DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 7, 2022

Administrator
Essentia Health Grace Home
116 West Second Street
Graceville, MN 56240

RE: CCN: 245579
Cycle Start Date: July 7, 2022

Dear Administrator:

On July 22, 2022, we notified you a remedy was imposed. On September 1, 2022 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, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective September 5, 2022 be discontinued as of September 30, 2022. (42 CFR 488.417 (b))

In our letter of July 22, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 5, 2022 due to denial of payment for new admissions. Since your facility attained substantial compliance on September 30, 2022, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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October 7, 2022

Administrator
Essentia Health Grace Home
116 West Second Street
Graceville, MN 56240

Re: Reinspection Results
Event ID: MHH312

Dear Administrator:

On September 1, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on September 1, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Electronically delivered
July 22, 2022

Administrator
Essentia Health Grace Home
116 West Second Street
Graceville, MN 56240

RE: CCN: 245579
Cycle Start Date: July 7, 2022

Dear Administrator:

On July 7, 2022, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567, whereby significant 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 Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 5, 2022.

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

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 5, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 5, 2022.

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.

This Department is also recommending that CMS impose:

- Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by September 5, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Essentia Health Grace Home will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 5, 2022. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable 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:

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Rd., Suite 300
Fergus Falls, Mn. 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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 January 7, 2023 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:

Tamika.Brown@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag) i.e., the plan of correction, request for waivers, should be directed to:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245579	A. BUILDING _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH GRACE HOME	116 WEST SECOND STREET GRACEVILLE, MN 56240

(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
E 000	Initial Comments On 7/5/22, to 7/7/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 7/5/22, to 7/7/22, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be UNSUBSTANTIATED: H55793010C (MN00084497). 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	Infection Prevention & Control	F 880		8/26/22

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

Electronically Signed | 08/01/2022

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

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F 880 SS=D	Continued From page 1 CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a	F 880		

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F 880	Continued From page 2 resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure staff were using proper personal protective equipment (PPE) according to the Center for Disease Control (CDC) guidelines during the COVID-19 pandemic while providing care to 3 of 3 residents (R5, R8, R16). Finding include:	F 880	Grace Home strives to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of disease. All Residents have the potential to be affected by this practice. All residents are monitored for signs and symptoms of COVID-19 at least daily. RN-A and NA-A received 1:1 education	

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F 880	Continued From page 3 The CDC COVID Data Tracker indicated Big Stone County community transmission rate was listed as "high" on 7/7/22. Review of the CDC guidance dated 2/2/22, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic indicated staff working in health care facilities should utilize source control which included a well-fitting facemask. The guidance identified HCP working in counties with substantial or high transmission should also wear eye protection such as goggles or a face shield covering the front and sides of the face, during all resident encounters. On 7/7/22, at 7:19 a.m. registered nurse (RN)-A was observed at the medication cart in the hallway wearing a surgical mask, standard eye glasses and no eye protection over the glasses while she prepared medications. RN-A entered R5's room, stood within a few inches of R5, administered eye drops, insulin and oral medications. RN-A proceeded to face R5, leaned over, donned a gait belt around R5's waist and transferred R5 into a recliner in her room. On 7/7/22, at 7:50 a.m. RN-A entered R16's room wearing a surgical mask, standard eye glasses and no eye protection over the glasses. RN-A stood approximately a few inches away from R16 and administered his insulin. On 7/7/22, at 7:57 a.m. RN-A walked into the activity room continuing to wear a surgical mask, standard eye glasses with no eye protection over the glasses. RN-A walked to where R8 was seated, stood a few inches from R8 and administered his insulin.	F 880	regarding need to wear protective eyewear on 7/27/22. The Facility added visual signage was added to the employee screening stations and the timeclock to indicate current level of community transmission and required PPE. The Infection Control Program Policy & Procedure was reviewed and updated. All staff were provided education on the source control, transmission-based CDC community positivity rate and PPE grid 7/29-8/1/22. Education was provided in-person, virtual and via phone 1:1. The Infection Preventionist, Clinical Coordinator or designated personnel will complete visual observation of Protective Eyewear Audits weekly x 4 then monthly x 3 then quarterly to monitor staff compliance with PPE in accordance with community transmission rates and CDC guidance. All nursing staff will complete a competency for donning and doffing of PPE. Results of the audits will be reviewed at the QAPI meetings.	

