Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
10/28/2024

Administrator
Fair Oaks Nursing & Rehab LLC
201 Shady Lane Drive
Wadena, MN 56482

RE: CCN: 245581
Cycle Start Date: June 27, 2024

Dear Administrator:

On August 16, 2024, Center for Medicare & Medicaid Services (CMS) forwarded the results of the Federal Monitoring Survey (FMS) to you and informed you that your facility was not in substantial compliance with the applicable Federal requirements for nursing homes participating in the Medicare and Medicaid programs and imposed enforcement remedies.

On October 18, 2024 the Minnesota Department(s) of Health and Public Safety, 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 September 30, 2024.

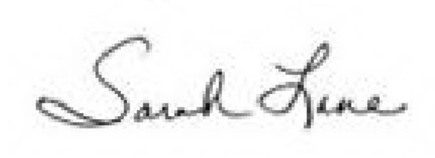
As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective September 27, 2024. be discontinued as of September 30, 2024. (42 CFR 488.417 (b))

However, as we notified you in our letter of July 23, 2024, 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), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from September 27, 2024. This does not apply to or affect any previously imposed NATCEP loss.

Feel free to contact me if you have questions.

Sincerely,



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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 28, 2024

Administrator
Fair Oaks Nursing & Rehab LLC
201 Shady Lane Drive
Wadena, MN 56482

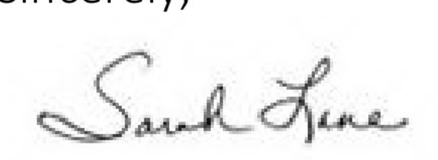
Re: Reinspection Results
Event ID: FV9Y12

Dear Administrator:

On September 18, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 15, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,



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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 30, 2024

Administrator
Fair Oaks Nursing & Rehab LLC
201 Shady Lane Drive
Wadena, MN 56482

RE: CCN: 245581
Cycle Start Date: June 27, 2024

Dear Administrator:

On July 23, 2024, we informed you of imposed enforcement remedies.

On August 15, 2024, the Minnesota Department(s) of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found 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.

REMEDIES

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

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 27, 2024

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 27, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 27, 2024.

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.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

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 $12,924, 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 September 27, 2024, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Fair Oaks Nursing & Rehab LLC will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 27, 2024. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

DEPARTMENT CONTACT

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

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 27, 2024 (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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

formal notification of that determination.

APPEAL RIGHTS

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

Steven.Delich@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

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

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

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900

St. Paul, Minnesota 55164-0900

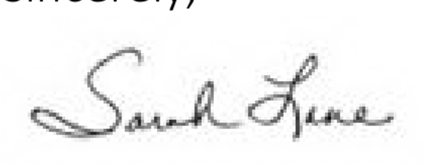
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://forms.web.health.state.mn.us/form/NHDisputeResolution

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

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

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
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 30, 2024

Administrator
Fair Oaks Nursing & Rehab LLC
201 Shady Lane Drive
Wadena, MN 56482

Re: State Nursing Home Licensing Orders
Event ID: FV9Y11

Dear Administrator:

The above facility was surveyed on August 14, 2024 through August 15, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

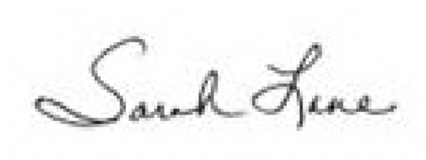
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting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

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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

Please feel free to call me with any questions.

Sincerely,



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING _____ B. WING _____	C 08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIR OAKS NURSING & REHAB LLC	201 SHADY LANE DRIVE WADENA, MN 56482

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 8/14/24 through 8/15/24, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H55816307C (MN00105227); H55817061C (MN00105229) with a deficiency issued at F880; H55817060C (MN00105226) with a deficiency issued at F808 and F689. 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 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.	F 689		9/13/24

