STATE LICENSING COMPLIANCE REPORT

Report #: HL307385523C

Date Concluded: September 20, 2023

Name, Address, and County of Facility Investigated:
Edgewood Virginia Senior Living
705 17th Street North
Virginia, MN 55792
St. Louis County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name: Rhylee Gilb, RN
Special Investigator

The Minnesota Department of Health conducted a complaint investigation to determine compliance with state laws and rules governing the provision of care under Minnesota Statutes, Chapter 144G. The purpose of this complaint investigation was to review if facility policies and practices comply with applicable laws and rules. No maltreatment under Minnesota Statutes, Chapter 626 was alleged.

To view a copy of the correction orders, if any, please visit: https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html, or call 651-201-4201 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached state form.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30738	A. BUILDING: _____ B. WING _____	C 09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD VIRGINIA I SENIOR LIV	705 17TH STREET NORTH VIRGINIA, MN 55792

(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
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL307385523C On September 19, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 167 residents receiving services under the provider's Assisted Living with Dementia Care license. The following immediate correction orders are issued for #HL307385523C, tag identification 0250, 0510, 2340.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is 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. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 250 SS=I	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a	0 250		

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0 250	Continued From page 1 result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under	0 250		

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0 250	Continued From page 2 section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record reviewed, the licensee provided inaccurate information to Minnesota Department of Health (MDH) personnel and performed acts detrimental to the health and welfare of residents due to lack of implementation of the Center for Disease Control (CDC) and MDH recommendations to contain a highly contagious bacterial infection. This practice impacted all 167 residents, staff and local community. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The CDC webpage titled, Healthcare Facilities:	0 250		

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0 250	Continued From page 3 Information about CRE (Carbapenemase-resistant Enterobacterales), reviewed November 4, 2019, indicated CRE infections are a serious threat to public health. Infections with CRE are difficult to treat and have been associated with mortality rates of up to 50% for hospitalized patients. Due to the movement of patients throughout the healthcare system, if CRE are a problem in one facility, then typically they are a problem in other facilities in the region as well. The CDC indicated when transferring a patient or resident, staff are required to notify the receiving facility about infection or colonization with CRE and other multidrug-resistant organisms. The CDC Interim guidance for a Public Health Response to Contain Novel or Targeted Multidrug-resistant Organisms (MDRO's), updated December 2022, indicated initial response by the facility included identity affected patients (residents) by colonization screening. R1 resided in the memory care unit. R1's progress note dated November 18, 2022, indicated the hospice aide identified a new sacrum wound and reported to nursing. Nursing implemented weekly dressing changes. On January 1, 2023, a urine analysis indicated positive for the bacteria E. Coli. On January 3, 2023, written by licensed practical nurse (LPN)-D, R1's urine culture showed ESBL resistant organism and organism was in critical levels. She also developed a new wound to her right lower leg. LPN-D updated hospice, the physician and registered nurse (RN)-B. The MDH lab report dated January 9, 2023, indicated Carbapenemase detected, and positive for NDM (New Dehli Metallo-beta-lactamase).	0 250		

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0 250	Continued From page 4 An MDH epidemiology email date January 11, 2023, indicated due to movement of residents in the memory care unit, colonization screening of NDM should be considered. The licensee nurse manager, RN-B said the staff use gloves, but not gowns while providing care to the residents with these types of organisms. RN-B reported R1's sacrum wound was new and developed January 5, 2023. An MDH epidemiology email dated January 12, 2023, indicated RN-B was updated about the precautions to include glove and gown use. MDH infection control preventionist conducted an onsite visit on February 10, 2023 from 10:00 a.m. to 12:00 p.m. The agenda included training and education on the organisms of concern, training, auditing, hand hygiene, transmission-based precautions, and environmental services (cleaning). The licensee was provided an Infection Control Assessment and Response (ICAR) program action plan specific for the licensee. The ICAR action plan included implementing a process for all transfers and admissions to inform the receiving facility of the infection and colonization and transmission based precautions for any residents transferred out of the facility, screening of all new admissions, develop a process for tracking all employee ill calls, tracking ill residents, develop an outbreak policy and procedure, review disinfection guidelines, staff training on PPE use and review CDC enhanced barrier precautions resources. RN-B and RN-A, the director of nursing, participated in the ICAR visit. R2's resided in the assisted living unit. R2's progress note dated July 10, 2023, indicated R2	0 250		

