DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 21, 2023

Administrator
Knute Nelson
420 12th Avenue East
Alexandria, MN 56308

RE: CCN: 245435
Cycle Start Date: July 13, 2023

Dear Administrator:

On August 30, 2023, 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
August 2, 2023

Administrator
Knute Nelson
420 12th Avenue East
Alexandria, MN 56308

RE: CCN: 245435
Cycle Start Date: July 13, 2023

Dear Administrator:

On July 13, 2023, 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:

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by October 13, 2023 (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 January 13, 2024 (six months after

the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

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

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Electronically delivered

August 2, 2023

Administrator
Knute Nelson
420 12th Avenue East
Alexandria, MN 56308

Re: Event ID: DPE211

Dear Administrator:

The above facility survey was completed on July 13, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

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

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245435	A. BUILDING _____ B. WING _____	C 07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNUTE NELSON	420 12TH AVENUE EAST ALEXANDRIA, MN 56308

(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 7/11/23 and 7/13/23, 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. H54353466C (MN00095020, MN00095023) As a result of the investigation, F880 was cited. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program.	F 880		8/25/23

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

Electronically Signed | 08/09/2023

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

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F 880	Continued From page 1 The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and	F 880		

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F 880	Continued From page 2 (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 appropriate use of personal protective equipment (PPE) while providing direct care for 1 of 1 resident (R3) with Methicillin-resistant Staphylococcus Aureus (MRSA) urinary tract infection (UTI). In addition, the facility failed to ensure proper disinfection of a multi-use full body mechanical lift was implemented to prevent the spread of infection for 1 of 1 residents (R2) observed to utilize the lift and failed to ensure proper hand hygiene was maintained during personal cares for 2 or 2 residents (R2, R3) observed during the provision of personal cares. Findings include: PPE and HAND HYGIENE R3's significant change Minimum Data Set (MDS) dated 6/5/23, identified R3 had severe cognitive impairment and diagnosis of dementia. R3 required expensive assistance with transfers,	F 880	F 880 Infection Prevention and Control How corrective action will be accomplished for those residents found to have been affected by the deficient practice. The facility will have an infection prevention and control program to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. For R 3 the deficient practice of not using proper PPE, staff were educated on the proper PPE to wear for a resident that is in contact precautions for MRSA urinary tract infection. Audits have been completed on proper PPE use in contact precautions with MRSA urinary tract infection. For R 2, and R 3 for the deficient practice of failing to ensure proper disinfection of a multi-use	

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F 880	Continued From page 3 personal hygiene, dressing, and toileting. R3 was frequently incontinent of bladder and always incontinent of bowel. R3's physician orders dated 7/6/23, start facility precautions for MRSA in urine. R3's care plan dated 7/6/23, identified MRSA colonization in urine and directed staff to bag and transport used linen according to facility protocol, preventing skin exposure or contamination. R3 placed in contact isolation and staff were directed to wear gown and masks when changing contaminated linens. During an observation on 7/11/23 at 10:05 a.m. R3 had three contact precaution signs outside the door reading: -Contact Precautions (example: Clostridium difficile [highly contagious bacteria causes diarrhea], Wounds, uncolonized MRSA), gloves on during providing care for a client, change gloves after contact with infectious material. Gown on upon entry of room and should have been worn when body contact with environment surfaces and items in room that maybe contaminated is anticipated. Masks, eye protection should be worn during client care activities likely to generate splashes or sprays of blood. Hand wash. -Sequence for putting on PPE identified how to apply a gown, mask or respirator, goggles, or face shield, and gloves. Use safe work practices to protect yourself and limit the spread of contamination. -How to Safely Remove PPE identified how to	F 880	mechanical lift, staff have been educated on disinfection of full mechanical lift after each use. Audits have been completed on disinfection of full mechanical lift after each use. For R 2 and R 3 the deficient practice of failing to ensure that proper hand hygiene before and after glove use was completed during personal cares and upon entering resident rooms, staff have been educated on proper hand hygiene before and after during personal cares and entering/exiting resident rooms. Audits completed on proper hand hygiene before and after during personal cares and entering/exiting resident rooms to ensure that there is compliance in these areas that were found deficient. We have reviewed our competencies for cleaning of all mechanical lifts after use, hand hygiene and proper PPE use have been reviewed by staff during audits, as well as additional educational materials put out for staff on the importance of hand hygiene during personal cares and entering/exiting resident rooms, wearing proper PPE and cleaning of the multi-use lifts. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the risk for potential cross contamination to others by staff failing to do hand hygiene upon entering/exiting a resident room. All residents that use mechanical lifts and receive personal care (incontinent care) from staff have the potential risk of being affected by this deficient practice. Staff have completed audits to ensure that all	