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

Electronically Signed | 09/09/2024

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

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F 689	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure adequate supervision was provided for 1 of 3 residents (R2) reviewed, who required supervision while eating due to assessed choking risk. Findings include: R2's admission Minimal Data Set (MDS) dated 6/5/24, indicated R2's diagnoses included epilepsy, hemiplegia and hemiparesis following cerebrovascular disease, and no cognitive impairment. Further, MDS revealed R2 did not have any swallowing concerns but was assessed to require a mechanically altered diet. R2's care plan dated 5/30/24, indicated R2 had potential for altered nutritional status and required Level 6 Soft and Bite Sized diet texture, and R2 was independent with eating however required to eat in the dining room as she needed to be supervised. R2's Risks vs Benefits document dated 6/26/24, indicated R2 had a risk of having swallowing issues related to diagnosis of hemiplegia and hemiparesis. R2 had minimal teeth that made it hard to properly chew food all the way. During continuous observation from 11:59 a.m. until 12:25 p.m., on 8/14/24, R2 was observed sitting in her standard wheelchair in a commons area room by the nursing station, at a table with another female resident. R2 appeared to be eating independently and there were no staff within vision of R2. There were two nursing assistants (NAs) in the day room assisting other	F 689	F689 (SS=D) Free of Accident Hazards/Supervision/Devices How corrective action will be accomplished for those residents found to have been affected by the deficient. • R2 has been supervised for all meals since the incident. • Staff were re-educated on making super people who are on modified diets are supervised during meals. How the facility will identify other residents having the potential to be affected by the same deficient practice. • All residents who are on modified diets have the potential to be affected by this deficient practice. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. • All nursing staff were re-educated on making sure that all residents who are on modified diets are supervised during meals. • All Dietary staff were educated on making sure a staff member is available to supervise a resident on a modified diet before the meal is served. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Audits on ensuring residents are supervised if they are on a modified diet will be completed 3x weekly for 1 month, 2x per week for 1 month, and 1x per week for 1 month to ensure all residents who fall have a post fall completed, neuros as	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 2 residents with their noon meal and licensed practical nurse (LPN)-A joined the residents in the day room as well, and R2 was not within visual sight of the staff. On 8/14/24 at 12:33 p.m., LPN-A stated a resident who would require supervision while eating would be identified in the resident's care plan and the staff on the unit "typically work on this floor" so all the staff were aware of who required supervision. LPN-A stated R2's cognition was severely impaired and was on a mechanically altered diet due to her teeth and required supervision during meals for encouragement to eat. LPN-A stated R2 had no history of choking or concerns related to swallowing. Further, LPN-A stated staff determined to separate R2 from the other residents in the day room during meals due to R2's increased behaviors. When questioned about R2's care plan which identified R2 required supervision, LPN-A stated, "that needs to be changed" and staff "watch her, we come out and check on her every couple minutes, we take turns". On 8/14/24 at 1:06 p.m., dietary manager (DM) stated she would expect residents who required an altered diet consistency, which included Level 6, to be supervised while eating and were encouraged to eat in the dining room. On 8/14/24 at 3:21 p.m., NA-A stated if a resident required supervision during meals, it would be identified in their care plan. NA-A stated R2 had impaired cognition and required staff supervision while eating due to being at risk for choking. On 8/15/24 at 10:55 a.m., registered nurse	F 689	needed, and monitoring orders put in place as needed. Review and analysis of these audits will be reviewed at QAPI to determine ongoing frequency and duration of audits. Date of compliance: 9/13/2024 Person responsible: Director of Nursing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 689	Continued From page 3 (RN)-A stated R2 had impaired cognition and required supervision while eating as she was on a soft and bite sized diet. RN-A stated R2 has had no incidents of choking. On 8/15/24 at 11:49 a.m., director of nursing (DON) stated R2's had impaired cognition and poor safety awareness. DON stated she was on a Level 6 diet and required supervision while eating for "safety reasons", however DON stated R2 had no history of choking or aspiration since admitting to the facility. Further, DON stated R2 was moved to a different unit and then, due to behaviors, was moved to a smaller area away from another resident in the dining room to create a "good dining experience". DON added due to the move, R2's supervision during meals "got lost" or forgotten and staff would be expected to refer to each resident's care plan for supervision needs. Review of facility policy titled Diet and Diet Orders revised 12/11/23, lacked evidence of staff direction on when residents require supervision while eating.	F 689		
F 808 SS=D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced	F 808		9/13/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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FAIR OAKS NURSING & REHAB LLC	201 SHADY LANE DRIVE WADENA, MN 56482