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F 880	Continued From page 4 On 07/7/22, at 8:09 a.m. nursing assistant (NA)-A was observed in the hallway wearing a surgical mask, standard eye glasses with no eye protection over the glasses. NA-A had a hold of R5's gait belt which was around R5's waist and assisted R5 to walk into the dining room and assisted R5 to sit down in a chair. NA-A was noted to be within six inches of R5 while assisting her to walk. On 7/7/22, at 8:14 RN-A entered the dining room wearing a surgical mask, standard eye glasses with no eye protection over the glasses, stood a few inches away from R8 and administered his medications. During an interview on 7/7/22, at 8:16 a.m. RN-A confirmed she had not been wearing eye protection and believed she was not required to wear them. RN-A indicated she had been unaware of the community transmission rate. During an interview on 7/7/22, at 11:17 a.m. infection preventionist (IP) confirmed the community transmission rate was high and staff were expected to wear a surgical mask and eye protection in all resident areas. During an interview on 7/7/22, at 11:45 a.m. director of nursing (DON) confirmed the community transmission rate was high and stated staff were expected to wear surgical masks and eye protection in all resident areas.	F 880		

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F 880	Continued From page 5	F 880		

During an observation on 7/7/22, at 8:11 a.m. R16 was seated in a recliner in his room when nursing assistant (NA)-A entered R16's room, faced R16, leaned over him and donned a gait belt around his waist. NA-A, who wore a surgical mask, standard eye glasses, and no eye protection over her eye glasses assisted R16 into a standing position while holding onto the gait belt. NA-A, who was approximately 18 inches from R16, stood next to R16 while assisting him to walk to the dining room. NA-A assisted R16 to a table in the dining room and transferred him into

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F 880	Continued From page 6 a chair. During an interview on 7/7/22, at 8:17 a.m. NA- A indicated she was required to wear a surgical mask for source control for COVID-19. She indicated within the last few days, it was her understanding, she did not have to wear eye protection over her standard eye glasses. NA-A indicated she was unsure of where or who the direction came from. A facility policy updated 2/2/22, indicated it was the policy of the facility to minimize exposures to respiratory pathogens and promptly identify residents with clinical features and an epidemiological risk from COVID-19 and to adhere to federal and State/Local recommendations (which included, for example:Admissions,Visitation, Precautions, Standard, Contact, Droplet and/or Airborne precautions, included the use of eye protection, testing, and vaccination. EH facilities would have followed the CMS recommended core principles of infection prevention. The policy included COVID-19 PPE and source control grid dated 4/7/22, which had indicated during high community transmission rates a face mask and eye protection which included goggles or a face shield which covered the front and sides of the face should have been worn during all resident encounters.	F 880		
F 881 SS=D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 881		8/26/22

