Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
October 9, 2024

Administrator
Viewcrest Health Center
3111 Church Street
Duluth, MN 55811

RE: CCN: 245414
Cycle Start Date: August 29, 2024

Dear Administrator:

On October 8, 2024, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 9, 2024

Administrator
Viewcrest Health Center
3111 Church Street
Duluth, MN 55811

Re: Reinspection Results
Event ID: VSPU12

Dear Administrator:

On October 8, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 29, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 11, 2024

Administrator
Viewcrest Health Center
3111 Church Street
Duluth, MN 55811

RE: CCN: 245414
Cycle Start Date: August 29, 2024

Dear Administrator:

On August 29, 2024, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting

the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by November 29, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by March 1, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

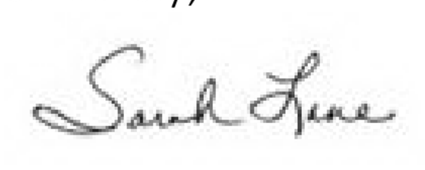
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

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

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

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
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Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245414	A. BUILDING _____ B. WING _____	C 08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIEWCREST HEALTH CENTER	3111 CHURCH STREET DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 8/27/24 through 8/29/24, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H54146895C (MN00105665) H54146823C (MN00105637) An unrelated deficiency was issued at F880. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	F 000		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		10/4/24

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

Electronically Signed | 09/21/2024

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

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F 880	Continued From page 1 §483.80(a)(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 §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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F 880	Continued From page 2 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper glove use and hand hygiene was performed during incontinence care and wound care for 2 of 3 residents (R3, R4) reviewed for infection control. In addition, the facility failed to use proper personal protective equipment (PPE) for 1 of 3 (R4) residents reviewed for infection control. Findings include: R3's Face Sheet dated 3/15/24 indicated R3 had orders for wound care to his left lower extremity every three days. On 8/27/24 at 1:11 p.m., registered nurse (RN)-A entered R3's room with a gown and gloves on. RN-A told R3 he was going to change the dressing on his left leg. RN-A used wound cleanser and gauze to cleanse R3's left leg which had multiple open areas. RN-A then removed his soiled gloves, and without performing hand hygiene donned clean gloves. RN-A grabbed calcium alginate (a wound dressing) and cut it to size for the wound on the	F 880	F: 880 It is Viewcrest Health Center's policy to use proper hand hygiene when caring for our residents per our resident's plan of care. DON and/or designee will implement corrective action for resident R3 and R4 affected by this practice by: 1.Staff caring for R3 will use proper hand hygiene while providing care and/or providing treatments. 2.Staff caring for R4 will wear proper PPE and use proper hand hygiene while providing care. DON and/or designee will assess residents having the potential to be affected by this practice including: 1.All residents have potential to be affected by deficient practice. DON and/or designee will implement measures to ensure that this practice does not recur including:	

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F 880	Continued From page 3 top of R3's left foot, and applied it to the wound bed. RN-A repeated cutting the calcium alginate and applied to three other wounds on R3's left shin and calf area. RN-A applied zinc oxide paste (a protestant) on the skin around the wounds. RN-A removed his soiled gloves, and without performing hand hygiene, donned clean gloves. RN-A applied Alevyn dressings (a wound dressing) to all four wounds on R3's left lower leg and left foot. RN-A applied Aquaphor ointment (moisturizing ointment) to the dry areas on R3's left leg and right leg. RN-A removed his soiled gloves, and without performing hand hygiene, donned clean gloves. On 8/27/24 at 2:03 p.m., RN-A stated he was nervous, and forgot to wash his hands between glove changes. RN-A stated staff should wash their hands before removing soiled gloves and donning clean gloves. R4's quarterly Minimum Data Set (MDS) dated 8/6/24, indicated R4 needed extensive assistance with toilet use. R4's care plan dated 1/12/24, indicated R4 was on enhanced barrier precautions (EBP) due to chronic wounds. On 8/27/24 at 11:35 a.m., nursing assistant (NA)-A was observed entering R4's room sanitizing hands and placing on gloves. NA-A told R4 she was going to check her incontinent brief. NA-A was not wearing proper PPE which would have included a gown. NA-A removed R4's incontinent brief straps, and cleansed R4's peri-area with a washcloth and soap. NA-A assisted R4 to turn onto her right side. NA-A used toilet paper to wipe feces off of R4's	F 880	1.Handwashing and infection control policies have been reviewed and all nursing staff will be re-educated regarding proper hand hygiene to include washing hands between glove changes, before entering a room, when leaving a room, when handling food items, and as needed and when to use PPE beginning the week of September 9th, 2024 2.All nursing staff will be provided information from the CDC on proper hand washing technique and will be competency tested on proper hand washing technique. DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: 1.Routine audits identifying handwashing will be completed by Director of Nursing/designee 5x/week on all 3 shifts, these audits will continue until substantial compliance is achieved. Audits will begin the week of September 23rd, 2024. 2.Audit results will be brought to the QAPI committee quarterly for review and further recommendation. Completion Date: 10/04/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 4 buttocks. NA-A removed the soiled incontinent brief. Without changing gloves, NA-A placed a clean incontinent brief under R4. NA-A removed her soiled gloves, and without performing hand hygiene, donned clean gloves. NA-A applied the incontinent brief on R4, then removed her gloves and performed hand hygiene. On 8/27/24 at 11:54 a.m., NA-A stated she forgot to wear the right PPE when caring for R4. She should have worn a gown along with her gloves when providing cares for R4. She should have sanitized her hands after taking her gloves off, but she was nervous. On 8/29/24 at 10:35 a.m., the director of nursing (DON) stated staff were expected to follow the EBP and hand hygiene policy. On 8/29/24 at 12:18 p.m., the administrator stated staff were expected to follow the hand hygiene and EBP policy. The facility policy Hand Hygiene dated 5/8/17 directed staff will perform hand hygiene when moving from a contaminated body site to a clean body site during cares and after removing gloves. The facility policy Enhanced Barrier Precautions (EBPs) revised 6/25/24 directed staff will use EBPs for all resident with chronic wound and when performing peri care activities.	F 880		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 11, 2024