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F 808	Continued From page 4 by: Based on observation, interview, and document review, the facility failed to ensure the residents received the prescribed diet, as ordered, for 1 of 2 residents (R2) reviewed for mechanically altered diets. Findings include: R2's admission Minimal Data Set (MDS) dated 6/5/24, indicated R2's diagnoses included epilepsy, hemiplegia and hemiparesis following cerebrovascular disease, and R2 had no cognitive impairment. Further, MDS revealed R2 did not have any swallowing concerns but required a mechanically altered diet. R2's Order Summary Report dated 8/14/24, indicated R2 required a regular diet, level 6 soft and bite sized texture, thin liquid consistency and directed staff to add fluid to foods and add salt to foods as or 5/29/24. Review of International Dysphasia Diet Standardization Initiative (IDDSI) dated 01/19, indicated Level 6 Soft and Bite-Sized for adults consisted of soft, tender and moist, ability to "bite off" a piece of food is not required, ability to chew "bite sized" pieces so that they are safe to swallow is required, pieces no bigger than 1.5 cm by 1.5 cm in size, food can be mashed or broken down with pressure from fork. Further, Level 6-Soft and Bite-Sized food may be used if the individual was not able to bite off pieces of food safely but are able to chew bite-sized pieces down into little pieces that are safe to swallow and pieces that are "bite-sized" to reduce choking risk. In addition, IDDSI indicated food textures to avoid due to choking risk for adults who need	F 808	F808 (SS=D) Therapeutic Diet Prescribed by Physician How corrective action will be accomplished for those residents found to have been affected by the deficient. • R2 had corn removed from meal tray when issue was identified. • All Dietary staff were re-educated on IDSSI diets and that a level 6 can not have food with husks such as corn. How the facility will identify other residents having the potential to be affected by the same deficient practice. • All residents who are on a modified diet have the potential to be affected by this deficient practice. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. • All Dietary staff were re-educated on IDSSI diets and that a level 6 can not have food with husks such as corn. • All nursing staff have been educated on IDSSI diets and will help to monitor residents who are on modified diets to ensure they get their proper consistency of meals. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Audits on diet consistency will be completed 3x weekly for 1 month, 2x per week for 1 month, and 1x per week for 1 month to ensure all residents who fall have a post fall completed, neuros as needed, and monitoring orders put in place as needed. Review and analysis of	

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F 808	Continued From page 5 Level 6 Soft and Bite-Sized food included foods with husks such as corn. During continuous observation from 11:59 a.m. until 12:25 p.m., on 8/14/24, R2 was observed sitting in her standard wheelchair in a commons area room by the nursing station, at a table with another female resident. R2 appeared to be eating independently and there were no staff within vision of R2. There were two nursing assistants (NAs) in the day room assisting other residents with their noon meal and licensed practical nurse (LPN)-A joined the residents in the day room as well, and R2 was not within visual sight of the staff. R2 was observed to have regular corn on her plate that appeared to be eaten. On 8/14/24 at 12:33 p.m., licensed practical nurse (LPN)-A stated R2 required a mechanical diet but was unsure for certain and stated R2 would be able to eat regular corn with her prescribed diet. LPN-A stated R2 has no history of choking or swallowing concerns that she was aware of. At 12:37 p.m., LPN-A was standing next to R2 while R2 was eating and did not remove R2's plate with incorrect diet. On 8/14/24 at 12:59 p.m., dietary manager (DM)-A stated R2 was assessed upon admission and determined to require a Level 6 Soft and Bite- Sized texture diet due to some difficulty she was having with foods. DM-A stated R2's diet would require creamed corn rather than regular corn. DM-A requested dietary aide (DA)-A to go remove R2's tray. On 8/14/24 at 1:05 p.m., DA-A entered the unit to remove R2's tray, and R2 was no longer at the	F 808	these audits will be reviewed at QAPI to determine ongoing frequency and duration of audits. Date of compliance: 9/13/2024 Person responsible: Dietary Manager	

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F 808	Continued From page 6	F 808		

table eating. DA-A stated R2 required Level 6 Soft and Bite-Sized texture foods which meant the food was required to be cut and a fork could cut through the food with ease. DA-A stated she was the cook that day and she would have been the staff that would have dished up R2's noon meal. DA-A stated each resident has a dietary slip on the tray the cook would review and determine which food the resident would get for their meal, and the plate was then delivered by the dietary aides who should also be verifying on the meal ticket that it is the correct resident and correct diet prior to serving the plate to the resident. In addition, DA-A stated she reviewed R1's dietary slip prior to dishing up the plate however stated, "I spaced it honestly" and R2 should have received the creamed corn instead of regular. DA-A confirmed R2 had ate some of the regular corn.