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F 880	Continued From page 4 remove all PPE, perform hand hygiene between steps if hands became contaminated, and immediately after removing all PPE. During an observation on 7/11/23 at 4:07 p.m., nurse aid (NA)-D pushed R3 in wheelchair into her room with contact precaution signs posted outside the door. NA-D did not apply PPE or sanitize hands and stated was taking R3 to the bathroom. NA-D placed the stand lift in front of the resident while she sat in her wheelchair. NA-D placed R3's feet on footrest, secured lower legs with a belt strap, lift belt around her abdomen, and instructed resident to grab onto the handles. NA-D lifted R3 out of the wheelchair with the sit to stand lift. NA-D placed gloves on her hands, removed saturated brief and then R3 stated "that smelled really bad". NA-D removed her gloves, did not sanitize hands, lowered R3 down onto the toilet, and stated R2's pants were saturated with urine and needed to be changed. NA-D knelt on the bathroom floor in front of the toilet while R3 sat on toilet, removed R3' shoes and pants with bare hands. R3 insisted she had to check the pockets of her pants and NA-D stated to be careful because the pants were wet with urine. R3 fumbled with the wet pants and placed her hand into each pocket. NA-D placed clean pants and brief on R3 and pulled to upper thigh area. NA-D placed R3's shoes back on. NA-D placed R3's feet on footrest, applied gloves, and raised R3 off the toilet with the sit to stand lift. NA wiped R3's peri area and rectal area from front to back with two separate wipes, pulled up R3's brief and pants, removed gloves and did not sanitize hands. NA-D pushed resident out of the bathroom on the sit to stand lift, lowered her down into her wheelchair, and removed lift belt loops from machine. NA-D placed R3's feet on	F 880	lifts are disinfected after each use, and staff have completed audits to ensure that during personal care (incontinent care) and after glove use staff are using proper hand hygiene and are completing hand hygiene when they enter/exit a resident room. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not occur. The staff will be educated in following the facility hand hygiene policy during personal care (incontinent care) and after glove use so that after each time that staff assist residents with personal cares proper hand hygiene is completed per policy. Staff educated on the need to complete hand hygiene upon entering/exiting resident rooms. Staff will be educated on the policy on disinfection of multi-use lifts after use, hand hygiene policy and proper PPE use. Staff were given a written quiz to fill out with questions on when to wash your hands, when to clean lifts, reviewed precautions, and what types of precautions we use and what PPE do we wear for each precaution. Continued education and review of the policies, quiz will take place on August 24, 2023, at 7:15 am and 2pm. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. QAPI (Quality Assurance and Performance Improvement) audits will be conducted to ensure that all staff are following facility Infection control policies	

