failure to recognize TBP in place for resident R6 when entering room to pass meal tray, inadequate hand hygiene when entering and exiting rooms while passing out laundry as well as inappropriate use of face mask during 1:1 encounter with resident R10. Written educations were provided to the following staff; DA-A for proper hand washing, NA-A for proper use of face mask and LA-A for proper hand washing. Potential of this occurring with other	

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F 880	Continued From page 3 levels are high, source control [well-fitting face mask] is recommended for everyone in a healthcare setting when they are in areas of the healthcare facility where they could encounter patients." The CDC Covid Data Tracker website reviewed on 12/16/22, identified Morrison County (county where facility resides) had a high SARS-CoV-2 community transmission level. On 12/16/22, 10:08 a.m. R6 was observed to have two transmission-based precaution (TBP) signs secured to the outside of his door, along with a container unit that housed gloves. Just inside R6's room doorway, to the left side, was a three drawer container with gowns and a lidded garbage container. One precaution sign identified R6 was on contact enteric precautions (in addition to standard precautions) and directed the following: "Everyone Must: Clean hands with sanitizer when entering room. Wash with SOAP AND WATER UPON LEAVING ROOM." The second sign identified R6 was on enhanced barrier precautions and directed the following: "EVERYONE MUST: Clean their hands, including before entering and when leaving the room." R6's quarterly Minimum Data Set (MDS) dated 11/28/22, identified R6 was moderately cognitively impaired, required extensive physical assist for his activities of daily living (ADLs), and was diagnosed with bacteremia (bacteria in the blood), urinary tract infection, candidiasis (fungal infection), and zoster (viral infection - shingles). In addition, the MDS identified R6 was administered antibiotic(s), presented with open lesion(s), and application of wound care dressing(s) with ointment(s)/medication(s) was performed. A	F 880	residents regarding inadequate infection prevention. Directors to complete audits within departments to ensure adequate infection prevention measures remain in place. Audits are to confirm adequate infection prevention measures remain in place and education to be completed if deficits are found. Policies were reviewed; showing no changes to be needed. Education to be provided to all staff regarding appropriate infection control. The following Educare modules were reassigned to all staff, to be completed by 1/2/23; Infection Prevention & Control □ SNF, Infection Prevention & Control □ PPE, COVID 19 Nursing □ SFHS (for nursing department), COVID 19 Ancillary □ SFHS (all other departments). Directors to complete audits 3x / week for 4 weeks, then 1x / week for 4 weeks. Audits to reflect proper infection control measures regarding appropriate hand hygiene, proper use of face mask, proper use of gloves, proper use of goggles if required and proper use of gown if required. Findings to be brought to QAPI for further recommendations for on-going monitoring. Completion date of 2/8/23.	

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F 880	Continued From page 4 Discharge Summary dated 11/21/22, identified R6 was admitted to the hospital for a third time due to recurrent sepsis (blood infection) and fevers with an unknown source or etiology. During continued observation on 12/16/22, from 12:00 p.m. to 12:07 p.m. dietary aide (DA)-A pushed a three tiered metal cart which housed resident meal trays toward the Lindbergh Park unit. -When adjacent to R6's room, DA-A procured a meal tray and entered R6's room. R6's room door continued to exhibit the two TBP signs. DA-A brought the tray to R6, who laid in bed with his upper body raised with a tray table positioned in front of him. DA-A touched the tray table and items on the tray table in order to make room for the meal tray. She prepared (setup) the tray and food. DA-A exited the room. DA-A failed to perform hand hygiene before she entered and after she exited R6's room. -DA-A pushed the meal cart to R7's room and procured a meal tray. DA-A touched R7's door handle to open the door, entered R7's room and handed the tray to R7. When R7 struggled to place the tray on a table in front of them, DA-A moved R7's call light out of the way and assisted R7 to place the tray on the table. DA-A exited R7's room and closed R7's door. DA-A failed to perform hand hygiene before she entered R7's room and after she exited. -DA-A pushed the meal cart to R8's room and procured a meal tray. DA-A touched R8's door handle to open the door, entered R8's room and placed the tray on the tray table. DA-A exited R8's room and closed R8's door. DA-A failed to perform hand hygiene before she entered R8's room and after she exited. -DA-A pushed the meal cart to R9's room and	F 880		

