Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 19, 2022

Administrator
Robbinsdale A Villa Center
3130 Grimes Avenue North
Robbinsdale, MN 55422

RE: CCN: 245417
Cycle Start Date: July 14, 2022

Dear Administrator:

On July 26, 2022, we notified you a remedy was imposed. On August 17, 2022 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 August 10, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective August 10, 2022 did not go into effect. (42 CFR 488.417 (b))

In our letter of July 26, 2022, 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 August 10, 2022 due to denial of payment for new admissions. Since your facility attained substantial compliance on August 10, 2022, 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 Therefore, the NATCEP prohibition is rescinded.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,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245417	A. BUILDING _____ B. WING _____	C 07/14/2022

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ROBBINSDALE A VILLA CENTER	3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422

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F 000	INITIAL COMMENTS On 7/13/22, through 7/14/22, 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, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H54173134C (MN84902), with a deficiency cited at (F880). The survey resulted in an Immediate Jeopardy (IJ) at F880. The immediate jeopardy (IJ) began on 7/13/22, when the facility failed to appropriately implement enhanced precautions for two positive and one confirmed positive residents with carbapenem-resistant Enterobacterales (CRE-type of bacteria that can cause serious infections that can be hard to treat; most often spread person-to-person in healthcare settings specifically through contact with the infected or colonized people through contact with wounds or stool). On 7/13/22, at 4:29 p.m., the facility administrator, the corporate vice president of operations and two regional directors of clinical operations were notified of the IJ. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the	F 000		

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

Electronically Signed | 08/03/2022

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

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F 000	Continued From page 1 regulations has been attained.	F 000		
F 880 SS=J	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: §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	F 880		8/10/22

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F 880	Continued From page 2 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. §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 Centers for Disease Control (CDC) transmission based precautions guidelines were followed to prevent and minimize the transmission of carbapenem-resistant Enterobacterales (CRE-type of bacteria that can cause serious infections that can be hard to treat; most often	F 880	The submission of this Plan of Correction is not an admission by the provider of any fact or conclusion set forth in the Statement of Deficiency. This Plan of Correction is being submitted because it is required by law. However, evidencing Robbinsdale A Villa Center good faith, the facility	

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F 880	Continued From page 3 spread person-to-person in healthcare settings specifically through contact with the infected or colonized people through contact with wounds or stool) for 3 of 3 residents (R1, R2, R3) who remained in the building and R5 and R6 who discharged from the facility that had confirmed or history of CRE results; failed to ensure proper hand hygiene and glove use to prevent the spread of CRE for 2 of 2 residents (R1, R2); failed to ensure education was provided to staff and residents about CRE and failed to ensure multi-use equipment was being disinfected in between residents as recommended by the manufacturer to prevent and minimize the spread of infections/disease. Further, the facility failed to conducting ongoing tracking and trending of infections which included the confirmed CRE. This had the potential to affect 69 residents currently residing at the facility. The immediate jeopardy (IJ) began on 7/13/22, when the facility failed to appropriately implement enhanced precautions for two positive and one confirmed positive residents with CRE. On 7/13/22, at 4:29 p.m. the facility administrator, the corporate vice president of operations and two regional directors of clinical operations were notified of the IJ. The IJ was removed on 7/14/22, at 7:22 p.m. but remained at a lower scope and severity of F, no actual harm with potential for more than minimal harm that is not immediate jeopardy, widespread. Findings include: R1 was admitted to the facility on 2/17/22, with diagnoses including syncope and collapse, adult failure to thrive and muscle wasting obtained from the quarterly Minimum Data Set (MDS) dated	F 880	offers the following Plan of Correction. F (880) 1.R5 and R6 are Discharged from the facility. R1, R2, R3 were immediately placed on Enhanced Barrier Precautions including correct signage outside their doors. R1, R2 and R3 still reside in facility with no adverse reaction from deficient practice. 2.All residents have the potential to be affected by the deficient practice. All residents were reviewed to ensure appropriate transmission-based precautions are in place on 7/13/22. Additional PPS testing is occurring per guidance and resident who refuse testing will be place on enhanced barrier precautions. Resident/Representative educated on CRE and testing. MD/NP updated on residents who refused testing. Update resident plan of care related to refusal of testing and on precautions. Reapproach with each testing sequence. The facility reviewed related policies and procedures and are updated as appropriate. the DON oversees the Infection preventionist and will review line listing/ surveillance logs daily with clinical morning meeting to ensure up to date and current. 3. All staff along with providers received education on CRE and Enhanced barrier Precautions. All licensed nurses, Nursing Assistants, and other ancillary staff educated on infection control related to hand hygiene, cleaning of shared	

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F 880	Continued From page 4 6/14/22. In addition, the MDS identified R1 required extensive physical assistance of one staff with activities of daily leaving (ADL's), was incontinent of both bowel and bladder and had severely impaired cognition. During review of R1's medical record, the following was revealed: -A laboratory result dated 3/29/22, indicated R1 had a confirmed positive result for CRE. -A progress note dated 4/2/22, 1:33 p.m. indicated "Laboratory Data: Klebsiella pneumonia carbapenemase [KPC] polymerase chain reaction [PCR] Positive, Action: Faxed to MD; Response: None at this time." -Nurse Practitioner (NP) note dated 4/7/22, identified R1 had tested positive for CRE however indicated resident was asymptomatic therefore likely colonized and no precautions were required. R1's medical record lacked documentation when precautions were implemented and what further action was put into place since the facility staff was aware of the confirmed CRE test result. R2 was admitted to the facility on 10/18/21, with diagnoses neurogenic bowel, neuromuscular dysfunction of bladder, paraplegia, and dementia obtained from the quarterly MDS dated 6/21/22. The MDS identified R1 required extensive to total dependence of one to two staff on all ADL's including toileting and wound care, had a indwelling catheter and colostomy and had moderately impaired cognition. During review of R2's medical record, it was revealed R2 had a confirmed positive laboratory result for CRE dated 3/23/20, however, medical record lacked documentation when and if	F 880	equipment, PPE, Donning/Doffing of PPE. Education was provided to IP and DON on tracking and trending of infections. The infection Preventionist, Director of Nursing, facility leadership, and Administrator have been educated on infection control practices, active surveillance, and tracking and trending. Education has been completed on 8/8/22 and 8/9/22. Employees that were not able to attend the large group education will be educated prior to working their next shift. 4. The Infection Preventionist/Designee will be responsible for audits on Hand Hygiene, disinfecting resident shared equipment between resident use, required PPE, Donning and Doffing of PPE, 4x per week for 2 weeks, 3x per week 2 weeks, 1x per week for 2 weeks and 2x a month for 1 month. Audit for tracking and trending of infections will be done during clinical startup for New Admission, potential admission, upcoming discharges and current residents. Infection surveillance line listing will be reviewed for trends and opportunities monthly during QAPI. Additional audits and education may be warranted for trending areas. 5. The Administrator, DON, and infection preventionist will review the results of audits and present at Quality Assurance meeting (QAPI) to review progress, trends, patterns and apply recommendations for ongoing monitoring. 6. Completion date 8/10/2022	