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0 250	Continued From page 5 presented more confused than normal and a urine analysis was obtained. On July 13, 2023, R2's urine culture was positive and sent the specimen to the MDH lab. R2's lab report dated July 13, 2023, indicated the urine culture was positive for ESBL bacteria, possible carbapenemase producer and sent to MDH lab for testing. R2's progress note dated July 17, 2023, indicated R2 stated an antibiotic to treat ESBL and "infection control complete." On August 11, 2023, written by RN-A, indicated there was no symptoms related to ESBL infection, R2 remained on enhanced barrier precautions. R3 resided in the assisted living unit. R3's progress note date August 30, 2023, indicated R3 was completing short term rehabilitation at a skilled nursing facility (SNF). The SNF reported R3's status and indicated R3 was positive for ESBL, was in a private room and RN-C wrote the SNF staff used gloves and eye protection when handling his urine. On September 7, 2023, R3 readmitted to the licensee with a suprapubic catheter and wound to his right lower leg. MDH conducted a phone conference on September 1, 2023, with the licensee leadership. MDH provided again education on NDM and recommendation to screening the residents per CDC recommendation. Licensee leadership indicated they needed to discuss an action plan. Additional resources emailed to the licensee by MDH epidemiology included CDC containment strategy, CRE technical information, antibiotic threats report and interim guidance for public health response to contain Multidrug-resistant Organisms (MDRO's).	0 250		

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0 250	Continued From page 6 The CDC Interim guidance for a Public Health Response to Contain Novel or Targeted Multidrug-resistant Organisms (MDRO's), updated December 2022, indicated initial response by the facility included identity affected patients (residents) by colonization screening. MDH emailed the licensee on September 5, 2023, to inquire if they were ready to move forward with testing. The licensee indicated they were meeting on September 8, 2023, to discuss. The licensee failed to communicate further with MDH between September 8 through September 18, 2023. During an interview on September 19, 2023, at 10:45 a.m., MDH epidemiology stated the facility was made aware of the second NDM case of R2 through direct contact from epidemiology on July 19, 2023 with the facility staff. During an onsite visit on September 19, 2023, at 10:20 a.m., RN-B stated she was not sure who had NDM in memory care, but the only person on precautions was R1 who died in January [2023]. RN-B stated she knew R2 was on precautions in assisted living, but RN-A would know more. At 10:25 a.m., RN-A stated they did not know about R1's positive lab until after she died. RN-A stated no residents have been made aware of NDM and positive CRE within the building and no testing of other residents has been completed. During an interview on September 19, 2023, at 1:02 p.m., RN-A stated she did not inform the SNF facility about CRE/NDM present in the facility when R3 transported out of the facility. RN-A stated she did not know what NDM was.	0 250		

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0 250	Continued From page 7 The investigator provided the acronym description and reminded RN-A she had been educated by MDH epidemiology. TIME PERIOD OF CORRECTION: IMMEDIATE	0 250		
0 510 SS=I	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to implement enhanced barrier precautions for two of two positive Multidrug-resistant Organisms (MDRO's) and Carbapenemase-resistant Enterobacterales (CRE) residents (R1, R3), which impacted spread to one confirmed resident (R2), potentially all 166 other residents and other community facilities. In addition, staff failed to perform adequate hand hygiene and provide standard precautions for other residents. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death,	0 510		

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0 510	Continued From page 8 or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The Center for Disease Control (CDC) webpage titled, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), updated July 12, 2022, indicated Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. Standard Precautions, which are a group of infection prevention practices, continue to apply to the care of all residents, regardless of suspected or confirmed infection or colonization status. The licensee memory care unit and assisted living unit are separate on the same campus. The two buildings do not connect and are separated by a parking lot. FAILURE TO IMPLEMENT ENHANCED BARRIER PRECAUTIONS R1's medical record was reviewed. R1 resided in the memory care unit. R1's service plan dated November 1, 2022, indicated R1 required assistance with all activities of daily living (ADLs), medication administration and assistance with transfers. R1's progress note dated November 18, 2022, indicated the hospice aide identified a new	0 510		