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F 880	Continued From page 5 procured a meal tray. DA-A touched R9's door handle to open the door and placed the tray on a table where R9 sat. DA-A removed the main plate from the insulated meal delivery dome unit and placed it in front of R9. DA-A took R9's silverware and cut up R9's food. DA-A took the remainder of the items off of the tray and sat them in front of R9. DA-A obtained a straw from a container of straws in R9's room, removed the entire protective paper straw covering, and placed the straw in R9's drink. DA-A exited R9's room and closed R9's door. DA-A failed to perform hand hygiene before she entered R9's room, during R9's meal setup, or after she exited R9's room. When interviewed on 12/16/22, at 12:07 p.m. DA-A stated she was not aware R6 was on precautions. DA-A explained she saw the gloves (container) on R6's door; however, not the TBP signs. DA-A stated it was her practice to look at doors for such signs as, depending on what the signs identified, she was expected to perform certain steps. Once R6's precautions were identified for DA-A, she stated she "probably" should have put gloves on and she should have performed hand hygiene after she exited the room. DA-A confirmed she failed to provide hand hygiene after she exited R6's room once she delivered his meal tray. In addition, she confirmed she failed to provide hand hygiene before she entered and once she exited R7, R8, and R9's rooms. DA-A explained she was educated on hand hygiene and she was expected to perform hand hygiene once she exited a resident's room so as to not enter another resident room with dirty hands. During interview on 12/16/22, at 12:31 p.m. registered nurse (RN)-A stated R6 was on contact	F 880		

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F 880	Continued From page 6 precautions due to a diagnosis of shingles in which he continued to have "a small opening" on his back. She stated R6 touched "everything" and verbalized she expected all staff, even if they only touched things in R6's room, to perform hand hygiene at least when they exited R6's room in order to prevent the spread of infection. When interviewed on 12/16/22, at 12:38 p.m. the dietary manager (DM) stated she was unaware of any residents with TBP; however, she expected dietary staff to look for precaution signs on resident doors before they entered. She explained, depending on what the reason for the precaution was, dietary staff may or may not enter a resident's room. If they were allowed to enter, as in the case of R6's room, they were expected to follow the sign instructions. In addition, she stated she expected dietary staff to sanitize their hands before they entered and after they exited any resident room in order to protect residents from disease cross contamination. During a medication pass observation on 12/16/22, at 12:58 p.m. nursing assistant (NA)-A assisted R10 out of the bathroom while he stood in a standing lift. NA-A's source control (surgical) mask was positioned under her chin in which her nose and mouth were uncovered. R10 lacked a face mask or any other source control. NA-A and R10's faces were within approximately one to two feet of each other as they conversed when she maneuvered him into the main entry area of his room. Licensed practical nurse (LPN)-A administered R10's medications to him as she, along with NA-A and R10, continued to converse with each other. LPN-A did not instruct NA-A in proper mask use while she administered R10 his medications. After LPN-A exited R10's room she	F 880		

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	245399	A. BUILDING _____ B. WING _____	12/19/2022

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F 880	Continued From page 7 was questioned on concerns related to NA-A's mask use. At 1:06 p.m. LPN-A returned to the room and instructed NA-A to position her mask appropriately. When interviewed on 12/16/22, at 1:06 p.m. LPN-A stated all staff were expected to properly wear their face masks over their mouth and nose related to infection control factors and to prevent the spread of COVID-19. During interview on 12/16/22, at 1:08 p.m. NA-A stated she was expected to have her face mask properly positioned (covered nose and mouth) at all times when around residents. NA-A confirmed she did not wear her face mask as expected while she cared for R10. She explained the purpose of proper face mask use was to not spread germs, especially COVID-19. During continued observation on 12/16/22, from 1:14 p.m. to 1:22 p.m. laundry aide (LA)-A pushed a covered laundry cart adjacent to R11's room. LA-A procured clothing from the cart and entered R11's room where she touched R11's tray table to move in from in front of R11's closet. LA-A opened R11's closet by the closet handle and placed the clothing in the closet. LA-A exited R11's room. -LA-A lifted the cart covering and procured R12's clothing. LA-A also adjusted plastic clothing hangers that hung from the side of the cart. LA-A entered R12's room and opened one of R12's closet doors by the handle. She placed the clothing in the closet and adjusted other clothing that was present. LA-A closed the closet and proceeded to open the second closet door. She adjusted the clothing in the closet and took out one article of clothing. LA-A closed the closet and	F 880		