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F 881	Continued From page 7 a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to help reduce unnecessary antibiotic use and reduce potential drug resistance for 1 of 2 residents (R1) reviewed for urinary tract infection (UTI) as part of their antibiotic stewardship program. Findings include: The Center's for Disease Control and Prevention (CDC)'s Core Elements Of Antibiotic Stewardship For Nursing Homes, dated 2015, included recommendations to identify clinical situations which may be driving inappropriate use of antibiotics such as UTI prophylaxis and implement specific interventions to improve use. R1's annual Minimum Data Set (MDS) dated 1/11/22, identified R1 had moderate cognitive impairment and diagnoses which included: heart failure, diabetes mellitus, chronic kidney failure and dementia. The MDS indicated R1 required limited assistance with dressing, supervision with personal hygiene and was independent with toileting. The MDS identified R1 had frequent urinary incontinence and had received antibiotics seven of the last seven days. R1's quarterly MDS dated 6/27/22, identified R1 had moderate cognitive impairment, required limited assistance with dressing, personal hygiene and toileting and had frequent urinary	F 881	Grace Home strives to provide an Antibiotic Stewardship Program that includes antibiotic use protocols and a system to monitor antibiotic use. All residents receiving antibiotics have the potential to be affected by this practice. The antibiotic for R1 was discontinued on 7/7/22 and the care plan updated. 100% of all residents were reviewed for prophylactic antibiotic use. No other prophylactic antibiotic use was identified in any resident. The Watchful Waiting Policy, and the Antibiotic Stewardship policy were reviewed and updated. The Infection Control Logs were reviewed and updated. All staff and Medical Staff were provided with education 7/29-8/1/22 to review the Watchful Waiting Program and Antibiotic Stewardship Program. Education was provided in-person, virtual and via phone 1:1. The Infection Preventionist, Clinical Coordinator or designee will complete audits of Infection Control Logs weekly x 4, then monthly x 3 then quarterly. The consulting pharmacist drug reviews will be	

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	245579	A. BUILDING _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH GRACE HOME	116 WEST SECOND STREET GRACEVILLE, MN 56240

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F 881	Continued From page 8 incontinence. The MDS indicated R1 had received antibiotics seven of the last seven days. R1's annual Care Area Assessment (CAA) dated 1/17/22, identified R1 had a history of UTIs and took Bactrim (antibiotic) prophylactically (taken to prevent infection). R1's care plan revised 7/7/22, identified R1 was at risk for increasing alteration in elimination related to dementia, history of fluctuating levels of urinary incontinence and history of UTIs. The care plan identified R1 was started on a prophylactic antibiotic called Bactrim. R1's care plan indicated R1 was at risk for infection related to problems which included: chronic conditions, advanced age, type ll diabetes and history of recurrent UTIs and dementia. R1's care plan identified on 11/22/21, R1's primary care physician (PCP)-A reviewed prophylactic antibiotic use and changed the administration time to be given in the morning due to stomach upset. The care plan indicated on 1/6/22, the provider reviewed antibiotic use and wanted to continue prophylactic antibiotic as previously ordered for recurrent UTIs. Review of R1's physician order report signed 6/21/22, identified R1 orders included: -Bactrim tablet 400-80 milligram (mg) 1 tablet oral (by mouth) once a day, diagnoses: prophylactic antibiotic to help prevent UTI.- Review of R1's medication administration records (MARs) reviewed from 10/1/21, to 7/7/22, identified the following: -10/1/21, to 10/31/21, R1 received Bactrim daily.	F 881	reviewed monthly x 3 then quarterly to identify any resident who may be on a prophylactic antibiotic. Results of the audits will be reported to the QAPI program.	

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F 881	Continued From page 9 -11/1/21, to 12/31/21, R1's MAR did not identify Bactrim received. -1/01/22, to 1/31/22, R1 received Bactrim 1/6/22, to 1/31/22, daily. -2/1/22, to 2/28/22, R1 received Bactrim daily. -3/1/22, t 3/31/22, R1 received Bactrim daily. -4/1/22, to 4/30/22, R1 received Bactrim daily. -5/1/22, to 5/31/22, R1 received Bactrim daily. -6/1/22, to 6/30/22, R1 received Bactrim daily. -7/1/22, to 7/7/22, R1 received Bactrim daily 7/1/22, to 7/6/22. Review of R1's progress notes dated 10/1/21, to 7/7/22, identified the following: -10/3/21- R1's had 2 days Cipro (antibiotic) remaining and R1's urine was dark yellow. A request was made to PCP-A for an on-going, prophylactic antibiotic for aid in preventing R1's UTIs. -10/4/21-IDPT (interdisciplinary team) reviewed R1 for treatment of UTI. R1 received a new order from PCP-A for Bactrim 400/80 mg 1 tablet orally everyday times 90 days and R1's family member was informed. -10/6/21-R1 had completed her course of antibiotics for UTI, and had no symptoms. R1 was prescribed a prophylactic antibiotic to see if it helped with recurrent UTIs and would be evaluated and reviewed with PCP-A for effectiveness in approximately 90 days. -11/22/21, R1 was seen by PCP-A. R1 had intermittent complaints of stomach aches which occurred more often in the afternoon or evening hours. PCP-A suggested to change administration time of Bactrim to morning and	F 881		