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F 880	Continued From page 5	F 880		

precautions were implemented when R2 had been admitted to the facility on 10/18/21. In addition, the medical record lacked documentation of what further action by the facility was put into place upon admission and on-going by the facility related to the confirmed CRE test result.

R3 was admitted to the facility on 10/22/21, with diagnoses including multiple sclerosis, neuromuscular dysfunction of bladder, paraplegia and resistance to other specified beta lactam antibiotics obtained from the quarterly MDS dated 5/13/22. The MDS identified R3 required extensive to total dependence of one to two staff on all ADL's including toileting and wound care, had an indwelling catheter and colostomy and had moderately impaired cognition.

During review of the medical record, it was revealed R3 had tested positive for CRE on 6/9/22, during a facility test prevalence study. The medical record lacked documentation from 6/9/22, to 6/14/22, on when precautions were implemented and what further action was put into place since the facility staff was aware of the confirmed CRE test result.

R5 was admitted to the facility 2/1/22, with diagnoses including acute respiratory failure with hypoxia, weakness, pneumonia, and acute cystitis without hematuria obtained from dated admission MDS dated 2/9/22. The MDS identified R5 required extensive physical assistance of two staff on all ADL's including toileting which R5 was incontinent of both bowel and bladder and was cognitively intact.

During review of R5's medical record it was

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F 880	Continued From page 6 revealed: -A laboratory result dated 3/24/22, indicated R5 had a confirmed positive result for CRE and a note on the sheet indicated the result had been seen by the nurse practitioner and R5 was started on an antibiotic on 3/25/22. -A review of a progress note dated 5/5/22, indicated R5 was sent to the hospital for evaluation and was not returning to the facility. The medical record lacked documentation of if precautions were implemented and what further action was put into place since the facility staff was aware of the confirmed CRE test result. In addition, the medical record lacked documentation of the receiving facility/hospital being informed of R5 being positive for CRE. R6 was admitted to the facility 2/16/22, with diagnoses including Fournier gangrene (infection in the scrotum) and muscle wasting obtained from the admission MDS dated 2/23/22. The MDS identified R6 required extensive physical assistance of two staff on all ADL's including toileting and wound care, had a indwelling catheter, was incontinent of bowel and was cognitively intact. During review of R6's medical record it was revealed: -A laboratory result dated 4/7/22, indicated R7 had a confirmed positive result for CRE. -A review of a progress note dated 4/11/22, indicated R6 was discharged home, however, the medical record lacked documentation of if precautions were implemented prior to the discharge and what further actions were put in place including education provided to the family/representative about CRE management in the community.	F 880		

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F 880	Continued From page 7 On 7/13/22, at 6:45 a.m. surveyors observed on the table next to the screening kiosk located at the front desk were several handouts titled "Frequently Asked Questions about screening Tests for Antibiotic-Resistant Germs that colonize the Gut, such as Carbapenem-Resistant Enterobacterales (CRE)." Also next to the handouts was a staff sign-in sheet which had five signatures of staff of which four signed it on 7/12/22 and one 7/13/22. On 7/13/22, at 7:33 a.m. registered nurse (RN)-B was observed to sanitize his hands before he prepared R4's medications. RN-B took the blood pressure cuff and went into the room R4's room to get R4's blood pressure.(applied cuff to upper arm and obtained a blood pressure reading. RN-B walked out of R4's room with blood pressure cuff, immediately placed it on top of the medication cart without disinfecting the cuff and did not sanitize or wash his hands.) -At 7:40 a.m. RN-B brought medications and blood glucose machine in a pink basin with supplies into R4's room, applied gloves and gave R4 her medications. RN-B then took the glucometer and placed it on the bedside table, proceeded to wipe R4's middle finger with a alcohol swab, stabbed it with a lancet. RN-B then placed a drop of blood on the glucometer strip to obtain a reading. After the reading was obtained, RN-B removed the dirty strip from the glucometer and returned to the pink basin with clean supplies. RN-B then removed his dirty gloves, threw them in the trash can and walked to the medication cart and sanitized his hands. RN-B then placed the pink basin with the clean with the dirty glucometer on the medication cart. RN-B did not disinfect the glucometer during the entire	F 880		

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F 880	Continued From page 8 observation. On 7/13/22, at 7:35 a.m. nursing assistant (NA)-D walked out of R8's room with a vital sign machine and went directly into R9's room with the vital sign machine without cleaning the machine between the residents. NA-D then came out of R9's room and placed vital sign machine in hallway and walked away without cleaning it. On 7/13/22 7:39 a.m. NA-D then grabbed the vital machine without cleaning it and went into R10's room. During interview on 7/13/22, at 8:08 a.m. NA-D stated "I was not trained to clean the vitals machine in between rooms. It makes sense to clean in between rooms to stop the infections." NA-D then verified she went into three rooms and did not clean the machine between the residents. On 7/13/22, at 7:39 a.m. NA-A was observed to enter R1's room wearing eye protection and mask only and did not have gloves or gown on. NA-A then approached R1 from the front and wrapped both arms around R1's torso and waist lifted R1 up and transferred R1 to the wheelchair. During the observation, NA-A's uniform brushed R1, R1's bedding and clothing during the transfer. NA-A immediately left the room without washing or sanitizing hands and brought R1 to a common area in the unit. NA-A immediately approached R7 in the common area and reached up to R7's face and and adjusted R7's nasal cannula in her nose. -At 7:43 a.m. NA-A stated she was supposed to wash her hands when entering and leaving resident rooms. -At 7:48 a.m. NA-A stated she knew R1 had a	F 880		