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F 880	Continued From page 8 exited R12's room with the article of clothing which she placed in with the clothing already in the cart. -LA-A pushed the covered cart adjacent to R13's room and procured R13's clothing. She entered R13's room and opened her closet door. She placed the clothing in the closet and adjusted other clothing. She removed plastic hangers from the closet and placed them on the cart edge after she exited R13's room. -LA-A procured a pair of folded pants for R14 from the cart after she adjusted the cart covering. LA-A entered R14's room and opened a drawer where she inserted the pants. While LA-A exited R14's room, she grabbed the privacy curtain within R14's doorway and moved it out of her way. -LA-A procured R15's clothing from the cart and entered R15's room. LA-A grabbed the privacy curtain to move it out of her way as she entered R15's room and then opened R15's closet. She adjusted clothing in the closet and then adjusted the privacy curtain as she exited R15's room. -LA-A pushed the covered cart adjacent to R16's room and procured R16's clothing. She entered R16's room as she grabbed the privacy curtain to adjust it. LA-A opened R16's closet and hung the clothing up. LA-A adjusted the privacy curtain as she exited the room and used hand sanitizer on her hands. LA-A failed to perform hand hygiene before she entered R16's room. In addition, LA-A failed to perform hand hygiene before she entered and after she exited R11, R12, R13, R14, and R15's rooms. When interviewed on 12/16/22, at 1:22 p.m. LA-A stated she was expected to use hand sanitizer every time she went into a residents room and when she exited. She explained she did not	F 880		

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F 880	Continued From page 9 always think of using the sanitizer. In addition, she explained she had burnt her ring finger and it really hurt when she used the sanitizer; however, she acknowledged she knew that was not an excuse for not sanitizing her hands. LA-A "thought" she performed hand hygiene after exited R13's room and confirmed she did not perform hand hygiene before she entered or when she exited R11, R12, and R14's room or before she entered R16's room. LA-A stated hand hygiene was important so that germs were not brought room to room. During interview on 12/16/22, at 1:26 pm. environmental services director (ESD) stated he expected hand hygiene to be performed between each resident room when laundry staff handed out laundry. He explained resident tray tables were "totally contaminated" and LA-A's action between R11 and R16's room was "not a good scenario at all." ESD stated hand hygiene was important to decrease the risk of germs being spread from resident to resident. When interviewed on 12/16/22, at 1:47 p.m. the director of nursing (DON), who at the time was the acting infection preventionist, stated she expected hand hygiene to be performed before any department staff entered a resident room and when they exited, or at a minimum when they exited depending on the actions they performed i.e. passing meal trays. In addition, she expected all staff to wear their face masks properly (covered nose and mouth) with any resident contact. The DON explained hand hygiene was important to prevent and control infection(s) within the resident population and amongst staff. During interview on 12/16/22, at 2:15 p.m. the	F 880		

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F 880	Continued From page 10 administrator stated hand hygiene was "a given" and he expected staff to use hand sanitizer before they entered a resident room and after they exited. He stated all staff were trained in this expectation and verbalized it was unfortunate hand hygiene had become "laxed." The administrator identified the facilities county transmission rate was high and thus he stated he expected all staff to wear their face masks appropriately during resident interactions. He explained the facility needed to protect their residents and when staff failed to follow infection control expectations the residents and staff were at risk for infections. A Standard Precaution policy dated 5/8/17, identified all facility staff were to practice standard precautions at all times regardless of resident infection status in order to prevent the spread of infections, in which washing hands was the primary means of preventing infection transmission. The policy directed standard precautions was to be used when cares and services were provided. The policy directed hands were to be washed immediately before the care of a resident, after resident contact, and before environmental surfaces were touched. A Hand Hygiene policy dated 5/8/17, identified alcohol-based hand sanitizer could be used, instead of soap and water, when hands did not appear soiled, before and after staff assisted a resident when not in contact with bodily fluids, before and after contact with environmental surfaces or equipment in the vicinity of residents, and before leaving a residents room if direct physical contact was not made with the resident or the resident's environmental surfaces or equipment.	F 880		