Administrator
Viewcrest Health Center
3111 Church Street
Duluth, MN 55811

Re: State Nursing Home Licensing Orders
Event ID: VSPU11

Dear Administrator:

The above facility was surveyed on August 27, 2024 through August 29, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

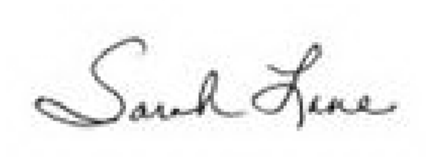
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

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

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00602	A. BUILDING: _____ B. WING _____	C 08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIEWCREST HEALTH CENTER	3111 CHURCH STREET DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 8/27/24 through 8/29/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure, and the following licensing order was	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00602	A. BUILDING: _____ B. WING _____	C 08/29/2024

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2 000	Continued From page 1 issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed with no deficiency issued. H54146895C (MN00105665) H54146823C (MN00105637) An unrelated licensing order was issued at 4658.0800 Subp 1. 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	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIEWCREST HEALTH CENTER	3111 CHURCH STREET DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 2 for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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 proper glove use and hand hygiene was performed during incontinence care and wound care for 2 of 3 residents (R3, R4) reviewed for infection control. In addition, the facility failed to use proper personal protective equipment (PPE) for 1 of 3 (R4) residents reviewed for infection control. Findings include: R3's Face Sheet dated 3/15/24 indicated R3 had	21375	Corrected	10/4/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00602	A. BUILDING: _____ B. WING _____	C 08/29/2024

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21375	Continued From page 3 orders for wound care to his left lower extremity every three days. On 8/27/24 at 1:11 p.m., registered nurse (RN)-A entered R3's room with a gown and gloves on. RN-A told R3 he was going to change the dressing on his left leg. RN-A used wound cleanser and gauze to cleanse R3's left leg which had multiple open areas. RN-A then removed his soiled gloves, and without performing hand hygiene donned clean gloves. RN-A grabbed calcium alginate (a wound dressing) and cut it to size for the wound on the top of R3's left foot, and applied it to the wound bed. RN-A repeated cutting the calcium alginate and applied to three other wounds on R3's left shin and calf area. RN-A applied zinc oxide paste (a protestant) on the skin around the wounds. RN-A removed his soiled gloves, and without performing hand hygiene, donned clean gloves. RN-A applied Alevyn dressings (a wound dressing) to all four wounds on R3's left lower leg and left foot. RN-A applied Aquaphor ointment (moisturizing ointment) to the dry areas on R3's left leg and right leg. RN-A removed his soiled gloves, and without performing hand hygiene, donned clean gloves. On 8/27/24 at 2:03 p.m., RN-A stated he was nervous, and forgot to wash his hands between glove changes. RN-A stated staff should wash their hands before removing soiled gloves and donning clean gloves. R4's quarterly Minimum Data Set (MDS) dated 8/6/24, indicated R4 needed extensive assistance with toilet use. R4's care plan dated 1/12/24, indicated R4 was on enhanced barrier precautions (EBP) due to chronic	21375		

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21375	Continued From page 4 wounds. On 8/27/24 at 11:35 a.m., nursing assistant (NA)-A was observed entering R4's room sanitizing hands and placing on gloves. NA-A told R4 she was going to check her incontinent brief. NA-A was not wearing proper PPE which would have included a gown. NA-A removed R4's incontinent brief straps, and cleansed R4's peri-area with a washcloth and soap. NA-A assisted R4 to turn onto her right side. NA-A used toilet paper to wipe feces off of R4's buttocks. NA-A removed the soiled incontinent brief. Without changing gloves, NA-A placed a clean incontinent brief under R4. NA-A removed her soiled gloves, and without performing hand hygiene, donned clean gloves. NA-A applied the incontinent brief on R4, then removed her gloves and performed hand hygiene. On 8/27/24 at 11:54 a.m., NA-A stated she forgot to wear the right PPE when caring for R4. She should have worn a gown along with her gloves when providing cares for R4. She should have sanitized her hands after taking her gloves off, but she was nervous. On 8/29/24 at 10:35 a.m., the director of nursing (DON) stated staff were expected to follow the EBP and hand hygiene policy. On 8/29/24 at 12:18 p.m., the administrator stated staff were expected to follow the hand hygiene and EBP policy. The facility policy Hand Hygiene dated 5/8/17 directed staff will perform hand hygiene when moving from a contaminated body site to a clean body site during cares and after removing gloves.	21375		

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21375	Continued From page 5 The facility policy Enhanced Barrier Precautions (EBPs) revised 6/25/24 directed staff will use EBPs for all resident with chronic wound and when performing peri care activities. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review policies and procedures regarding hand hygiene and EBPs. The DON or designee could provide education on these policies and procedures to all staff who provide direct care. The DON or designee could and establish a system to monitor staff for infection control practices including hand hygiene and EPB use, including, but not limited to, glove use, gown use, and hand washing, and report the results of these audits to the Quality Assessment Performance Improvement (QAPI) committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		