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0 510	Continued From page 9 sacrum wound and reported to nursing. Nursing implemented weekly dressing changes. On December 8, 2022, R1 developed an infection, cellulitis, and required an antibiotic. On January 1, 2023, a urine analysis indicated positive for the bacteria E. Coli. On January 3, 2023, written by licensed practical nurse (LPN)-D, R1's urine culture showed ESBL resistant organism and organism was in critical levels. She also developed a new wound to her right lower leg. LPN-D updated hospice, the physician and registered nurse (RN)-B. The Minnesota Department of Health (MDH) lab report dated January 9, 2023, indicated Carbapenemase detected, and positive for NDM (New Dehli Metallo-beta-lactamase). The CDC Tracking CRE in the United States January 2, 2020, New Delhi Metallo-beta-lactamase (NDM): A less common carbapenemase in the United States but concerning because it can be resistant to even more antibiotics than a more common CRE. An MDH epidemiology email date January 11, 2023, indicated due to movement of residents in the memory care unit, colonization screening of NDM should be considered. The licensee nurse manager, RN-B said the staff use gloves, but not gowns while providing care to the residents with these types of organisms. MDH infection control preventionist indicated the staff should be using personal protective equipment (PPE) to include gowns and should have those readily available. The plan was to communicate appropriate PPE use with the facility staff and plan an infection control onsite visit to the facility. An MDH epidemiology email dated January 12,	0 510		

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0 510	Continued From page 10 2023, indicated RN-B was updated about the precautions to include glove and gown use. RN-B indicated R1 had been using a communal shower and at this point in time will complete bathing in her own room. R1's progress notes dated January 13, 2023, indicated R1 died. R1's record lacked documentation enhanced barrier precautions were implemented. MDH infection control preventionist conducted an onsite visit on February 10, 2023 from 10:00 a.m. to 12:00 p.m. The agenda included training and education on the organisms of concern, training, auditing, hand hygiene, transmission-based precautions, and environmental services (cleaning). The licensee was provided an Infection Control Assessment and Response (ICAR) program action plan specific for the licensee. The ICAR action plan included implementing a process for all transfers and admissions to inform the receiving facility of the infection and colonization and transmission based precautions for any residents transferred out of the facility, screening of all new admissions, develop a process for tracking all employee ill calls, tracking ill residents, develop an outbreak policy and procedure, review disinfection guidelines, staff training on PPE use and review CDC enhanced barrier precautions resources. RN-B and RN-A, the director of nursing, participated in the ICAR visit. R2's medical record was reviewed. R2 resided in the assisted living unit. R2's service plan dated May 31, 2022, indicated R2 required assistance with all ADLs, transfer assistance, escorts and medication administration.	0 510		

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0 510	Continued From page 11 R2's progress note dated July 10, 2023, indicated R2 presented more confused than normal and a urine analysis was obtained. On July 13, 2023, R2's urine culture was positive and sent the specimen to the MDH lab. R2's lab report dated July 13, 2023, indicated the urine culture was positive for ESBL bacteria, possible carbapenemase producer and sent to MDH lab for testing. R2's progress note dated July 17, 2023, indicated R2 stated an antibiotic to treat ESBL and "infection control complete." On August 11, 2023, written by RN-A, indicated there was no symptoms related to ESBL infection, R2 remained on enhanced barrier precautions. R3's medical record was reviewed. R3's service plan date September 8, 2023, indicated R3 required assistance with catheter cares, wound dressing changes, dressing, showers, transfers and medication administration. R3's lab report dated July 8, 2023, indicated R3's urine culture was positive for ESBL bacteria and showed MDRO. R3's progress note date August 30, 2023, written by registered nurse (RN)-C, indicated R3 was completing short term rehabilitation at a skilled nursing facility (SNF). The SNF reported R3's status and indicated R3 was positive for ESBL, was in a private room and RN-C wrote the SNF staff used gloves and eye protection when handling his urine. On September 7, 2023, R3 readmitted to the licensee with a suprapubic catheter and wound to his right lower leg.	0 510		