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F 880	Continued From page 11 A Transmission Based Precautions policy dated 6/7/17, identified TBP included contact precautions which was designated when a resident was known or suspected to be infected or colonized with microorganisms that could be transmitted by direct resident contact or indirect contact with environmental surfaces or care items in the resident's environment. Zoster was provided as an example for contact precautions. The policy directed staff to wash hands/perform hand hygiene immediately with soap or an antimicrobial agent or waterless antiseptic agent before they exited the resident's room. A Coronavirus Prevention, Screening, and Identification policy dated 10/9/22, directed staff would wear a mask in all resident areas during working hours based on county transmission rates.	F 880		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 5, 2023

Administrator
Little Falls Care Center
1200 First Avenue Northeast
Little Falls, MN 56345

Re: State Nursing Home Licensing Orders
Event ID: VIBF11

Dear Administrator:

The above facility was surveyed on December 16, 2022 through December 19, 2022 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:

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

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.

Sincerely,

Kamala Fiske-Downing

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

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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 12/16/22, through 12/19/22, a complaint survey was conducted at your facility by a surveyor from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date	2 000		

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2 000	Continued From page 1 when they will be completed. The following complaints were found to be SUBSTANTIATED: H53996493C (MN00089257 and MN00088947); however, NO licensing orders were issued due to actions taken by the facility prior to survey. As a result of the investigation a licensing order was issued at 4658.0800 subp. 1. 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 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	2 000		

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2 000	Continued From page 2 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. 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 standards of practice for hand hygiene was completed between residents and residents' rooms, to prevent the spread of infection, and to maintain infection control measures for 10 of 10 residents (R6, R7, R8, R9, R11, R12, R13, R14, R15, and R16) observed during the passing of meal trays and the passing of residents' laundry. In addition, the facility failed to ensure appropriate source control was utilized in accordance with national standards during the provision of care for 1 of 1 residents (R10).	21375	Little Falls Health Services was found to have inadequate infection prevention measures in place. Inadequate infection prevent measures were found under the following circumstances; inadequate hand hygiene when entering and exiting rooms to pass meal trays, failure to recognize TBP in place for resident R6 when entering room to pass meal tray, inadequate hand hygiene when entering and exiting rooms while passing out laundry as well as inappropriate use of face mask during 1:1 encounter with resident R10. Written	1/20/23

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21375	Continued From page 3 Findings include: The CDC (Centers for Disease Control and Prevention) website dated 9/23/22, identified "When SARS-CoV-2 Community Transmission levels are high, source control [well-fitting face mask] is recommended for everyone in a healthcare setting when they are in areas of the healthcare facility where they could encounter patients." The CDC Covid Data Tracker website reviewed on 12/16/22, identified Morrison County (county where facility resides) had a high SARS-CoV-2 community transmission level. On 12/16/22, 10:08 a.m. R6 was observed to have two transmission-based precaution (TBP) signs secured to the outside of his door, along with a container unit that housed gloves. Just inside R6's room doorway, to the left side, was a three drawer container with gowns and a lidded garbage container. One precaution sign identified R6 was on contact enteric precautions (in addition to standard precautions) and directed the following: "Everyone Must: Clean hands with sanitizer when entering room. Wash with SOAP AND WATER UPON LEAVING ROOM." The second sign identified R6 was on enhanced barrier precautions and directed the following: "EVERYONE MUST: Clean their hands, including before entering and when leaving the room." R6's quarterly Minimum Data Set (MDS) dated 11/28/22, identified R6 was moderately cognitively impaired, required extensive physical assist for his activities of daily living (ADLs), and was diagnosed with bacteremia (bacteria in the blood), urinary tract infection, candidiasis (fungal infection), and zoster (viral infection - shingles). In	21375	educations were provided to the following staff; DA-A for proper hand washing, NA-A for proper use of face mask and LA-A for proper hand washing. Potential of this occurring with other residents regarding inadequate infection prevention. Directors to complete audits within departments to ensure adequate infection prevention measures remain in place. Audits are to confirm adequate infection prevention measures remain in place and education to be completed if deficits are found. Policies were reviewed; showing no changes to be needed. Education to be provided to all staff regarding appropriate infection control. The following Educare modules were reassigned to all staff, to be completed by 1/2/23; Infection Prevention & Control □ SNF, Infection Prevention & Control □ PPE, COVID 19 Nursing □ SFHS (for nursing department), COVID 19 Ancillary □ SFHS (all other departments). Directors to complete audits 3x / week for 4 weeks, then 1x / week for 4 weeks. Audits to reflect proper infection control measures regarding appropriate hand hygiene, proper use of face mask, proper use of gloves, proper use of goggles if required and proper use of gown if required. Findings to be brought to QAPI for further recommendations for on-going monitoring. Completion date of 2/8/23.	