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F 880	Continued From page 9 bacteria and stated she was supposed to use contact precautions while assisting R1, however, she thought since she had assisted R1 to get ready that morning and because she was not doing cares, she did not need to wear the PPE when assisting R1. NA-A stated she should have put on a gown when in R1's room as she had come in contact with R1's personal items including bedding. On 7/13/22, at 7:59 a.m. RN-B was observed to prepare R11's medications and took with him a cup of water and pink basin with the same glucometer that was used at 7:40 a.m. for R4 and was not cleaned after use and entered R11's room and approached the resident in bed. As RN-B was going to use the multiple resident use glucometer on R11, surveyor intervened. RN-B stated "I should have cleaned the accucheck machine with the bleach wipes." RN-B then picked up the container and showed surveyor the container of wipes and then stated, "I'm not familiar if the wipes have a dry time but they dry very fast." RN-B then confirmed the glucometer in the pink basin was a common use glucometer and without cleaning multiple resident use equipment he could spread infections. During observation on 7/13/22 8:25 a.m. outside of R1's room was a cart with personal protective equipment which included gowns and wipes for cleaning. On R1's door was a sign which indicated "Contact precautions for special enteric. Must perform hand hygiene. Wear gloves. Wear gown when entering room and whenever anticipating that clothing will touch patient items or potentially contaminated environmental surfaces and use patient dedicated equipment."	F 880		

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F 880	Continued From page 10 During observation on 7/13/22, at 8:36 a.m. housekeeping staff (HK)-A was observed apply gloves and then entered R12's room with a wet mop. HK-A was observed go into R12's bathroom and mopped the floor, then went to mop by R12's bed while resident was in the bed. During the observation a sign on door indicated "Enhanced barrier precautions. Providers and staff must use gloves and gowns. Gowns only if they are doing cares to resident. As HK-A was coming out of the room surveyor asked why R12 was on precautions and HK-A stated, "I don't know why he is on precautions." HK-A had come out of the room with both pairs of gloves on and started pushing his cart down the hallway and had grabbed the broom and was sweeping the hallway. HK-A, then still wearing the same gloves from R12's room, then opened R2's door. HK-A then went in with the same gloves on and was observed to gather trash in the room and came out of the room and disposed it in the cart. HK-A then picked up a cleaner and went into R2's bathroom and was observed clean R2's sink with the same gloves still on. HK-A then came out of the room and at this time surveyor intervened and HK-A stated "I should have removed the gloves and washed my hands before doing anything else or going into another room. I could spread infection". On 7/13/22, at 8:48 a.m. NA-B was observed to push R1 in her wheelchair, using the handles on the chair near R1's body, down the hallway into the resident room. The Enhanced Barrier Precaution sign remained on the door. She stopped, briefly touched her shoulder and spoke to R1 and then immediately left the room without washing or sanitizing her hands despite sign on the door which directed staff to wash hands while	F 880		

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ROBBINSDALE A VILLA CENTER	3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422

(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 880	Continued From page 11	F 880		

leaving the room as this was a contact precaution room related to R1's confirmed CRE positive test.

On 7/13/22, at 9:23 a.m. NA-B stated there were three residents in the facility who had an infection but did not know the name of it. NA-B stated the director of nursing (DON) had given the staff a paper which had information about the infection. NA-B then stated, "I should always have a gown and gloves on and to take close precautions because you could get it from them even touching our clothing and we should always wash our hands and keep washing our hands." NA-B confirmed she had not washed her hands when she had brought R1 back to the room and after touching her shoulder and wheelchair because she was trying to do several different things.

On 7/13/22, at 9:23 a.m. NA-C stated was a regular at the facility and worked all units. NA-C stated he did not know why R1, R2 and R3 were on precautions "the nurse should know." NA-C then stated he was just following the signs on the door with personal protective equipment (PPE) into the resident rooms with the signs on and staff was supposed to wear the appropriate PPE while in the rooms.

On 7/13/22, at 9:30 a.m. licensed practical nurse (LPN)-A stated there was three residents on the floor with confirmed CRE positive tests and for any contact and touching anything in the room they were supposed to wear all the PPE and the staff was supposed to sanitizer in and out of the room.
-At 9:40 a.m. LPN-A stated she did not know why R12 was on enhanced precautions at the door. LPN-A stated she knew R12 had history of Clostridiodes difficile and was in and out of the

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F 880	Continued From page 12 hospital but was not still certain the reason for the precautions as nothing had been communicated to her or the other staff on the unit. During review of the facility Infection Control Logs for January 2022 through July 2022, it was revealed the facility did not conduct ongoing tracking and trending of the confirmed CRE cases at the facility. During a review of facility CRE testing worksheet revealed the facility had attempted to conduct facility wide testing on 7/10/22, 7/11/22 and 7/12/22, however on 7/13/22, at 1:49 p.m. the worksheet had a note that listed 14 residents had refused testing. Through observations on 7/13/22, on the nursing units these residents that refused testing did not have signs on their doors to indicate they were on any precautions. The DON and director of clinical operations (DCO) both stated they were following infection control assessment and response program (ICAR) recommendations and had not implemented precautions due to not having enough PPE carts available in the facility to hold supplies for staff to utilize. During an interview on 7/13/22, at 11:15 a.m. to 12:15 p.m. with the interim DON, DCO and RN-A infection control preventionist (IP), the DON stated one of the challenges the facility was experiencing was 45 to 50% of the staff who currently worked at the facility were agency staff which made it a hard to educate. The DON stated the facility leadership was fragmented as there had not been a full time DON and two nurse managers which created a challenge in some issues. The DON stated the facility had policies and procedures in place and the current staff	F 880		