On 8/14/24 at 1:06 p.m. DM-A stated the facility process to ensure residents receive the correct prescribed diet consisted of DM-A creating a pink slip of paper for each resident's tray that would identify diet order, fluid restrictions, or allergies that would draw attention for the dietary staff. DM-A stated the cook would be expected to review the slip of paper to ensure the resident received the proper diet and the aid delivering the resident's meal tray would verify the tray was for the correct resident containing the correct diet.

On 8/15/24 at 11:49 a.m., director of nursing (DON) stated R2's had impaired cognition and poor safety awareness. DON stated she was on a Level 6 diet and required supervision while eating for "safety reasons", however DON stated R2 had no history of choking or aspiration since admitting to the facility. Further, DON stated staff were expected to verify with each resident's tray

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F 808	Continued From page 7 card, which included the resident's prescribed diet, prior to giving the resident the meal tray. Review of facility policy titled Diet and Diet Orders revised 12/11/23, indicated the facility would utilize a tray identification system to ensure diet accuracy in the service of the meals. Further, policy directed food service director or dietary manager would ensure that food provided was consistent with diet order and that the tray card accurately reflects resident diet order and food preferences. Review of facility policy titled Hospitality and Dining Services dated 1/1/20, stated tray line and set up procedures were planned for an efficient and orderly delivering system and all meal orders were checking by dining service personnel for accuracy. Further, policy indicated meal orders were also checked by staff serving the meal before giving it to the individual. Policy also indicated each meal staff would be expected to check for: correct individual name, dining area and diet order.	F 808		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F 880		9/13/24

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F 880	Continued From page 8 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 §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed	F 880		

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F 880	Continued From page 9 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 hand hygiene was performed while assisting with toileting cares for 1 of 1 residents (R3) reviewed. Findings include: R3's significant change Minimal Data Set (MDS) dated 6/26/24, indicated R3 had diagnoses which included fusion of spine and reflex neuropathic bladder. R3's care plan dated 8/2/24, indicated R3 required assist of one staff for toileting and personal hygiene needs. On 8/14/24 at 2:39 p.m., nursing assistant (NA)-B and NA-C knocked and entered R3's room. R3 was sitting on the commode and was hooked up to the mechanical sit to stand lift. NA-B and NA-C applied gloves, NA-C got out wipes and assisted R3 with toileting hygiene cares. NA-C tossed the wipes into the garbage can and NA-B assisted	F 880	F880 (SS=D) Infection Prevention & Control How corrective action will be accomplished for those residents found to have been affected by the deficient. • Staff member with identified infection control concern, was immediately re-educated on proper use / changing of gloves in accordance with our Infection control Policy & procedure. How the facility will identify other residents having the potential to be affected by the same deficient practice. • All residents have the potential to be affected by this deficient practice. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. • All nursing staff were re-educated on when to wear and change gloves in accordance with our infection control Policy & Procedure. How the facility will monitor its corrective	

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F 880	Continued From page 10 with pulling up R3's brief and pants. NA-C continued to wear the same gloves and grabs R3's wheelchair, touched the mechanical lift, grabbed the garbage, and touched the doorknob. NA-C was stopped by surveyor prior to exiting the room with the same gloves on, and NA-C removed the gloves. On 8/14/24 at 3:08 p.m., NA-C stated staff would be expected to remove soiled gloves after every task and change gloves between different cares. NA-C confirmed changing gloves when going from dirty to clean would be expected as well as performing hand hygiene. On 8/15/24 at 11:49 a.m., director of nursing (DON) stated staff would be expected to remove their gloves after assisting with peri care as the gloves would be considered soiled, perform hand hygiene, and apply new gloves to continue with cares as needed. Review of facility policy title Hand Hygiene revised 5/8/24, indicated staff will perform hand hygiene before applying gloves and after removing gloves, after contact with body fluids, and after providing direct resident care. Further, policy directed staff to perform hand hygiene before moving from a contaminated body site to a clean body site during resident care, for example, after providing peri-care, before applying moisture barrier or other treatments.	F 880	actions to ensure that the deficient practice is being corrected and will not recur. Audits on hand hygiene, glove changing, and infection control practices will be completed 3x weekly for 1 month, 2x per week for 1 month, and 1x per week for 1 month to ensure all residents who fall have a post fall completed, neuros as needed, and monitoring orders put in place as needed. Review and analysis of these audits will be reviewed at QAPI to determine ongoing frequency and duration of audits. Date of compliance: 9/13/2024 Person responsible: Director of Nursing	