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21375	Continued From page 4 addition, the MDS identified R6 was administered antibiotic(s), presented with open lesion(s), and application of wound care dressing(s) with ointment(s)/medication(s) was performed. A Discharge Summary dated 11/21/22, identified R6 was admitted to the hospital for a third time due to recurrent sepsis (blood infection) and fevers with an unknown source or etiology. During continued observation on 12/16/22, from 12:00 p.m. to 12:07 p.m. dietary aide (DA)-A pushed a three tiered metal cart which housed resident meal trays toward the Lindbergh Park unit. -When adjacent to R6's room, DA-A procured a meal tray and entered R6's room. R6's room door continued to exhibit the two TBP signs. DA-A brought the tray to R6, who laid in bed with his upper body raised with a tray table positioned in front of him. DA-A touched the tray table and items on the tray table in order to make room for the meal tray. She prepared (setup) the tray and food. DA-A exited the room. DA-A failed to perform hand hygiene before she entered and after she exited R6's room. -DA-A pushed the meal cart to R7's room and procured a meal tray. DA-A touched R7's door handle to open the door, entered R7's room and handed the tray to R7. When R7 struggled to place the tray on a table in front of them, DA-A moved R7's call light out of the way and assisted R7 to place the tray on the table. DA-A exited R7's room and closed R7's door. DA-A failed to perform hand hygiene before she entered R7's room and after she exited. -DA-A pushed the meal cart to R8's room and procured a meal tray. DA-A touched R8's door handle to open the door, entered R8's room and placed the tray on the tray table. DA-A exited R8's room and closed R8's door. DA-A failed to	21375		

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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) COMPLETE DATE
21375	Continued From page 5 perform hand hygiene before she entered R8's room and after she exited. -DA-A pushed the meal cart to R9's room and procured a meal tray. DA-A touched R9's door handle to open the door and placed the tray on a table where R9 sat. DA-A removed the main plate from the insulated meal delivery dome unit and placed it in front of R9. DA-A took R9's silverware and cut up R9's food. DA-A took the remainder of the items off of the tray and sat them in front of R9. DA-A obtained a straw from a container of straws in R9's room, removed the entire protective paper straw covering, and placed the straw in R9's drink. DA-A exited R9's room and closed R9's door. DA-A failed to perform hand hygiene before she entered R9's room, during R9's meal setup, or after she exited R9's room. When interviewed on 12/16/22, at 12:07 p.m. DA-A stated she was not aware R6 was on precautions. DA-A explained she saw the gloves (container) on R6's door; however, not the TBP signs. DA-A stated it was her practice to look at doors for such signs as, depending on what the signs identified, she was expected to perform certain steps. Once R6's precautions were identified for DA-A, she stated she "probably" should have put gloves on and she should have performed hand hygiene after she exited the room. DA-A confirmed she failed to provide hand hygiene after she exited R6's room once she delivered his meal tray. In addition, she confirmed she failed to provide hand hygiene before she entered and once she exited R7, R8, and R9's rooms. DA-A explained she was educated on hand hygiene and she was expected to perform hand hygiene once she exited a resident's room so as to not enter another resident room with dirty hands.	21375		