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F 881	Continued From page 10 give with food. R1's Bactrim was changed to 8:00 a.m. and 10:30 a.m. R1's medical record lacked documentation that a risk verses benefit was completed with resident or family regarding R1's use of prophylactic antibiotic use. Review of R1's Pharmacist Drug Regimen Reviews from 10/22/21, to 7/5/22, identified the following: -10/25/21, R1 placed on antimicrobial prophylaxis related to recurrent urinary tract infection, will monitor. -12/10/21-no comments or recommendations related to R1's antimicrobial prophylaxis use of Bactrim -12/29/21, no comments or recommendations related to R1's antimicrobial prophylaxis use of Bactrim -1/29/22, the note identified R1 would continue antimicrobial prophylaxis at this time. -2/28/22, no comments or recommendations related to R1's antimicrobial prophylaxis use of Bactrim -3/31/22, no comments or recommendations related to R1's antimicrobial prophylaxis use of Bactrim -4/26/21, no comments or recommendations related to R1's antimicrobial prophylaxis use of Bactrim -6/2/22, no comments or recommendations related to R1's antimicrobial prophylaxis use of Bactrim -7/5/22, no comments or recommendations related to R1's antimicrobial prophylaxis use of Bactrim	F 881		

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F 881	Continued From page 11 R1's pharmacist drug regimen reviews lacked documentation of review of continued prophylactic antibiotic use. Review of R1' physician visit notes from 10/18/21, to 6/21/22, revealed the following: -10/18/21, R1 seen by PCP-A. R1's medications, treatments and care plan reviewed, no new orders. -11/22/21, R1 seen by PCP-A. R1's note revealed significant changes and concerns included afternoon stomachache. R1's medications, treatments and care plan reviewed, adjust time of the Bactrim. -12/23/21, R1 seen by PCP-A. R1's medications, treatments and care plan reviewed, no new orders. -1/24/22, R1 seen by PCP-A. R1's medications, treatments and care plan reviewed, no new orders. -2/17/22, R1 seen by PCP-A. R1's medications, treatments and care plan reviewed, no new orders. -3/17/22, R1 seen by PCP-A. R1's medications, treatments and care plan reviewed, would try some mild antianxiety medication. -4/13/22, R1 seen by medical director (MD)-A. R1's medications, treatments and care plan reviewed, no new orders. -5/25/22, R1 seen by MD-A. R1's medications, treatments and care plan reviewed, no new orders. -6/21/22, R1 seen by MD-A. R1's medications, treatments and care plan reviewed, no new orders. The notes lacked documentation the risks and benefits of long term antibiotic use had been	F 881		

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F 881	Continued From page 12 reviewed and discussed. During an interview on 7/6/22, at 12:57 p.m. registered nurse (RN)-A indicated R1 had a history of recurrent UTIs. RN-A stated their usual practice was to complete watchful waiting (a time period to monitor resident's symptoms prior to antibiotic use to determine if antibiotic use would be appropriate) for 72 hours to determine if at least 3 symptoms were present before a resident was placed on an antibiotic. RN-A indicated she believed R1 was still receiving prophylactic antibiotics. During a telephone interview on 7/6/22, at 1:26 p.m. pharmacy consultant (PC)-A stated she attended the facility Quality Assurance and Performance Improvement (QAPI) meetings and they reviewed the facility antibiotic stewardship program during those meetings. PC-A indicated prophylactic antibiotic use was appropriate if someone had repeated infections which were severe, they had sepsis (life-threatening response to an infection) or had a hospital stay. PC-A stated her usual practice was to ask the provider again if the antibiotic order was appropriate however confirmed she had not contacted the provider about R1's antibiotic order. PC-A stated she planned to ask about R1's prophylactic antibiotic use a year from the start date which would be October 2022. At 2:35 p.m. during a follow up telephone interview PC-A indicated R1 had repeated UTIs the previous year and Bactrim had been initially prescribed in October 2021. PC-A stated infection preventionist (IP)-A had been tracking antimicrobial (agent that kills microorganisms, including antibiotics) use monthly, and PC-A had	F 881		