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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 8/14/24 through 8/15/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders	2 000		

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2 000	Continued From page 1 and identify the date when they will be completed. The following complaints were reviewed: H55816307C (MN00105227); H55817061C (MN00105229) with a licensing order issued at 1375, H55817060C (MN00105226) with a licensing order issued at 0965 and 0830. 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	2 000		

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2 000	Continued From page 2 the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure adequate supervision was provided for 1 of 3 residents (R2) reviewed, who required supervision while eating due to assessed choking risk. Findings include:	2 830	corrected	9/13/24

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2 830	Continued From page 3 R2's admission Minimal Data Set (MDS) dated 6/5/24, indicated R2's diagnoses included epilepsy, hemiplegia and hemiparesis following cerebrovascular disease, and no cognitive impairment. Further, MDS revealed R2 did not have any swallowing concerns but was assessed to require a mechanically altered diet. R2's care plan dated 5/30/24, indicated R2 had potential for altered nutritional status and required Level 6 Soft and Bite Sized diet texture, and R2 was independent with eating however required to eat in the dining room as she needed to be supervised. R2's Risks vs Benefits document dated 6/26/24, indicated R2 had a risk of having swallowing issues related to diagnosis of hemiplegia and hemiparesis. R2 had minimal teeth that made it hard to properly chew food all the way. During continuous observation from 11:59 a.m. until 12:25 p.m., on 8/14/24, R2 was observed sitting in her standard wheelchair in a commons area room by the nursing station, at a table with another female resident. R2 appeared to be eating independently and there were no staff within vision of R2. There were two nursing assistants (NAs) in the day room assisting other residents with their noon meal and licensed practical nurse (LPN)-A joined the residents in the day room as well, and R2 was not within visual sight of the staff. On 8/14/24 at 12:33 p.m., LPN-A stated a resident who would require supervision while eating would be identified in the resident's care plan and the staff on the unit "typically work on this floor" so all the staff were aware of who	2 830		

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2 830	Continued From page 4 required supervision. LPN-A stated R2's cognition was severely impaired and was on a mechanically altered diet due to her teeth and required supervision during meals for encouragement to eat. LPN-A stated R2 had no history of choking or concerns related to swallowing. Further, LPN-A stated staff determined to separate R2 from the other residents in the day room during meals due to R2's increased behaviors. When questioned about R2's care plan which identified R2 required supervision, LPN-A stated, "that needs to be changed" and staff "watch her, we come out and check on her every couple minutes, we take turns". On 8/14/24 at 1:06 p.m., dietary manager (DM) stated she would expect residents who required an altered diet consistency, which included Level 6, to be supervised while eating and were encouraged to eat in the dining room. On 8/14/24 at 3:21 p.m., NA-A stated if a resident required supervision during meals, it would be identified in their care plan. NA-A stated R2 had impaired cognition and required staff supervision while eating due to being at risk for choking. On 8/15/24 at 10:55 a.m., registered nurse (RN)-A stated R2 had impaired cognition and required supervision while eating as she was on a soft and bite sized diet. RN-A stated R2 has had no incidents of choking. On 8/15/24 at 11:49 a.m., director of nursing (DON) stated R2's had impaired cognition and poor safety awareness. DON stated she was on a Level 6 diet and required supervision while eating for "safety reasons", however DON stated R2 had no history of choking or aspiration since	2 830		