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F 880	Continued From page 5 wheelchair peddles, combed R3's hair, squirted lotion into R3's hands, and sprayed perfume onto R3's wrists. NA-D pushed R3 towards the doorway in wheelchair, paused to squirt hand sanitizer into her hand, rubbed hands together, then continued to push R3 in wheelchair out of the room, and down the hallway. NA-D did not sanitize R3's hands. At 4:15 p.m. NA-D re-entered R3's room, did not apply any PPE, bagged up the wet pants into a plastic bag without gloves, and sanitized hands as she exited the room carrying the plastic bag. During an interview on 7/11/23 at 4:20 p.m. NA-D confirmed R3 had MRSA infection in her urine and thought that would be the reason to be on contact precautions. NA-D also stated she unsure if a gown was needed to enter R3's room and toilet her but felt she should have placed more PPE on prior to taking R3 to the bathroom. NA-D indicated staff received emails with contact precautions information but she had not read them. NA-D stated she wore gloves but should have protected herself from infection and worn additional PPE. During an interview on 7/12/23 at 2:27 p.m. RN-B stated specific signage was placed by the resident's door indicating which type of precautions they were placed on. RN-B indicted staff were required to read the communications on point click care prior to the start of every shift so they would known how to care for each resident. RN-B stated staff were expected to wipe down and disinfect the multi-use lift machines with the purple top santi cloth wipe after every use and important for infection control. During an interview on 7/12/23 at 4:15 p.m. RN-A	F 880	on hand hygiene and cleaning of multi-use lifts. Audits will include observation of facility staff during personal care (incontinent care) to ensure that proper hand hygiene is completed per facility policy and that staff are doing proper hand hygiene upon entering/exiting resident rooms and that lifts are disinfected after each resident transfer per policy. These audits will be done weekly by different staff to reach 100% compliance and as needed to ensure compliance rates, then randomly by Director of Nursing/designee. Results of the audits will be taken to the QAPI committee for further recommendations. The date that each deficiency will be corrected. Completion date: August 25, 2023.	

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F 880	Continued From page 6 stated prior to assisting R3 with toileting staff were expected to wear at the least minimum a gown and gloves but encouraged to also wear goggles and a mask to prevent the spread of MRSA infection to other residents and staff. RN-A staff were expected to disinfect all multi-use lift machines prior to and after resident use with a purple cover bleach wipe to help prevent the spread of nosocomial (facility acquired) infections around the facility. HOYER LIFT and HAND HYGIENE R2's quarterly MDS dated 4/19/23 indicated severely impaired and diagnoses of Parkinson's, dementia, and depression. R2 required total dependence of staff for transfers, morbidly, personal hygiene, dressing, and toilet use. R2 was always incontinent of bowel and bladder. R2's care plan dated 9/23/22, identified R2 had alteration in elimination due to Parkinson's and history of urinary tract infections (UTI's). Staff were directed to check and change R2 due to frequent incontinence of bowel and bladder, monitor for UTI symptoms, foul-smelling urine, darkening of urine color, and provide peri care after each incontinent episode. During an observation on 7/11/23 at 4:30 p.m., R2 laid in low bed positioned on her back. NA-B and NA-C sanitized hands and entered the room. R2's room had a very strong urine odor. NA-B pushed the total lift machine into R2's room while NA-C raised R2's bed up and removed blanket from R2. NA-B and NA-C applied gloves and removed R2's urine saturated brief from underneath her. NA-C cleaned R2's front peri area from front to back with a wipe. NA-B turned R2 onto her right side while NA-C wiped her	F 880		

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F 880	Continued From page 7	F 880		

rectal area from front to back. Together NA-B and NA-C placed a clean brief on R2, pulled up pants, and placed lift sheet underneath her. Both NA-B and NA-C removed gloves but failed to sanitized hands. NA-B and NA-C attached the lift sheet loops to lift machine. NA-C raised R2 out of bed, lowered her into the wheelchair, and removed the loops from lift machine. NA-B covered R2 with a blanket, placed R2's glasses on her face, picked up the water mug, and offered R2 a drink of water. NA-C made R2's bed, combed her hair, then faced R2, leaned forward, placed her hands on R2's shoulders, asked if she was ok and needed anything else, then positioned R2's soft touch call light on her lap. NA-C sanitized her hands prior to exiting R2's room. NA-B pushed total lift machine out of R2's room without sanitizing her hands.

During an interview on 7/11/23 at 4:32 p.m. NA-C stated once the soiled gloves were removed after peri cares were completed hands should have been sanitized and that was not done. NA-C also stated bacteria could have been on the gloves and hands after peri cares were completed, hand sanitization would have helped prevent the spread of bacteria to others.