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F 881	Continued From page 13	F 881		

recommended to the facility to track the use every six months in order to provide more data to the physician. PC-A stated IP-A had evaluated R1's Bactrim order in January 2022. PC-A confirmed she had not made recommendations to R1's primary care physician to discontinue prophylactic antibiotic use prior to today. PC-A confirmed she would not recommend a facility nurse to request prophylactic antimicrobial medication use for any resident. PC-A confirmed there was potential harm risks with use of antibiotics prophylactically, which included increased resistance to antibiotics, and if an actual infection occurred, current antimicrobial treatment would not fight the infection.

During an interview on 7/7/22, at 10:03 a.m. MD-A stated he had recently assumed the role of R1's primary care provider and had seen R1 on rounds. MD-A indicated he believed R1 had been placed on Bactrim prophylactically for reoccurring UTIs however would have to check R1's record. MD-A confirmed it was not the facility's usual practice to order prophylactic antibiotics however believed the benefits may have outweighed the risks for R1. MD-A indicated he could not recall if R1's antibiotic use had been discussed at QAPI meetings. MD-A stated it was a rare incident for R1 to continue to be on Bactrim. MD-A indicated risks of prolonged use of antibiotics could affect kidney function, however if the resident had no UTIs and tolerated the antibiotic, he usually did not change the order.

During an interview on 7/6/22, at 2:59 p.m. infection preventionist (IP)-A indicated the facility had an antibiotic stewardship program in place. IP-A stated she could not recall if she had discussed concerns related to R1's continued

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F 881	Continued From page 14 Bactrim prophylactic use with PCP-A. IP-A stated the usual facility practice was to review prophylactic antibiotic use every six months, because if reviewed monthly, they felt they would not have as much data to present to the physician. IP-A indicated PC-A's role was to consult and provide guidance to their antibiotic stewardship program. IP-A confirmed risks of prolonged prophylactic antibiotic use included antibiotic resistance and clostridium difficile (an infectious bacterium that causes severe diarrhea and inflammation of the colon-C-Diff). During a follow-up interview on 7/7/22, at 10:42 a.m. IP-A indicated she had been informed by PC-A at QAPI meetings the CDC recommended antibiotic prophylactic use should be reviewed every six months. IP-A stated she had not reviewed the actual CDC recommendation to confirm the accuracy of the every six month review. IP-A confirmed she had never discussed risks verses benefits of prolonged antibiotic use with R1 or R1's family. Review of QAPI Meeting minutes dated 4/15/21, identified a discussion related to infection prevention and antibiotic stewardship was to address prophylactic medications every six months verses (vs) one month vs CDC recommendations. To obtain more information (info)/data in relations to the prophylactic. Review of QAPI Meeting minutes dated 7/16/21, identified one resident was on a prophylactic antibiotic for UTI prevention the past quarter. The minutes indicated the resident had still been currently taking and recommended the provider address prophylactic medications every six months vs one month.	F 881		