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2 830	Continued From page 5 admitting to the facility. Further, DON stated R2 was moved to a different unit and then, due to behaviors, was moved to a smaller area away from another resident in the dining room to create a "good dining experience". DON added due to the move, R2's supervision during meals "got lost" or forgotten and staff would be expected to refer to each resident's care plan for supervision needs. Review of facility policy titled Diet and Diet Orders revised 12/11/23, lacked evidence of staff direction on when residents require supervision while eating. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to altered diets, accidents and resident supervision to assure proper assessment and interventioins are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 965	MN Rule 4658.0600 Subp. 2 Dietary Service -Nutritional Status Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value	2 965		9/13/24

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2 965	Continued From page 6 must be offered to residents who refuse food served. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the residents received the prescribed diet, as ordered, for 1 of 2 residents (R2) reviewed for mechanically altered diets. Findings include: R2's admission Minimal Data Set (MDS) dated 6/5/24, indicated R2's diagnoses included epilepsy, hemiplegia and hemiparesis following cerebrovascular disease, and R2 had no cognitive impairment. Further, MDS revealed R2 did not have any swallowing concerns but required a mechanically altered diet. R2's Order Summary Report dated 8/14/24, indicated R2 required a regular diet, level 6 soft and bite sized texture, thin liquid consistency and directed staff to add fluid to foods and add salt to foods as or 5/29/24. Review of International Dysphasia Diet Standardization Initiative (IDDSI) dated 01/19, indicated Level 6 Soft and Bite-Sized for adults consisted of soft, tender and moist, ability to "bite off" a piece of food is not required, ability to chew "bite sized" pieces so that they are safe to swallow is required, pieces no bigger than 1.5 cm by 1.5 cm in size, food can be mashed or broken down with pressure from fork. Further, Level 6-Soft and Bite-Sized food may be used if the	2 965	corrected	

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2 965	Continued From page 7 individual was not able to bite off pieces of food safely but are able to chew bite-sized pieces down into little pieces that are safe to swallow and pieces that are "bite-sized" to reduce choking risk. In addition, IDDSI indicated food textures to avoid due to choking risk for adults who need Level 6 Soft and Bite-Sized food included foods with husks such as corn. During continuous observation from 11:59 a.m. until 12:25 p.m., on 8/14/24, R2 was observed sitting in her standard wheelchair in a commons area room by the nursing station, at a table with another female resident. R2 appeared to be eating independently and there were no staff within vision of R2. There were two nursing assistants (NAs) in the day room assisting other residents with their noon meal and licensed practical nurse (LPN)-A joined the residents in the day room as well, and R2 was not within visual sight of the staff. R2 was observed to have regular corn on her plate that appeared to be eaten. On 8/14/24 at 12:33 p.m., licensed practical nurse (LPN)-A stated R2 required a mechanical diet but was unsure for certain and stated R2 would be able to eat regular corn with her prescribed diet. LPN-A stated R2 has no history of choking or swallowing concerns that she was aware of. At 12:37 p.m., LPN-A was standing next to R2 while R2 was eating and did not remove R2's plate with incorrect diet. On 8/14/24 at 12:59 p.m., dietary manager (DM)-A stated R2 was assessed upon admission and determined to require a Level 6 Soft and Bite- Sized texture diet due to some difficulty she was having with foods. DM-A stated R2's diet would require creamed corn rather than regular	2 965		

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2 965	Continued From page 8 corn. DM-A requested dietary aide (DA)-A to go remove R2's tray. On 8/14/24 at 1:05 p.m., DA-A entered the unit to remove R2's tray, and R2 was no longer at the table eating. DA-A stated R2 required Level 6 Soft and Bite-Sized texture foods which meant the food was required to be cut and a fork could cut through the food with ease. DA-A stated she was the cook that day and she would have been the staff that would have dished up R2's noon meal. DA-A stated each resident has a dietary slip on the tray the cook would review and determine which food the resident would get for their meal, and the plate was then delivered by the dietary aides who should also be verifying on the meal ticket that it is the correct resident and correct diet prior to serving the plate to the resident. In addition, DA-A stated she reviewed R1's dietary slip prior to dishing up the plate however stated, "I spaced it honestly" and R2 should have received the creamed corn instead of regular. DA-A confirmed R2 had ate some of the regular corn. On 8/14/24 at 1:06 p.m. DM-A stated the facility process to ensure residents receive the correct prescribed diet consisted of DM-A creating a pink slip of paper for each resident's tray that would identify diet order, fluid restrictions, or allergies that would draw attention for the dietary staff. DM-A stated the cook would be expected to review the slip of paper to ensure the resident received the proper diet and the aid delivering the resident's meal tray would verify the tray was for the correct resident containing the correct diet. On 8/15/24 at 11:49 a.m., director of nursing (DON) stated R2's had impaired cognition and poor safety awareness. DON stated she was on a Level 6 diet and required supervision while	2 965		