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	00382	A. BUILDING: _____ B. WING _____	12/19/2022

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21375	Continued From page 6 During interview on 12/16/22, at 12:31 p.m. registered nurse (RN)-A stated R6 was on contact precautions due to a diagnosis of shingles in which he continued to have "a small opening" on his back. She stated R6 touched "everything" and verbalized she expected all staff, even if they only touched things in R6's room, to perform hand hygiene at least when they exited R6's room in order to prevent the spread of infection. When interviewed on 12/16/22, at 12:38 p.m. the dietary manager (DM) stated she was unaware of any residents with TBP; however, she expected dietary staff to look for precaution signs on resident doors before they entered. She explained, depending on what the reason for the precaution was, dietary staff may or may not enter a resident's room. If they were allowed to enter, as in the case of R6's room, they were expected to follow the sign instructions. In addition, she stated she expected dietary staff to sanitize their hands before they entered and after they exited any resident room in order to protect residents from disease cross contamination. During a medication pass observation on 12/16/22, at 12:58 p.m. nursing assistant (NA)-A assisted R10 out of the bathroom while he stood in a standing lift. NA-A's source control (surgical) mask was positioned under her chin in which her nose and mouth were uncovered. R10 lacked a face mask or any other source control. NA-A and R10's faces were within approximately one to two feet of each other as they conversed when she maneuvered him into the main entry area of his room. Licensed practical nurse (LPN)-A administered R10's medications to him as she, along with NA-A and R10, continued to converse with each other. LPN-A did not instruct NA-A in proper mask use while she administered R10 his	21375		

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21375	Continued From page 7 medications. After LPN-A exited R10's room she was questioned on concerns related to NA-A's mask use. At 1:06 p.m. LPN-A returned to the room and instructed NA-A to position her mask appropriately. When interviewed on 12/16/22, at 1:06 p.m. LPN-A stated all staff were expected to properly wear their face masks over their mouth and nose related to infection control factors and to prevent the spread of COVID-19. During interview on 12/16/22, at 1:08 p.m. NA-A stated she was expected to have her face mask properly positioned (covered nose and mouth) at all times when around residents. NA-A confirmed she did not wear her face mask as expected while she cared for R10. She explained the purpose of proper face mask use was to not spread germs, especially COVID-19. During continued observation on 12/16/22, from 1:14 p.m. to 1:22 p.m. laundry aide (LA)-A pushed a covered laundry cart adjacent to R11's room. LA-A procured clothing from the cart and entered R11's room where she touched R11's tray table to move in from in front of R11's closet. LA-A opened R11's closet by the closet handle and placed the clothing in the closet. LA-A exited R11's room. -LA-A lifted the cart covering and procured R12's clothing. LA-A also adjusted plastic clothing hangers that hung from the side of the cart. LA-A entered R12's room and opened one of R12's closet doors by the handle. She placed the clothing in the closet and adjusted other clothing that was present. LA-A closed the closet and proceeded to open the second closet door. She adjusted the clothing in the closet and took out one article of clothing. LA-A closed the closet and	21375		

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21375	Continued From page 8 exited R12's room with the article of clothing which she placed in with the clothing already in the cart. -LA-A pushed the covered cart adjacent to R13's room and procured R13's clothing. She entered R13's room and opened her closet door. She placed the clothing in the closet and adjusted other clothing. She removed plastic hangers from the closet and placed them on the cart edge after she exited R13's room. -LA-A procured a pair of folded pants for R14 from the cart after she adjusted the cart covering. LA-A entered R14's room and opened a drawer where she inserted the pants. While LA-A exited R14's room, she grabbed the privacy curtain within R14's doorway and moved it out of her way. -LA-A procured R15's clothing from the cart and entered R15's room. LA-A grabbed the privacy curtain to move it out of her way as she entered R15's room and then opened R15's closet. She adjusted clothing in the closet and then adjusted the privacy curtain as she exited R15's room. -LA-A pushed the covered cart adjacent to R16's room and procured R16's clothing. She entered R16's room as she grabbed the privacy curtain to adjust it. LA-A opened R16's closet and hung the clothing up. LA-A adjusted the privacy curtain as she exited the room and used hand sanitizer on her hands. LA-A failed to perform hand hygiene before she entered R16's room. In addition, LA-A failed to perform hand hygiene before she entered and after she exited R11, R12, R13, R14, and R15's rooms. When interviewed on 12/16/22, at 1:22 p.m. LA-A stated she was expected to use hand sanitizer every time she went into a residents room and when she exited. She explained she did not always think of using the sanitizer. In addition,	21375		