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F 880	Continued From page 13	F 880		

available was doing the best that they could. The IP then stated although she had completed the training a couple months back, and had gone through training with the DCO, she was currently the nurse manager for two floors which created a challenge for her to fully resume responsibility for infection control at the facility. The DCO stated she had received a call from Infectious Disease Epidemiology, Prevention and Control (IDEPC) at the beginning of June but not a lot was communicated to her, and she was informed IDEPC wanted to conduct a point of prevalence testing at the facility. The DCO then stated she was out of the facility, however, a meeting had been scheduled for 6/14/22, with the facility IP and DON. The DON stated at the meeting on 6/14/22, she had asked IDEPC staff for more time to be able to get some education done and wanted to have a follow up meeting after 7/4/22, as she thought this would give her more time to do more testing on the residents. The DON, DCO and IP all confirmed following the meeting with ICAR the facility had at that time placed all three residents with confirmed positive CRE results on precautions. The DON stated there was another meeting which was scheduled for 7/14/22, which the facility staff was going to show IDEPC staff the facility action plan and on what the facility was following up on.

The IP reviewed the infection control logs and the IP, DON and DCO confirmed the resident(s) who had past confirmed positive CRE results should have been on the infection control logs for the last 6 months reviewed. The DCO stated "If they have an active infection they should go on the listing." The DCO stated she was not able to address what past staff managed the infection control logs did with tracking and stated this was

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F 880	Continued From page 14 something the facility staff was planning to address. The DCO stated the tracking of infections was something they had identified when IDEPC had called them at the beginning of June 2022, however, she confirmed the June and July infection logs were not fixed to address the issue. The DCO stated they were trying to get residents to be tested and figure out those who refused to be tested were going to be put on enhanced precautions. The DCO confirmed this had not been implemented despite knowing 14 residents had refused to be tested as of 7/13/22. The DON stated she had started to put signs on doors for resident who had refused as they were just finishing up the point prevalence testing. The DON stated the education that was being provided to staff was by the front door for anyone to take and sign off. The DON stated they had also put the sign-in sheet on the floors by kiosk as they thought staff would see it there. The DON also stated she and the IP were starting to do shift by shift basis education to ensure staff was educated, however, they were still in the process of putting the education together. The DON stated she felt staff did not need to know why the resident was on precautions due to the Health Insurance Portability and Accountability Act (HIPAA) and staff only needed to follow precautions as posted on the door. The DCO stated although they were working with ICAR, there was not clear instructions on what they should do when they first called her. She then stated "The expectations have changed since 2016 so we were just trying to get on the same page from ICARs guidance. We were trying to get everyone on the same page, so everyone is safe." The DON then stated when they had a meeting with ICAR on 6/14/22, she thought ICAR	F 880		

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F 880	Continued From page 15 was going to be "our helper to help educate and help us be proactive and move forward with them." The DON then stated the delay in education was not done because she was new but because she was busy. The DON and DCO stated staff were supposed to wear gown, gloves, masks, and eye protection when assisting resident on enhanced precautions for CRE and resident shared equipment was all supposed be cleaned between residents and hand hygiene was supposed to be done when entering and leaving a room and per the facility policy. The facility Infection Prevention and Control Guideline revised 3/25/20, directed: "The Infection Prevention and Control Program includes 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 regulatory requirements and following accepted national standards. 1. Written standards, practices, and procedures for the Infection Prevention and Control program, include: a. Surveillance: A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility. c. Standard and transmission-based precautions to be followed to prevent the spread of infections. a. Hand Hygiene to be followed by staff with direct care, handling resident care equipment and the environment b. Selection and Use of PPE..." The facility Hand Hygiene Guideline policy	F 880		

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F 880	Continued From page 16 revised 3/4/20, directed: "Hand hygiene is one of the most effective ways to prevent the spread of microorganisms. Clean hands can stop germs from spreading from one person to another and throughout an entire facility or community. Multiple opportunities for hand hygiene may occur during a single care episode. The following are the clinical indications for hand hygiene: -Before and after care -When hands are visibly soiled -Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices -After caring for a person with known or suspected infectious diseases -Before moving from work on a soiled body site to a clean body site on the same patient -After known or suspected exposure to spores (e.g. C difficile outbreaks- hand sanitizer cannot replace soap and water) -After touching a patient's immediate environment -After contact with blood, body fluids or contaminated surfaces -Immediately after glove removal..." The facility Guideline for Standard and Transmission-based Precautions revised 11/9/20, directed: "Standard and Transmission-based precautions represent the infection prevention measures that apply to all resident care, regardless of suspected or confirmed infection status of the resident, in any setting where healthcare is being delivered. These evidence-based practices are designed to protect healthcare staff and residents by preventing the spread of infections among residents and ensuring staff do not carry infectious pathogens on their hands or via	F 880		

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F 880	Continued From page 17 equipment during resident care. As mentioned in the definitions section, standard precautions include hand hygiene, use of PPE (e.g., gloves, gowns, facemasks), respiratory hygiene and cough etiquette, safe injection practices, and safe handling of equipment or items that are likely contaminated with infectious body fluids, as well as cleaning and disinfecting or sterilizing of potentially contaminated equipment. In order to perform hand hygiene appropriately, soap, water, ABHR2, and a sink should be readily accessible in appropriate locations including but not limited to resident care areas, and food and medication preparation areas. Staff must perform hand hygiene (even if gloves are used): · Before and after contact with the resident; · Before performing an aseptic task; · After contact with blood, body fluids, visibly contaminated surfaces or after contact with objects in the resident ' s room; · After removing personal protective equipment (e.g., gloves, gown, facemask); · After using the restroom; and · Before meals..." The IJ was removed on 7/14/22, at 7:22 p.m. when it could be verified by observation, interview, and record review that the facility took the following steps: -Identified residents RI, R2, and R3 were placed on Enhanced Barrier Precautions to include correct signage outside their doors. -The facility implemented Enhanced Barrier Precautions with signage for 20 residents that are awaiting CRE lab results and for residents that had refused CRE testing. -The infection control line listing logs were updated and ongoing tracking and trending of infections in the facility was implemented by the	F 880		