During an interview on 7/11/23 at 4:42 p.m. NA-B stated R2's peri cares were completed by NA-C, she assisted with removal of the soiled brief with gloves on, removed gloves, completed additional cares with R2, then sanitized hands while exiting the room. NA-B verified the multi-use lift was pushed down to the end of hallway and placed in a storage area with out being disinfected. NA-C stated the lift was not disinfected every time a resident used it and only cleaned at the end of every shift. NA-C indicated the total lift machine

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	245435	A. BUILDING _____ B. WING _____	C 07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNUTE NELSON	420 12TH AVENUE EAST ALEXANDRIA, MN 56308

(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 8	F 880		

was not touched by residents and they each had their own lift sheet.

During an interview on 7/12/23 at 10:30 a.m. NA-A stated staff were expected to take the multi-use lift out of the resident room after use and disinfect them with a bleach wipe with the purple cover. NA-A indicated all multi-use lifts were expected to be sanitized prior to and after every resident use so that they were cleaned from bacteria and germs and helped avoid transfer of bacteria from resident to resident.

During an interview on 7/12/23 at 2:27 p.m. RN-B stated staff were expected to sanitize their hands before entering and prior to leaving a resident room. RN-B also stated staff were expected to remove gloves after cares, sanitize their hands prior to completing other personal cares such as combing hair, placement of call light to help prevent the spread of infection and good hygiene.

During an interview on 7/12/23 at 4:15 p.m. RN-A stated staff were expected to foam in and out of every resident room, apply gloves, complete peri cares, remove gloves, and sanitize hands prior to completing additional cares such as combing hair, place the call light, and cover up resident with a blanket to keep all residents safe and prevent the spread of infection.

During an interview on 7/13/23 at 11:04 a.m. director of nursing interim (DON) stated staff are expected to foam in and out of all resident rooms. DON also stated staff are expected to wear gloves during peri care, remove the gloves, then sanitize their hands to prevent the spread of germs. DON indicated hand hygiene was the best way to keep everyone healthy. DON verified all

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F 880	Continued From page 9 multi use lifts were expected to be disinfected with a purple top bleach wipe between each resident use. DON expected staff to wipe down all parts of the lift to also include areas touched by residents to prevent infectious germs to be transferred from one resident room to another. DON indicated staff are expected to wear a gown, gloves, mask, and any eye protection needed to complete toileting cares in an MRSA contact precaution room to help prevent the spread of MRSA to themselves and residents. Facility policy titled Hand Hygiene dated 7/2018, identified hand hygiene continues to be the primary means of preventing the transmission of infection. Perform hand hygiene before and after direct contact with residents, after contact with blood, body fluids or excretions, mucus membranes, non-invasive skin, or wound dressings. Before and after providing personal cares for a resident such as peri-care, bathing, and oral cares. Wash hands with non-antimicrobial soap and water or with antimicrobial soap and water if contact with spores is likely to have occurred. Facility policy titled Nurse Manager Responsibilities for Patient with the need for Certain Precautions, dated 8/2015, identified the nurse manager was responsible to assure staff were updated and educated on reason for precautions, resident room number, and type of precautions used for each resident via email and during report. Facility policy titled Cleaning and Disinfecting Mechanical Lifts dated 6/2018, mechanical lifts may transmit pathogens if devices contaminated with blood or body fluids are shared between	F 880		

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F 880	Continued From page 10 residents without cleaning and disinfecting between residents. Facility staff were instructed to disinfect all lifts used by a resident and prior to reuse on another resident with a hospital grade disinfectant provided by the facility.	F 880		

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	00113	A. BUILDING: _____ B. WING _____	C 07/13/2023

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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 7/11/23 and 7/13/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure. The following complaints were reviewed during	2 000		

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2 000	Continued From page 1 the survey. H54353466C (MN00095020, MN00095023) Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software.	2 000		