Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 20, 2024

Administrator
Rochester Rehabilitation and Living Center
1900 Ballington Boulevard NW
Rochester, MN 55901

RE: CCN: 245626
Cycle Start Date: June 28, 2024

Dear Administrator:

On July 12, 2024, we notified you a remedy was imposed. On August 19, 2024, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of August 12, 2024.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective September 28, 2024, did not go into effect. (42 CFR 488.417 (b))

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 20, 2024

Administrator
Rochester Rehabilitation and Living Center
1900 Ballington Boulevard NW
Rochester, MN 55901

Re: Reinspection Results
Event ID: 1GRH12

Dear Administrator:

On August 19, 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 June 28, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 11, 2024

Administrator
Rochester Rehabilitation and Living Center
1900 Ballington Boulevard NW
Rochester, MN 55901

RE: CCN: 245626
Cycle Start Date: June 28, 2024

Dear Administrator:

On June 28, 2024, a survey was completed at your facility by the Minnesota Department of Health, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by September 28, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by December 28, 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,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245626	A. BUILDING _____ B. WING _____	C 06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHESTER REHABILITATION AND LIVING CENTER	1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901

(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 6/27/24 and 6/28/24, 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 complaint was reviewed: H56265054C (MN00104448, MN00104444, MN00104427) A deficiency was issued at F880. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. 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		8/12/24

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

Electronically Signed | 07/23/2024

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

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F 880	Continued From page 1 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	F 880		

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F 880	Continued From page 2 transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement enhanced barrier precautions (EBP) for 3 of 3 (R2, R3, R4) residents reviewed for infection prevention. R2's Diagnoses List undated included open wound of abdominal wall. R2's admission Minimum Data Set (MDS) dated 6/23/24 indicated intact cognition with open lesions, and application of non-surgical dressings. R2's Physician's Orders dated 6/18/24 instructed wound care to abdominal wall wound. Remove old dressing. Clean with Vashe cleanser (a wound cleanser). Gently pat dry. Cover with Xeroform (a wound dressing). Cover with 4x4 Mepilex boarder (a wound dressing). Change daily. The orders lack direction on enhanced barrier precautions.	F 880	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of, or agreement with the facts and conclusions in the statement of deficiencies. This Plan of Correction is prepared and executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and it constitutes the facility's allegation of compliance. Based on observation, interview and document review, the facility failred toimiplement enhanced barrier precautions for 3 of 3 (R2, R3, R4) resident reviewed for infection prevention. Affected Resident(s): enhanced Barrier Precautions were added to R2, R3, and R4's resident's orders. The care plans were updated with	

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F 880	Continued From page 3 On 6/27/2024 at 2:01 p.m., R2 stated facility staff wear only gloves when completing the daily dressing changes. R3's Diagnoses List undated included non-pressure chronic wound of left heel. R3's admission MDS dated 6/23/24 indicated intact cognition with pressure and non-pressure injuries and a surgical wound requiring wound care. R3's Physician's Orders dated 6/18/24 instructed to remove old dressing to left heel. Cleanse ulcer base with rough gauze and Vashe in circular motion. Moisten new rough gauze with Vashe. Apply gauze directly to the wound base and areas around the wound. Allow gauze to sit for 20 minutes. Remove gauze and pat dry. Apply a layer of barrier cream around the wound. Apply 1 layer of Derma Blue Transfer (a foam wound dressing) to the ulcer base. Cover with non-woven (soft) gauze and secure with cover roll stretch tape. Change dressing daily. R3's Physician's Orders dated 6/17/24 instructed change midline dressings 2 times daily with saline moistened Kerlix gauze wrap covered with an abdominal pad. The orders lack direction on enhanced barrier precautions. On 6/27/24 at 3:40 p.m., R3 stated the dressings on her wounds are changed as the provider ordered. Staff washed hands and changed gloves frequently during dressing changes, but did not wear a gown.	F 880	Enhanced Barrier precautions. isolation protocol was completed including putting an isolation cart outside the rooms with signage indicating Enhanced Barrier Precautions. A covered trash receptacle was placed in the residents' rooms. The residents were educated on the protocol for Enhanced Barrier Precautions and the rationale behind it. Measures/Systematic Changes: The policy on Enhanced Barrier Precautions was reviewed and remains current. All resident records were reviewed for need for Enhanced Barrier Precautions according to the most current guidelines from CMS and VOANs policy. Appropriate residents were provided Enhanced Barrier Precautions and given education regarding Enhanced Barrier Precautions including the use of cover trash receptacles. nursing leadership, including the Infection Preventionist, were provided with education on the policy and procedure for implementation and discontinuation of Enhanced Barrier Precautions by the Corporate Nurse Consultant. Education also included the VOANS policy and procedure on implementing these precautions including the use of covered trash receptacles. All verbalized understanding. The Infection Preventionist or Nursing leadership to review all admissions prior to the admission for the need for isolation using current CMS guidelines.	