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F 880	Continued From page 18 infection preventionist. -RI, R2, and R3 medical records were reviewed and updated to ensure appropriate diagnosis of CRE and precautions were reflective in the record. -The facility stocked adequate amounts of PPE supplies for staff. -All residents in the facility have been reviewed to ensure appropriate transmission-based precautions are in place in regards to CRE. -The facility reviewed policies and procedures and updated as appropriate. -Staff was educated on use of PPE for Transmission Based precautions and Enhanced Barrier Precautions, appropriate PPE usage, CRE, hand hygiene and disinfection of shared equipment between resident use. -Education for providers was implemented on CRE and Enhanced Barrier Precautions. -Residents and responsible parties were mailed or received education via handouts and face to face on CRE and enhanced precautions.	F 880		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 19, 2022

Administrator
Robbinsdale A Villa Center
3130 Grimes Avenue North
Robbinsdale, MN 55422

Re: Reinspection Results
Event ID: 906Y12 and BYCI12

Dear Administrator:

On August 17, 2022 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 surveys completed on July 14, 2022 and August 10, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
July 26, 2022

Administrator
Robbinsdale A Villa Center
3130 Grimes Avenue North
Robbinsdale, MN 55422

RE: CCN: 245417
Cycle Start Date: July 14, 2022

Dear Administrator:

On July 14, 2022, survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On July 14, 2022, the situation of immediate jeopardy to potential health and safety cited at F880 was removed. However, continued non-compliance remains at the lower scope and severity of F.

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 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:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 10, 2022.

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

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 10, 2022 (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 10, 2022 (42 CFR 488.417 (b)).

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 August 10, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Robbinsdale A Villa Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 10, 2022. 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 plan of correction (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 "E" tag), i.e., the plan of correction should be directed to:

Sarah Grebenc, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: sarah.grebenc@state.mn.us
Office: (651) 238-8786 Mobile (651)238-8786

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 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 January 14, 2023 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

APPEAL RIGHTS DENIAL OF PAYMENT

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:

Tamika.Brown@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 Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at 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

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 26, 2022

Administrator
Robbinsdale A Villa Center
3130 Grimes Avenue North
Robbinsdale, MN 55422

Re: State Nursing Home Licensing Orders
Event ID: 906Y11

Dear Administrator:

The above facility was surveyed on July 13, 2022 through July 14, 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:

Sarah Grebenc, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: sarah.grebenc@state.mn.us
Office: (651) 238-8786 Mobile (651)238-8786

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

Please feel free to call me with any questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00122	A. BUILDING: _____ B. WING _____	C 07/14/2022

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ROBBINSDALE A VILLA CENTER	3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422

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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 7/13/22, through 7/14/22, a complaint survey was conducted at your facility by surveyors 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 when they will be completed.	2 000	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.	

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H54173134C (MN84902) with a licensing order issued at (1375). Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000	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 which are in violation of the state statute after the statement, "This Rule 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.	

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2 000	Continued From page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure Centers for Disease Control (CDC) transmission based precautions guidelines were followed to prevent and minimize the transmission of carbapenem-resistant Enterobacterales (CRE-type of bacteria that can cause serious infections that can be hard to treat; most often spread person-to-person in healthcare settings specifically through contact with the infected or colonized people through contact with wounds or stool) for 3 of 3 residents (R1, R2, R3) who remained in the building and R5 and R6 who discharged from the facility that had confirmed or history of CRE results; failed to ensure proper hand hygiene and glove use to prevent the spread of CRE for 2 of 2 residents (R1, R2); failed to ensure education was provided to staff and residents about CRE and failed to ensure multi-use equipment was being disinfected in between residents as recommended by the manufacturer to prevent and minimize the spread	21375	Not required	8/10/22

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21375	Continued From page 3 of infections/disease. Further, the facility failed to conducting ongoing tracking and trending of infections which included the confirmed CRE. This had the potential to affect 69 residents currently residing at the facility. The immediate jeopardy (IJ) began on 7/13/22, when the facility failed to appropriately implement enhanced precautions for two positive and one confirmed positive resident with CRE. On 7/13/22, at 4:29 p.m. the facility administrator, the corporate vice president of operations and two regional directors of clinical operations were notified of the IJ. The IJ was removed on 7/14/22, at 7:22 p.m. but remained at a lower scope and severity of F, no actual harm with potential for more than minimal harm that is not immediate jeopardy, widespread. Findings include: R1 was admitted to the facility on 2/17/22, with diagnoses including syncope and collapse, adult failure to thrive and muscle wasting obtained from the quarterly Minimum Data Set (MDS) dated 6/14/22. In addition, the MDS identified R1 required extensive physical assistance of one staff with activities of daily leaving (ADL's), was incontinent of both bowel and bladder and had severely impaired cognition. During review of R1's medical record, the following was revealed: -A laboratory result dated 3/29/22, indicated R1 had a confirmed positive result for CRE. -A progress note dated 4/2/22, 1:33 p.m. indicated "Laboratory Data: Klebsiella pneumonia carbapenemase [KPC] polymerase chain reaction [PCR] Positive, Action: Faxed to MD; Response: None at this time."	21375		

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21375	Continued From page 4 -Nurse Practitioner (NP) note dated 4/7/22, identified R1 had tested positive for CRE however indicated resident was asymptomatic therefore likely colonized and no precautions were required. R1's medical record lacked documentation when precautions were implemented and what further action was put into place since the facility staff was aware of the confirmed CRE test result. R2 was admitted to the facility on 10/18/21, with diagnoses neurogenic bowel, neuromuscular dysfunction of bladder, paraplegia, and dementia obtained from the quarterly MDS dated 6/21/22. The MDS identified R1 required extensive to total dependence of one to two staff on all ADL's including toileting and wound care, had a indwelling catheter and colostomy and had moderately impaired cognition. During review of R2's medical record, it was revealed R2 had a confirmed positive laboratory result for CRE dated 3/23/20, however, medical record lacked documentation when and if precautions were implemented when R2 had been admitted to the facility on 10/18/21. In addition, the medical record lacked documentation of what further action by the facility was put into place upon admission and on-going by the facility related to the confirmed CRE test result. R3 was admitted to the facility on 10/22/21, with diagnoses including multiple sclerosis, neuromuscular dysfunction of bladder, paraplegia and resistance to other specified beta lactam antibiotics obtained from the quarterly MDS dated 5/13/22. The MDS identified R3 required extensive to total dependence of one to two staff on all ADL's including toileting and wound care,	21375		