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21375	Continued From page 9 she explained she had burnt her ring finger and it really hurt when she used the sanitizer; however, she acknowledged she knew that was not an excuse for not sanitizing her hands. LA-A "thought" she performed hand hygiene after exited R13's room and confirmed she did not perform hand hygiene before she entered or when she exited R11, R12, and R14's room or before she entered R16's room. LA-A stated hand hygiene was important so that germs were not brought room to room. During interview on 12/16/22, at 1:26 pm. environmental services director (ESD) stated he expected hand hygiene to be performed between each resident room when laundry staff handed out laundry. He explained resident tray tables were "totally contaminated" and LA-A's action between R11 and R16's room was "not a good scenario at all." ESD stated hand hygiene was important to decrease the risk of germs being spread from resident to resident. When interviewed on 12/16/22, at 1:47 p.m. the director of nursing (DON), who at the time was the acting infection preventionist, stated she expected hand hygiene to be performed before any department staff entered a resident room and when they exited, or at a minimum when they exited depending on the actions they performed i.e. passing meal trays. In addition, she expected all staff to wear their face masks properly (covered nose and mouth) with any resident contact. The DON explained hand hygiene was important to prevent and control infection(s) within the resident population and amongst staff. During interview on 12/16/22, at 2:15 p.m. the administrator stated hand hygiene was "a given" and he expected staff to use hand sanitizer	21375		

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21375	Continued From page 10 before they entered a resident room and after they exited. He stated all staff were trained in this expectation and verbalized it was unfortunate hand hygiene had become "laxed." The administrator identified the facilities county transmission rate was high and thus he stated he expected all staff to wear their face masks appropriately during resident interactions. He explained the facility needed to protect their residents and when staff failed to follow infection control expectations the residents and staff were at risk for infections. A Standard Precaution policy dated 5/8/17, identified all facility staff were to practice standard precautions at all times regardless of resident infection status in order to prevent the spread of infections, in which washing hands was the primary means of preventing infection transmission. The policy directed standard precautions was to be used when cares and services were provided. The policy directed hands were to be washed immediately before the care of a resident, after resident contact, and before environmental surfaces were touched. A Hand Hygiene policy dated 5/8/17, identified alcohol-based hand sanitizer could be used, instead of soap and water, when hands did not appear soiled, before and after staff assisted a resident when not in contact with bodily fluids, before and after contact with environmental surfaces or equipment in the vicinity of residents, and before leaving a residents room if direct physical contact was not made with the resident or the resident's environmental surfaces or equipment. A Transmission Based Precautions policy dated 6/7/17, identified TBP included contact	21375		

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21375	Continued From page 11 precautions which was designated when a resident was known or suspected to be infected or colonized with microorganisms that could be transmitted by direct resident contact or indirect contact with environmental surfaces or care items in the resident's environment. Zoster was provided as an example for contact precautions. The policy directed staff to wash hands/perform hand hygiene immediately with soap or an antimicrobial agent or waterless antiseptic agent before they exited the resident's room. A Coronavirus Prevention, Screening, and Identification policy dated 10/9/22, directed staff would wear a mask in all resident areas during working hours based on county transmission rates. SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee should re-educate all facility staff to appropriately implement hand hygiene practices during the provision of care and services (i.e. meal tray and laundry delivery). In addition, the DON or designess should educate all staff to appropriate source control use per national standards. The DON or designee could review and revise infection control and/or hand hygiene policies to ensure appropriateness. The DON or designee should 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. Time Period for Correction: Twenty-one (21) days.	21375		