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F 881	Continued From page 15 During an interview on 7/7/22, at 11:52 a.m. director of nursing (DON) confirmed R1 received prophylactic antibiotics and the usual facility practice was to review prophylactic antibiotic use every six months. The DON indicated she was not aware how often the review was expected in the facility policy. DON stated it was best practice not to use prophylactic antibiotics, due to the risk for a super bug infection and the possibility the resident could develop an infection that became resistant to treatment. The facility policy titled Policy For Antibiotic Stewardship Program reviewed 9/2021, identified widespread use of antibiotics had resulted in an alarming increase in antibiotic-resistant infections and increased risk of Clostridium difficile infection and adverse drug reactions. The policy identified the facility would review infections and monitor antibiotic usage patterns on a quarterly basis. The policy further identified that the antibiotic stewardship team (AST) would identify actions to directly impact inappropriate antibiotic use for specific syndromes and prophylactic indications. The policy identified education would be provided for clinical staff, as well as residents and their families on appropriate use of antibiotics.	F 881		

Electronically delivered
July 22, 2022

Administrator
Essentia Health Grace Home
116 West Second Street
Graceville, MN 56240

Re: State Nursing Home Licensing Orders
Event ID: MHH311

Dear Administrator:

The above facility was surveyed on July 5, 2022 through July 7, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Rd., Suite 300
Fergus Falls, Mn. 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245420	A. BUILDING **NN - LAKEWOOD NURSING HOME** B. WING _____	**07/19/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD HEALTH SYSTEM	**401 PRAIRIE AVENUE NORTHEAST STAPLES, MN 56479**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 07/19/2022. At the time of this survey, Lakewood Health System Nursing Home was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/09/2022

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Lakewood Health Systems Care Center is a 1-story building with a partial basement. The building was constructed in 1976, was determined to be of Type II (000) construction. A dining room addition was constructed in 1992 to the south east, is one story, without a basement and was determined to be Type II (000) construction. The 1965 old hospital building, which is separated from the 1976 building with a 2- hour fire barrier, has a partial basement, is a Type II (000) construction, has been remodeled	K 000		

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LAKEWOOD HEALTH SYSTEM	**401 PRAIRIE AVENUE NORTHEAST STAPLES, MN 56479**

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K 000	Continued From page 2 and part of it is part of the Lakewood Health System Care Center. The building is fully sprinkler protected and has a manual fire alarm system with smoke detection in the sleeping rooms, corridors and spaces open to the corridors that are monitored for automatic fire department notification. The facility has a capacity of 87 beds and had a census of 76 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results.	K 914		8/9/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245420	A. BUILDING **NN - LAKEWOOD NURSING HOME** B. WING _____	**07/19/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 914	Continued From page 3 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect electrical outlets on an annual basis per NFPA 99 (2012 edition), Health Care Facilities Code, sections 6.3.3.2, 6.3.4.1.1, and 6.3.4.1.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/19/2022, between 12:00 PM to 2:00 PM, a review of the available documentation revealed that records could not be provided to show that an annual electrical outlet inspection had occurred since 2020. An interview with the Maintenance Director verified this finding at the time of discovery.	K 914	Electrical inspection completed by Electrician on 8/5/22, without concerns. We had a changeover in Electricians, where one went on leave and then wasn't able to return. The new Electrician has now taken over and has set up a reminder system to avoid this from occurring in the future. This didn't effect any resident care. It was an isolated incident.	

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	00762	A. BUILDING: _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH GRACE HOME	116 WEST SECOND STREET GRACEVILLE, MN 56240

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 7/5/22, to 7/7/22, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). A complaint investigation was also conducted. Your facility was found NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your	2 000		

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2 000	Continued From page 1 electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaint was found to be UNSUBSTANTIATED: H55793010C (MN00084497). 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 surveyors 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000		

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2 000	Continued From page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure staff were using proper personal protective equipment (PPE) according to the Center for Disease Control (CDC) guidelines during the COVID-19 pandemic while providing care to 3 of 3 residents (R5, R8, R16). Finding include: The CDC COVID Data Tracker indicated Big Stone County community transmission rate was listed as "high" on 7/7/22. Review of the CDC guidance dated 2/2/22, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic indicated staff working in health care facilities should utilize	21375	Corrected	8/26/22