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ROCHESTER REHABILITATION AND LIVING CENTER	1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901

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F 880	Continued From page 4 R4's Diagnoses List undated included orthopedic aftercare following surgical amputation. R4's admission MDS dated 6/10/24 indicated intact cognition with surgical wounds requiring wound care. R4's care plan dated 6/13/24 indicated a surgical incision to right foot and left below the knee amputation. R4's Physician's Orders dated 6/04/24 instructed moisten soft gauze with Vashe wound cleanser. Apply moistened product directly to wound base. Allow application to sit for at least 1-5 minutes. Remove application and exfoliate with rough gauze to removed devitalized tissue. May place gauze in-between toes and loosely wrap foot with Kerlix gauze wrap twice daily. The orders lacked information on enhanced barrier precautions. On 6/28/24 at 11:29 a.m., licensed practical nurse (LPN)-C was observed completing wound dressing change for R4 wearing gloves. LPN-C was not wearing any other personal protective equipment (PPE). R4 stated staff wear only gloves when completing R4's wound care. On 6/28/24 at 10:16 a.m., LPN-A stated he would look by a resident's door for a sign and precaution cart to know if a resident was on any type of EBP. LPN-A confirmed there was no sign or precaution cart by R3's door. On 6/28/2024 at 10:40 a.m., LPN-B stated there would be a sign and precaution cart by the door if a resident was on EBP. LPN-B confirmed there	F 880	Residents are reviewed for change in condition that may indicate a need for Enhanced Barrier Precaution daily during the Morning Clinical meeting. Monitoring: All new admissions will be screened during the pre-admission process for any infection Control Precautions, and placed on appropriate precautions. This will be audited by the DON or designee to assure Enhanced Barrier Precautions have been placed in guidance with CMS guidelines. These audits will be completed weekly for 4 weeks then monthly for 2 months. Random audits will be done of current to assure that Enhanced Barrier Precautions have been implemented if needed. Results of monitoring shall be reported at the facility QAPI meeting with ongoing frequency and duration to be determined through analysis and review of results. DON or designee are responsible for compliance. Completion Date: 8/12/2024	

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F 880	Continued From page 5 was no sign or precaution cart by R2's door. On 6/28/24 at 12:05 p.m., LPN-C stated she would get information about what enhanced barrier precautions a resident was on through report, and a sign should be near the resident door. LPN-C confirmed she did not receive any information about EBP for R4, and there were no sign or precaution cart by R4's door. On 6/28/24 at 2:49 p.m., the infection preventionist (IP) stated she was the person who would place a resident in any type of precautions. IP confirmed R2, R3, and R4 were not on EBP. IP stated if a resident is not placed on appropriate precautions there is risk of transmission of a multi drug resistant organism or other bacteria or virus to staff and other residents which could result in illness. On 6/28/24 at 3:30 p.m., the director of nursing (DON) stated the IP oversees placing residents in precautions. Staff are alerted to precautions by an order in the electronic health record and a sign and precaution cart by the resident's door. DON stated according to facility policy, any resident with a wound should be placed in EBP. DON confirmed R2, R3 and R4 should have been placed on EBP because of wounds but currently were not on any type of precautions. The Infection Prevention and Control Manual Transmission-Based Precautions policy dated 2023 directed EBP require gown and glove use for residents with a novel or targeted multi-drug resisted organisms (MDRO) or any resident with a wound or indwelling medical device during specific high-contact resident care activities. High-contact	F 880		

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F 880	Continued From page 6 resident care activities include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, and wound care. Clear signage should be posted on the door/wall outside the resident room. An isolation care with personal protective equipment (PPE) should be placed immediately outside the resident room. Alcohol-based hand rub should be provided both in and outside of the resident room. A trash receptacle placed inside the resident room for PPE removal. Communication and education should be provided to all staff caring for or entering the resident room as well as the resident and resident family/friends.	F 880		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 11, 2024

Administrator
Rochester Rehabilitation and Living Center
1900 Ballington Boulevard NW
Rochester, MN 55901

Re: State Nursing Home Licensing Orders
Event ID: 1GRH11

Dear Administrator:

The above facility was surveyed on June 27, 2024, through June 28, 2024, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

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

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

Please feel free to call me with any questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29822	A. BUILDING: _____ B. WING _____	C 06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHESTER REHABILITATION AND LIVING CENTER	1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 6/27/24 and 6/28/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order was	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29822	A. BUILDING: _____ B. WING _____	C 06/28/2024

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2 000	Continued From page 1 issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaint was reviewed: H56265054C (MN00104448, MN00104444, MN00104427) with a licensing order issued at 4658.0800 Subp. 1 Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be	2 000		

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2 000	Continued From page 2 corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement enhanced barrier precautions (EBP) for 3 of 3 (R2, R3, R4) residents reviewed for infection prevention. R2's Diagnoses List undated included open wound of abdominal wall. R2's admission Minimum Data Set (MDS) dated 6/23/24 indicated intact cognition with open lesions, and application of non-surgical dressings. R2's Physician's Orders dated 6/18/24 instructed wound care to abdominal wall wound. Remove old dressing. Clean with Vashe cleanser (a wound	21375	Completed	8/12/24