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21375	Continued From page 5 had an indwelling catheter and colostomy and had moderately impaired cognition. During review of the medical record, it was revealed R3 had tested positive for CRE on 6/9/22, during a facility test prevalence study. The medical record lacked documentation from 6/9/22, to 6/14/22, on when precautions were implemented and what further action was put into place since the facility staff was aware of the confirmed CRE test result. R5 was admitted to the facility 2/1/22, with diagnoses including acute respiratory failure with hypoxia, weakness, pneumonia, and acute cystitis without hematuria obtained from dated admission MDS dated 2/9/22. The MDS identified R5 required extensive physical assistance of two staff on all ADL's including toileting which R5 was incontinent of both bowel and bladder and was cognitively intact. During review of R5's medical record it was revealed: -A laboratory result dated 3/24/22, indicated R5 had a confirmed positive result for CRE and a note on the sheet indicated the result had been seen by the nurse practitioner and R5 was started on an antibiotic on 3/25/22. -A review of a progress note dated 5/5/22, indicated R5 was sent to the hospital for evaluation and was not returning to the facility. The medical record lacked documentation of if precautions were implemented and what further action was put into place since the facility staff was aware of the confirmed CRE test result. In addition, the medical record lacked documentation of the receiving facility/hospital being informed of R5 being positive for CRE.	21375		

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21375	Continued From page 6 R6 was admitted to the facility 2/16/22, with diagnoses including Fournier gangrene (infection in the scrotum) and muscle wasting obtained from the admission MDS dated 2/23/22. The MDS identified R6 required extensive physical assistance of two staff on all ADL's including toileting and wound care, had a indwelling catheter, was incontinent of bowel and was cognitively intact. During review of R6's medical record it was revealed: -A laboratory result dated 4/7/22, indicated R7 had a confirmed positive result for CRE. -A review of a progress note dated 4/11/22, indicated R6 was discharged home, however, the medical record lacked documentation of if precautions were implemented prior to the discharge and what further actions were put in place including education provided to the family/representative about CRE management in the community. On 7/13/22, at 6:45 a.m. surveyors observed on the table next to the screening kiosk located at the front desk were several handouts titled "Frequently Asked Questions about screening Tests for Antibiotic-Resistant Germs that colonize the Gut, such as Carbapenem-Resistant Enterobacterales (CRE)." Also next to the handouts was a staff sign-in sheet which had five signatures of staff of which four signed it on 7/12/22 and one 7/13/22. On 7/13/22, at 7:33 a.m. registered nurse (RN)-B was observed to sanitize his hands before he prepared R4's medications. RN-B took the blood pressure cuff and went into the room R4's room to get R4's blood pressure.(applied cuff to upper arm and obtained a blood pressure reading.	21375		

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21375	Continued From page 7 RN-B walked out of R4's room with blood pressure cuff, immediately placed it on top of the medication cart without disinfecting the cuff and did not sanitize or wash his hands.) -At 7:40 a.m. RN-B brought medications and blood glucose machine in a pink basin with supplies into R4's room, applied gloves and gave R4 her medications. RN-B then took the glucometer and placed it on the bedside table, proceeded to wipe R4's middle finger with a alcohol swab, stabbed it with a lancet. RN-B then placed a drop of blood on the glucometer strip to obtain a reading. After the reading was obtained, RN-B removed the dirty strip from the glucometer and returned to the pink basin with clean supplies. RN-B then removed his dirty gloves, threw them in the trash can and walked to the medication cart and sanitized his hands. RN-B then placed the pink basin with the clean with the dirty glucometer on the medication cart. RN-B did not disinfect the glucometer during the entire observation. On 7/13/22, at 7:35 a.m. nursing assistant (NA)-D walked out of R8's room with a vital sign machine and went directly into R9's room with the vital sign machine without cleaning the machine between the residents. NA-D then came out of R9's room and placed vital sign machine in hallway and walked away without cleaning it. On 7/13/22 7:39 a.m. NA-D then grabbed the vital machine without cleaning it and went into R10's room. During interview on 7/13/22, at 8:08 a.m. NA-D stated "I was not trained to clean the vitals machine in between rooms. It makes sense to clean in between rooms to stop the infections." NA-D then verified she went into three rooms and	21375		

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21375	Continued From page 8 did not clean the machine between the residents. On 7/13/22, at 7:39 a.m. NA-A was observed to enter R1's room wearing eye protection and mask only and did not have gloves or gown on. NA-A then approached R1 from the front and wrapped both arms around R1's torso and waist lifted R1 up and transferred R1 to the wheelchair. During the observation, NA-A's uniform brushed R1, R1's bedding and clothing during the transfer. NA-A immediately left the room without washing or sanitizing hands and brought R1 to a common area in the unit. NA-A immediately approached R7 in the common area and reached up to R7's face and and adjusted R7's nasal cannula in her nose. -At 7:43 a.m. NA-A stated she was supposed to wash her hands when entering and leaving resident rooms. -At 7:48 a.m. NA-A stated she knew R1 had a bacteria and stated she was supposed to use contact precautions while assisting R1, however, she thought since she had assisted R1 to get ready that morning and because she was not doing cares, she did not need to wear the PPE when assisting R1. NA-A stated she should have put on a gown when in R1's room as she had come in contact with R1's personal items including bedding. On 7/13/22, at 7:59 a.m. RN-B was observed to prepare R11's medications and took with him a cup of water and pink basin with the same glucometer that was used at 7:40 a.m. for R4 and was not cleaned after use and entered R11's room and approached the resident in bed. As RN-B was going to use the multiple resident use glucometer on R11, surveyor intervened. RN-B stated "I should have cleaned the accucheck machine with the bleach wipes." RN-B then	21375		