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21375	Continued From page 3 source control which included a well-fitting facemask. The guidance identified HCP working in counties with substantial or high transmission should also wear eye protection such as goggles or a face shield covering the front and sides of the face, during all resident encounters. On 7/7/22, at 7:19 a.m. registered nurse (RN)-A was observed at the medication cart in the hallway wearing a surgical mask, standard eye glasses and no eye protection over the glasses while she prepared medications. RN-A entered R5's room, stood within a few inches of R5, administered eye drops, insulin and oral medications. RN-A proceeded to face R5, leaned over, donned a gait belt around R5's waist and transferred R5 into a recliner in her room. On 7/7/22, at 7:50 a.m. RN-A entered R16's room wearing a surgical mask, standard eye glasses and no eye protection over the glasses. RN-A stood approximately a few inches away from R16 and administered his insulin. On 7/7/22, at 7:57 a.m. RN-A walked into the activity room continuing to wear a surgical mask, standard eye glasses with no eye protection over the glasses. RN-A walked to where R8 was seated, stood a few inches from R8 and administered his insulin. On 07/7/22, at 8:09 a.m. nursing assistant (NA)-A was observed in the hallway wearing a surgical mask, standard eye glasses with no eye protection over the glasses. NA-A had a hold of R5's gait belt which was around R5's waist and assisted R5 to walk into the dining room and assisted R5 to sit down in a chair. NA-A was noted to be within six inches of R5 while assisting her to walk.	21375		

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21375	Continued From page 4 On 7/7/22, at 8:14 RN-A entered the dining room wearing a surgical mask, standard eye glasses with no eye protection over the glasses, stood a few inches away from R8 and administered his medications. During an interview on 7/7/22, at 8:16 a.m. RN-A confirmed she had not been wearing eye protection and believed she was not required to wear them. RN-A indicated she had been unaware of the community transmission rate. During an interview on 7/7/22, at 11:17 a.m. infection preventionist (IP) confirmed the community transmission rate was high and staff were expected to wear a surgical mask and eye protection in all resident areas. During an interview on 7/7/22, at 11:45 a.m. director of nursing (DON) confirmed the community transmission rate was high and stated staff were expected to wear surgical masks and eye protection in all resident areas. During an observation on 7/7/22, at 8:11 a.m. R16 was seated in a recliner in his room when nursing assistant (NA)-A entered R16's room, faced R16, leaned over him and donned a gait belt around his waist. NA-A, who wore a surgical mask, standard eye glasses, and no eye protection over her eye glasses assisted R16 into a standing position while holding onto the gait belt. NA-A, who was approximately 18 inches from R16, stood next to R16 while assisting him to walk to the dining room. NA-A assisted R16 to a table in the dining room and transferred him into a chair. During an interview on 7/7/22, at 8:17 a.m. NA- A	21375		

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21375	Continued From page 5 indicated she was required to wear a surgical mask for source control for COVID-19. She indicated within the last few days, it was her understanding, she did not have to wear eye protection over her standard eye glasses. NA-A indicated she was unsure of where or who the direction came from. A facility policy updated 2/2/22, indicated it was the policy of the facility to minimize exposures to respiratory pathogens and promptly identify residents with clinical features and an epidemiological risk from COVID-19 and to adhere to federal and State/Local recommendations (which included, for example:Admissions,Visitation, Precautions, Standard, Contact, Droplet and/or Airborne precautions, included the use of eye protection, testing, and vaccination. EH facilities would have followed the CMS recommended core principles of infection prevention. The policy included COVID-19 PPE and source control grid dated 4/7/22, which had indicated during high community transmission rates a face mask and eye protection which included goggles or a face shield which covered the front and sides of the face should have been worn during all resident encounters. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review infection control practices during personal care and educate staff. The director of nursing or designee, could conduct random audits of the delivery of care to ensure appropriate care and services are implemented in order to reduce the risk of infection. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		

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