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21375	Continued From page 3 cleanser). Gently pat dry. Cover with Xeroform (a wound dressing). Cover with 4x4 Mepilex boarder (a wound dressing). Change daily. The orders lack direction on enhanced barrier precautions. On 6/27/2024 at 2:01 p.m., R2 stated facility staff wear only gloves when completing the daily dressing changes. R3's Diagnoses List undated included non-pressure chronic wound of left heel. R3's admission MDS dated 6/23/24 indicated intact cognition with pressure and non-pressure injuries and a surgical wound requiring wound care. R3's Physician's Orders dated 6/18/24 instructed to remove old dressing to left heel. Cleanse ulcer base with rough gauze and Vashe in circular motion. Moisten new rough gauze with Vashe. Apply gauze directly to the wound base and areas around the wound. Allow gauze to sit for 20 minutes. Remove gauze and pat dry. Apply a layer of barrier cream around the wound. Apply 1 layer of Derma Blue Transfer (a foam wound dressing) to the ulcer base. Cover with non-woven (soft) gauze and secure with cover roll stretch tape. Change dressing daily. R3's Physician's Orders dated 6/17/24 instructed change midline dressings 2 times daily with saline moistened Kerlix gauze wrap covered with an abdominal pad. The orders lack direction on enhanced barrier precautions. On 6/27/24 at 3:40 p.m., R3 stated the dressings on her wounds are changed as the provider	21375		

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21375	Continued From page 4 ordered. Staff washed hands and changed gloves frequently during dressing changes, but did not wear a gown. R4's Diagnoses List undated included orthopedic aftercare following surgical amputation. R4's admission MDS dated 6/10/24 indicated intact cognition with surgical wounds requiring wound care. R4's care plan dated 6/13/24 indicated a surgical incision to right foot and left below the knee amputation. R4's Physician's Orders dated 6/04/24 instructed moisten soft gauze with Vashe wound cleanser. Apply moistened product directly to wound base. Allow application to sit for at least 1-5 minutes. Remove application and exfoliate with rough gauze to removed devitalized tissue. May place gauze in-between toes and loosely wrap foot with Kerlix gauze wrap twice daily. The orders lacked information on enhanced barrier precautions. On 6/28/24 at 11:29 a.m., licensed practical nurse (LPN)-C was observed completing wound dressing change for R4 wearing gloves. LPN-C was not wearing any other personal protective equipment (PPE). R4 stated staff wear only gloves when completing R4's wound care. On 6/28/24 at 10:16 a.m., LPN-A stated he would look by a resident's door for a sign and precaution cart to know if a resident was on any type of EBP. LPN-A confirmed there was no sign or precaution cart by R3's door.	21375		

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21375	Continued From page 5 On 6/28/2024 at 10:40 a.m., LPN-B stated there would be a sign and precaution cart by the door if a resident was on EBP. LPN-B confirmed there was no sign or precaution cart by R2's door. On 6/28/24 at 12:05 p.m., LPN-C stated she would get information about what enhanced barrier precautions a resident was on through report, and a sign should be near the resident door. LPN-C confirmed she did not receive any information about EBP for R4, and there were no sign or precaution cart by R4's door. On 6/28/24 at 2:49 p.m., the infection preventionist (IP) stated she was the person who would place a resident in any type of precautions. IP confirmed R2, R3, and R4 were not on EBP. IP stated if a resident is not placed on appropriate precautions there is risk of transmission of a multi drug resistant organism or other bacteria or virus to staff and other residents which could result in illness. On 6/28/24 at 3:30 p.m., the director of nursing (DON) stated the IP oversees placing residents in precautions. Staff are alerted to precautions by an order in the electronic health record and a sign and precaution cart by the resident's door. DON stated according to facility policy, any resident with a wound should be placed in EBP. DON confirmed R2, R3 and R4 should have been placed on EBP because of wounds but currently were not on any type of precautions. The Infection Prevention and Control Manual Transmission-Based Precautions policy dated 2023 directed EBP require gown and glove use for residents with a novel or targeted multi-drug resisted organisms (MDRO) or any resident with a	21375		

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21375	Continued From page 6 wound or indwelling medical device during specific high-contact resident care activities. High-contact resident care activities include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, and wound care. Clear signage should be posted on the door/wall outside the resident room. An isolation care with personal protective equipment (PPE) should be placed immediately outside the resident room. Alcohol-based hand rub should be provided both in and outside of the resident room. A trash receptacle placed inside the resident room for PPE removal. Communication and education should be provided to all staff caring for or entering the resident room as well as the resident and resident family/friends. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review revise policies and procedures on infectioncontrol practices. The DON or designee could educate all staff on these policies and procedures. The DON or designee could audit infection control practices and take the results of those audits to the Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. Time Period for Correction: Twenty-one (21) days.	21375		