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2 965	Continued From page 9 eating for "safety reasons", however DON stated R2 had no history of choking or aspiration since admitting to the facility. Further, DON stated staff were expected to verify with each resident's tray card, which included the resident's prescribed diet, prior to giving the resident the meal tray. Review of facility policy titled Diet and Diet Orders revised 12/11/23, indicated the facility would utilize a tray identification system to ensure diet accuracy in the service of the meals. Further, policy directed food service director or dietary manager would ensure that food provided was consistent with diet order and that the tray card accurately reflects resident diet order and food preferences. Review of facility policy titled Hospitality and Dining Services dated 1/1/20, stated tray line and set up procedures were planned for an efficient and orderly delivering system and all meal orders were checking by dining service personnel for accuracy. Further, policy indicated meal orders were also checked by staff serving the meal before giving it to the individual. Policy also indicated each meal staff would be expected to check for: correct individual name, dining area and diet order. SUGGESTED METHOD OF CORRECTION: The administrator, registered dietician, or designee should ensure dietary interventions are implemented in a timely manner. The facility should review and/or update or create policies and procedures, and educate staff on specific requirements or interventions related altered diet orders. The administrator, registered dietician, or designee should perform audits for a measurable amount of time as determined by the Quality Assurance Performance Improvement (QAPI)	2 965		

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2 965	Continued From page 10 committee to ensure food items given, offered, or consumed by residents are implemented as identified or ordered. The facility should report those findings to QAPI for further recommendations and determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 965		
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 appropriate hand hygiene was performed while assisting with toileting cares for 1 of 1 residents (R3) reviewed. Findings include: R3's significant change Minimal Data Set (MDS) dated 6/26/24, indicated R3 had diagnoses which included fusion of spine and reflex neuropathic bladder. R3's care plan dated 8/2/24, indicated R3 required assist of one staff for toileting and personal hygiene needs. On 8/14/24 at 2:39 p.m., nursing assistant (NA)-B and NA-C knocked and entered R3's room. R3	21375	corrected	9/13/24

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21375	Continued From page 11 was sitting on the commode and was hooked up to the mechanical sit to stand lift. NA-B and NA-C applied gloves, NA-C got out wipes and assisted R3 with toileting hygiene cares. NA-C tossed the wipes into the garbage can and NA-B assisted with pulling up R3's brief and pants. NA-C continued to wear the same gloves and grabs R3's wheelchair, touched the mechanical lift, grabbed the garbage, and touched the doorknob. NA-C was stopped by surveyor prior to exiting the room with the same gloves on, and NA-C removed the gloves. On 8/14/24 at 3:08 p.m., NA-C stated staff would be expected to remove soiled gloves after every task and change gloves between different cares. NA-C confirmed changing gloves when going from dirty to clean would be expected as well as performing hand hygiene. On 8/15/24 at 11:49 a.m., director of nursing (DON) stated staff would be expected to remove their gloves after assisting with peri care as the gloves would be considered soiled, perform hand hygiene, and apply new gloves to continue with cares as needed. Review of facility policy title Hand Hygiene revised 5/8/24, indicated staff will perform hand hygiene before applying gloves and after removing gloves, after contact with body fluids, and after providing direct resident care. Further, policy directed staff to perform hand hygiene before moving from a contaminated body site to a clean body site during resident care, for example, after providing peri-care, before applying moisture barrier or other treatments. SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee should	21375		

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21375	Continued From page 12 re-educate nursing staff to appropriately implement correct hand hygiene when assisting residents with cares. The DON or designee could review and revise policies to ensure appropriateness. The DON or designee should perform audits to ensure the policies are being followed. The results of those audits should be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. Time Period for Correction: Twenty-one (21) days.	21375		