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21375	Continued From page 9 picked up the container and showed surveyor the container of wipes and then stated, "I'm not familiar if the wipes have a dry time but they dry very fast." RN-B then confirmed the glucometer in the pink basin was a common use glucometer and without cleaning multiple resident use equipment he could spread infections. During observation on 7/13/22 8:25 a.m. outside of R1's room was a cart with personal protective equipment which included gowns and wipes for cleaning. On R1's door was a sign which indicated "Contact precautions for special enteric. Must perform hand hygiene. Wear gloves. Wear gown when entering room and whenever anticipating that clothing will touch patient items or potentially contaminated environmental surfaces and use patient dedicated equipment." During observation on 7/13/22, at 8:36 a.m. housekeeping staff (HK)-A was observed apply gloves and then entered R12's room with a wet mop. HK-A was observed go into R12's bathroom and mopped the floor, then went to mop by R12's bed while resident was in the bed. During the observation a sign on door indicated "Enhanced barrier precautions. Providers and staff must use gloves and gowns. Gowns only if they are doing cares to resident. As HK-A was coming out of the room surveyor asked why R12 was on precautions and HK-A stated, "I don't know why he is on precautions." HK-A had come out of the room with both pairs of gloves on and started pushing his cart down the hallway and had grabbed the broom and was sweeping the hallway. HK-A, then still wearing the same gloves from R12's room, then opened R2's door. HK-A then went in with the same gloves on and was observed to gather trash in the room and came out of the room and disposed it in the cart. HK-A	21375		

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21375	Continued From page 10 then picked up a cleaner and went into R2's bathroom and was observed clean R2's sink with the same gloves still on. HK-A then came out of the room and at this time surveyor intervened and HK-A stated "I should have removed the gloves and washed my hands before doing anything else or going into another room. I could spread infection". On 7/13/22, at 8:48 a.m. NA-B was observed to push R1 in her wheelchair, using the handles on the chair near R1's body, down the hallway into the resident room. The Enhanced Barrier Precaution sign remained on the door. She stopped, briefly touched her shoulder and spoke to R1 and then immediately left the room without washing or sanitizing her hands despite sign on the door which directed staff to wash hands while leaving the room as this was a contact precaution room related to R1's confirmed CRE positive test. On 7/13/22, at 9:23 a.m. NA-B stated there were three residents in the facility who had an infection but did not know the name of it. NA-B stated the director of nursing (DON) had given the staff a paper which had information about the infection. NA-B then stated, "I should always have a gown and gloves on and to take close precautions because you could get it from them even touching our clothing and we should always wash our hands and keep washing our hands." NA-B confirmed she had not washed her hands when she had brought R1 back to the room and after touching her shoulder and wheelchair because she was trying to do several different things. On 7/13/22, at 9:23 a.m. NA-C stated was a regular at the facility and worked all units. NA-C stated he did not know why R1, R2 and R3 were on precautions "the nurse should know." NA-C	21375		

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21375	Continued From page 11 then stated he was just following the signs on the door with personal protective equipment (PPE) into the resident rooms with the signs on and staff was supposed to wear the appropriate PPE while in the rooms. On 7/13/22, at 9:30 a.m. licensed practical nurse (LPN)-A stated there was three residents on the floor with confirmed CRE positive tests and for any contact and touching anything in the room they were supposed to wear all the PPE and the staff was supposed to sanitizer in and out of the room. -At 9:40 a.m. LPN-A stated she did not know why R12 was on enhanced precautions at the door. LPN-A stated she knew R12 had history of Clostridiodes difficile and was in and out of the hospital but was not still certain the reason for the precautions as nothing had been communicated to her or the other staff on the unit. During review of the facility Infection Control Logs for January 2022 through July 2022, it was revealed the facility did not conduct ongoing tracking and trending of the confirmed CRE cases at the facility. During a review of facility CRE testing worksheet revealed the facility had attempted to conduct facility wide testing on 7/10/22, 7/11/22 and 7/12/22, however on 7/13/22, at 1:49 p.m. the worksheet had a note that listed 14 residents had refused testing. Through observations on 7/13/22, on the nursing units these residents that refused testing did not have signs on their doors to indicate they were on any precautions. The DON and director of clinical operations (DCO) both stated they were following infection control assessment and response program (ICAR) recommendations and had not implemented	21375		

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21375	Continued From page 12 precautions due to not having enough PPE carts available in the facility to hold supplies for staff to utilize. During an interview on 7/13/22, at 11:15 a.m. to 12:15 p.m. with the interim DON, DCO and RN-A infection control preventionist (IP), the DON stated one of the challenges the facility was experiencing was 45 to 50% of the staff who currently worked at the facility were agency staff which made it a hard to educate. The DON stated the facility leadership was fragmented as there had not been a full time DON and two nurse managers which created a challenge in some issues. The DON stated the facility had policies and procedures in place and the current staff available was doing the best that they could. The IP then stated although she had completed the training a couple months back, and had gone through training with the DCO, she was currently the nurse manager for two floors which created a challenge for her to fully resume responsibility for infection control at the facility. The DCO stated she had received a call from Infectious Disease Epidemiology, Prevention and Control (IDEPC) at the beginning of June but not a lot was communicated to her, and she was informed IDEPC wanted to conduct a point of prevalence testing at the facility. The DCO then stated she was out of the facility, however, a meeting had been scheduled for 6/14/22, with the facility IP and DON. The DON stated at the meeting on 6/14/22, she had asked IDEPC staff for more time to be able to get some education done and wanted to have a follow up meeting after 7/4/22, as she thought this would give her more time to do more testing on the residents. The DON, DCO and IP all confirmed following the meeting with ICAR the facility had at that time placed all three residents with confirmed positive CRE results on	21375		

