DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 1, 2019

Administrator
Ebenezer Ridges Geriatric Care Center
13820 Community Drive
Burnsville, MN 55337

RE: Project Number H5213037C

Dear Administrator:

On March 22, 2019, the Minnesota Department of Health, completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance. Based on our visit, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

Electronically delivered
February 16, 2019

Administrator
Ebenezer Ridges Geriatric Care Center
13820 Community Drive
Burnsville, MN 55337

RE: Project Number H5213037C

Dear Administrator:

On January 28, 2019, an abbreviated standard 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 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.

OPPORTUNITY TO CORRECT - DATE OF CORRECTION

The date by which the deficiencies must be corrected to avoid imposition of remedies is March 9, 2019.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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 a 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:

- Discretionary denial of payment for new Medicare and Medicaid admissions (42 CFR 88.417 (a));

- Civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the 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" tag), i.e., the plan of correction should be directed to:

Eva Loch, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: eva.loch@state.mn.us
Phone: (651) 201-3792
Fax: (651) 215-9697

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 April 28, 2019 (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 July 28, 2019 (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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@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
	245213	A. BUILDING _____ B. WING _____	C 01/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EBENEZER RIDGES GERIATRIC CARE CENTER	**13820 COMMUNITY DRIVE BURNSVILLE, MN 55337**

(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 1/28/19, an abbreviated standard survey was conducted to investigate complaint H5213037C. The facility is not in compliance with 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. During the survey complaint H5213037C was found to be substantiated at F880. The facility is enrolled in the electronic Plan of Correction (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 you acknowledge receipt of the electronic documents.	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. 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	F 880		3/8/19

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

Electronically Signed | 02/22/2019

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

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F 880	Continued From page 2 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 infection control procedures related to handwashing and glove usage for 2 of 2 residents (R1, R2) observed for personal cares. Findings include: R1 On 1/28/19, at 2:41 p.m. R1 was observed lying on her back on her bed. Nursing Assistant (NA)-A with gloves on rolled R1 to her right side and with eight sani wipes cleaned off stool from R1's bottom and tossed the wipes into the wastebasket. NA-A with assist of the registered nurse (RN)-A rolled R1 on to her back and NA-A proceeded to take three wipes and wiped in front peri area and down between upper legs and then toss into waste basket. NA-A and RN-A removed the soiled brief and applied new brief and taped up the brief tabs. With same gloves on NA-A touched wound vac tubing, pulled R1's sweater down, pulled up pants, pulled up sheet, blanket and adjusted R1's pillow. When asked NA-A stated she had not taken off her soiled gloves and had kept the same pair of gloves on through the entire procedure. NA-A stated, "I knew to [take off my gloves], but did not." NA-A stated, "I have contaminated a lot of surfaces." At 3:00 p.m. RN-A stated NA-A should have	F 880	• R1 and R2 care plan reviewed and remain current. • NA-A received re-education and a corrective action for not following facility policy regarding hand hygiene. • R1 and R2 rooms and personal equipment were sanitized. • Education will be conducted with nursing staff regarding proper hand hygiene and gloving. • Random infection control audits will be conducted daily to ensure; proper hand hygiene is performed prior to, during and after resident cares and before and after glove application. Findings of audits reported to the QA committee. The QA committee will determine the frequency and duration of audits. • The Director of Nursing or Designee will be responsible for ongoing compliance.	

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F 880	Continued From page 3	F 880		

removed her gloves after wiping off R1's stool and should have washed her hands before applying a clean brief. RN-A stated, "handwashing is expected with donning and doffing [washing hands before applying gloves and washing hands after removing gloves]."

R2
On 1/28/19, at 4:57 p.m. NA-A and NA-B transferred R2 to lying on the bed. NA-A and NA-B untaped and pulled down R2's brief which was soiled heavily with bowel movement and wet with urine with strong odor. With gloves on NA-A wiped the front of R2's peri area with three wipes and then discarded them into a wastebasket. NA-A and NA-B rolled R2 to her side and NA-B with gloves on wiped R2's buttocks covered with stool with 10 wipes and tossed them into the wastebasket. NA-B then proceeded to go to the bathroom and wash his hands and donn a clean set of gloves. NA-A stood holding R2's hip with her same gloves on. NA-A and NA-B then applied a clean brief, NA-A pulled down R2's nightgown with out removing the contaminated gloves. NA-A stated she should have taken off her gloves before touching the clean brief and R2's nightgown as she had wiped the front of R2's peri area. NA-A stated, "I thought of asking him [NA-B] for a new pair of gloves when he was in the bathroom, but didn't."