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21375	Continued From page 13 precautions. The DON stated there was another meeting which was scheduled for 7/14/22, which the facility staff was going to show IDEPC staff the facility action plan and on what the facility was following up on. The IP reviewed the infection control logs and the IP, DON and DCO confirmed the resident(s) who had past confirmed positive CRE results should have been on the infection control logs for the last 6 months reviewed. The DCO stated "If they have an active infection they should go on the listing." The DCO stated she was not able to address what past staff managed the infection control logs did with tracking and stated this was something the facility staff was planning to address. The DCO stated the tracking of infections was something they had identified when IDEPC had called them at the beginning of June 2022, however, she confirmed the June and July infection logs were not fixed to address the issue. The DCO stated they were trying to get residents to be tested and figure out those who refused to be tested were going to be put on enhanced precautions. The DCO confirmed this had not been implemented despite knowing 14 residents had refused to be tested as of 7/13/22. The DON stated she had started to put signs on doors for resident who had refused as they were just finishing up the point prevalence testing. The DON stated the education that was being provided to staff was by the front door for anyone to take and sign off. The DON stated they had also put the sign-in sheet on the floors by kiosk as they thought staff would see it there. The DON also stated she and the IP were starting to do shift by shift basis education to ensure staff was educated, however, they were still in the process of putting the education together. The DON stated she felt staff did not need to know why the	21375		

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21375	Continued From page 14 resident was on precautions due to the Health Insurance Portability and Accountability Act (HIPAA) and staff only needed to follow precautions as posted on the door. The DCO stated although they were working with ICAR, there was not clear instructions on what they should do when they first called her. She then stated "The expectations have changed since 2016 so we were just trying to get on the same page from ICARs guidance. We were trying to get everyone on the same page, so everyone is safe." The DON then stated when they had a meeting with ICAR on 6/14/22, she thought ICAR was going to be "our helper to help educate and help us be proactive and move forward with them." The DON then stated the delay in education was not done because she was new but because she was busy. The DON and DCO stated staff were supposed to wear gown, gloves, masks, and eye protection when assisting resident on enhanced precautions for CRE and resident shared equipment was all supposed be cleaned between residents and hand hygiene was supposed to be done when entering and leaving a room and per the facility policy. The facility Infection Prevention and Control Guideline revised 3/25/20, directed: "The Infection Prevention and Control Program includes 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 regulatory requirements and following accepted national standards. 1. Written standards, practices, and procedures for the Infection Prevention and Control program,	21375		

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21375	Continued From page 15 include: a. Surveillance: A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility. c. Standard and transmission-based precautions to be followed to prevent the spread of infections. a. Hand Hygiene to be followed by staff with direct care, handling resident care equipment and the environment b. Selection and Use of PPE..." The facility Hand Hygiene Guideline policy revised 3/4/20, directed: "Hand hygiene is one of the most effective ways to prevent the spread of microorganisms. Clean hands can stop germs from spreading from one person to another and throughout an entire facility or community. Multiple opportunities for hand hygiene may occur during a single care episode. The following are the clinical indications for hand hygiene: -Before and after care -When hands are visibly soiled -Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices -After caring for a person with known or suspected infectious diseases -Before moving from work on a soiled body site to a clean body site on the same patient -After known or suspected exposure to spores (e.g. C difficile outbreaks- hand sanitizer cannot replace soap and water) -After touching a patient's immediate environment -After contact with blood, body fluids or contaminated surfaces -Immediately after glove removal..." The facility Guideline for Standard and	21375		

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21375	Continued From page 16 Transmission-based Precautions revised 11/9/20, directed: "Standard and Transmission-based precautions represent the infection prevention measures that apply to all resident care, regardless of suspected or confirmed infection status of the resident, in any setting where healthcare is being delivered. These evidence-based practices are designed to protect healthcare staff and residents by preventing the spread of infections among residents and ensuring staff do not carry infectious pathogens on their hands or via equipment during resident care. As mentioned in the definitions section, standard precautions include hand hygiene, use of PPE (e.g., gloves, gowns, facemasks), respiratory hygiene and cough etiquette, safe injection practices, and safe handling of equipment or items that are likely contaminated with infectious body fluids, as well as cleaning and disinfecting or sterilizing of potentially contaminated equipment. In order to perform hand hygiene appropriately, soap, water, ABHR2, and a sink should be readily accessible in appropriate locations including but not limited to resident care areas, and food and medication preparation areas. Staff must perform hand hygiene (even if gloves are used): · Before and after contact with the resident; · Before performing an aseptic task; · After contact with blood, body fluids, visibly contaminated surfaces or after contact with objects in the resident ' s room; · After removing personal protective equipment (e.g., gloves, gown, facemask); · After using the restroom; and · Before meals..." The IJ was removed on 7/14/22, at 7:22 p.m. when it could be verified by observation, interview, and record review that the facility took	21375		

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21375	Continued From page 17 the following steps: -Identified residents RI, R2, and R3 were placed on Enhanced Barrier Precautions to include correct signage outside their doors. -The facility implemented Enhanced Barrier Precautions with signage for 20 residents that are awaiting CRE lab results and for residents that had refused CRE testing. -The infection control line listing logs were updated and ongoing tracking and trending of infections in the facility was implemented by the infection preventionist. -RI, R2, and R3 medical records were reviewed and updated to ensure appropriate diagnosis of CRE and precautions were reflective in the record. -The facility stocked adequate amounts of PPE supplies for staff. -All residents in the facility have been reviewed to ensure appropriate transmission-based precautions are in place in regards to CRE. -The facility reviewed policies and procedures and updated as appropriate. -Staff was educated on use of PPE for Transmission Based precautions and Enhanced Barrier Precautions, appropriate PPE usage, CRE, hand hygiene and disinfection of shared equipment between resident use. -Education for providers was implemented on CRE and Enhanced Barrier Precautions. -Residents and responsible parties were mailed or received education via handouts and face to face on CRE and enhanced precautions. SUGGESTED METHOD FOR CORRECTION: The DON (Director of Nursing) or designee could review/revise facility policies to ensure they contain all components of an infection control program, including tracking/trending of all	21375		

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21375	Continued From page 18 illnesses and infections in the facility. In addition, the DON or designee could educate staff on infections, equipment cleaning, hand hygiene and will perform audits to ensure the policies are being followed. Time Period for Correction: Twenty-one (21) days.	21375		