At 6:05 p.m. director of nursing (DON) stated her expectation was staff were to wash front to back, remove gloves and provide hand hygiene before touching a new brief or any other clean surface. DON stated she had re-educated staff on hand hygiene and had been completing ongoing audits. DON stated hand hygiene practice should be done every shift, "that is our expectation, we have

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F 880	Continued From page 4 worked hard on it." The facility's Hand Hygiene policy dated 11/18, indicated, " ... Change gloves during patient care if the hands will move from a contaminated body-site [e.g., perineal area) to a clean body-site ..."	F 880		

Electronically delivered
February 16, 2019

Administrator
Ebenezer Ridges Geriatric Care Center
13820 Community Drive
Burnsville, MN 55337

Re: State Nursing Home Licensing Orders - Project Number H5213037C

Dear Administrator:

The above facility was surveyed on January 28, 2019 through January 28, 2019 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . 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:

Eva Loch, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: eva.loch@state.mn.us
Phone: (651) 201-3792
Fax: (651) 215-9697

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 note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division

Telephone: 651-201-4118 Fax: 651-215-9697
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	00756	A. BUILDING: _____ B. WING _____	C 01/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EBENEZER RIDGES GERIATRIC CARE CENTE	13820 COMMUNITY DRIVE BURNSVILLE, MN 55337

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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: An abbreviated standard survey was conducted on 1/28/19, to investigate complaint H5213037C. During the survey the complaint H5213037C was found to be substantiated. The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is	2 000		

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2 000	Continued From page 1 not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	2 000		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by:	21390		3/8/19

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21390	Continued From page 2 Based on observation, interview and document review, the facility failed to implement infection control procedures related to handwashing and glove usage for 2 of 2 residents (R1, R2) observed for personal cares. Findings include: R1 On 1/28/19, at 2:41 p.m. R1 was observed lying on her back on her bed. Nursing Assistant (NA)-A with gloves on rolled R1 to her right side and with eight sani wipes cleaned off stool from R1's bottom and tossed the wipes into the wastebasket. NA-A with assist of the registered nurse (RN)-A rolled R1 on to her back and NA-A proceeded to take three wipes and wiped in front peri area and down between upper legs and then toss into waste basket. NA-A and RN-A removed the soiled brief and applied new brief and taped up the brief tabs. With same gloves on NA-A touched wound vac tubing, pulled R1's sweater down, pulled up pants, pulled up sheet, blanket and adjusted R1's pillow. When asked NA-A stated she had not taken off her soiled gloves and had kept the same pair of gloves on through the entire procedure. NA-A stated, "I knew to [take off my gloves], but did not." NA-A stated, "I have contaminated a lot of surfaces." At 3:00 p.m. RN-A stated NA-A should have removed her gloves after wiping off R1's stool and should have washed her hands before applying a clean brief. RN-A stated, "handwashing is expected with donning and doffing [washing hands before applying gloves and washing hands after removing gloves]." R2 On 1/28/19, at 4:57 p.m. NA-A and NA-B	21390	• R1 and R2 care plan reviewed and remain current. • NA-A received re-education and a corrective action for not following facility policy regarding hand hygiene • R1 and R2 rooms and personal equipment were sanitized. • Education will be conducted with nursing staff regarding proper hand hygiene and gloving. • Random infection control audits will be conducted daily to ensure; proper hand hygiene is performed prior to, during and after resident cares and before and after glove application. Findings of audits reported to the QA committee. The QA committee will determine the frequency and duration of audits. • The Director of Nursing or Designee will be responsible for ongoing compliance.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EBENEZER RIDGES GERIATRIC CARE CENTE	13820 COMMUNITY DRIVE BURNSVILLE, MN 55337

(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
21390	Continued From page 3	21390		

transferred R2 to lying on the bed. NA-A and NA-B untaped and pulled down R2's brief which was soiled heavily with bowel movement and wet with urine with strong odor. With gloves on NA-A wiped the front of R2's peri area with three wipes and then discarded them into a wastebasket. NA-A and NA-B rolled R2 to her side and NA-B with gloves on wiped R2's buttocks covered with stool with 10 wipes and tossed them into the wastebasket. NA-B then proceeded to go to the bathroom and wash his hands and donn a clean set of gloves. NA-A stood holding R2's hip with her same gloves on. NA-A and NA-B then applied a clean brief, NA-A pulled down R2's nightgown with out removing the contaminated gloves. NA-A stated she should have taken off her gloves before touching the clean brief and R2's nightgown as she had wiped the front of R2's peri area. NA-A stated, "I thought of asking him [NA-B] for a new pair of gloves when he was in the bathroom, but didn't."

At 6:05 p.m. director of nursing (DON) stated her expectation was staff were to wash front to back, remove gloves and provide hand hygiene before touching a new brief or any other clean surface. DON stated she had re-educated staff on hand hygiene and had been completing ongoing audits. DON stated hand hygiene practice should be done every shift, "that is our expectation, we have worked hard on it."

The facility's Hand Hygiene policy dated 11/18, indicated, " ... Change gloves during patient care if the hands will move from a contaminated body-site [e.g., perineal area) to a clean body-site ..."

SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could assure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00756	A. BUILDING: _____ B. WING _____	C 01/28/2019

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21390	Continued From page 4 that a system wide infection control program is developed, implemented, monitored, staff trained, and precautions taken to assure appropriate infection control techniques are performed to prevent and/or minimize the spread of infections. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		