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0 510	Continued From page 12 R3's record lacked documentation enhanced barrier precautions were implemented. Review of R1's service delivery records dated December 1, 2023 through January 13, 2023, R2's service delivery records dated July 1, 2023 through September 19, 2023 and R3's service delivery records dated July 1, 2023 through July 31, 2023, indicated there were three total staff members who work with R1, R2 and R3 collectively. During observation on September 19, 2023, at 12:50 p.m., R3's room was observed. R3's room lacked an isolation cart with gloves and gowns for EBP. R3's room lacked signage R3 required EBP. During an interview on September 19, 2023, at 1:02 p.m., RN-A stated R3 was not placed on precautions when he readmitted to the facility and staff used just gloves when handling R3's urine. When shown the progress note written by RN-C about R3 and the SNF use of gloves and eye protection with handling R3's urine, which would indicate use of contact precautions (a higher level of precautions than EBP), and asked why R3 was not placed at least on EBP when he readmitted, RN-A stated she asked a nurse practitioner if he needed precautions and was told he did not. When asked if RN-A had updated the nurse practitioner about positive NDM within the facility, RN-A stated the nurse practitioner "probably knows." FAILURE TO REPORT CRE INFECTIONS TO RECEIVING FACILITIES The CDC webpage titled, Healthcare Facilities: Information about CRE, reviewed November 4, 2019, indicated CRE infections are a serious	0 510		

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0 510	Continued From page 13 threat to public health. Infections with CRE are difficult to treat and have been associated with mortality rates of up to 50% for hospitalized patients. Due to the movement of patients throughout the healthcare system, if CRE are a problem in one facility, then typically they are a problem in other facilities in the region as well. The CDC indicated when transferring a patient or resident, staff are required to notify the receiving facility about infection or colonization with CRE and other multidrug-resistant organisms. R3's progress note date August 30, 2023, indicated R3 was completing short term rehabilitation at a SNF. The SNF reported R3's status and indicated R3 was positive for ESBL, was in a private room and RN-C wrote the SNF staff used gloves and eye protection when handling his urine. On September 7, 2023, R3 readmitted to the licensee with a suprapubic catheter and wound to his right lower leg. During an interview on September 19, 2023, at 1:02 p.m., RN-A stated she did not inform the SNF facility about CRE/NDM present in the facility when R3 transported out of the facility. FAILURE TO CORRECTLY DON/DOFF PPE During observation on September 19, 2023, at 11:30 a.m., unlicensed personnel (ULP)-E donned a gown and then gloves prior to entering R2's rooms. FAILURE TO PRACTICE STANDARD PRECAUTIONS During observation on September 19, 2023, at 11:25 a.m., R2's room had the EBP sign posted on the door. Next to R2's room door was an isolation cart that included gloves and washable gowns. The isolation cart lacked hand-sanitizer	0 510		

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0 510	Continued From page 14 nor was there no hand-sanitizer available in the near proximity to R2's room. During observation on September 19, 2023, at 11:37 a.m., ULP-E escorted R2 to the dining room for lunch. R2 was seated at a four top table with three other residents. There was no hand sanitizer available for the residents to cleanse their hands prior to eating nor after eating. During dining room observations on September 19, 2023, from 11:41 a.m. through 12:07 p.m., there were three dietary aides present serving residents and one cook behind the kitchen counter. The cook wore gloves during dishing plates of food. None of the three dietary aides wore gloves. The dietary aides handled dishing salad from a plastic bin and tons with no handwashing or hand-sanitizer use prior to dishing. The dietary aides while handles plates and bowls with no gloves came in contact with the residents' food they were serving. The dietary aides removed dirty dishes from residents, scrapped off waste into a bin, poured liquids into cups and delivered fresh food on plates to other residents with no handwashing in between the dirty task and clean tasks. The dietary aides washed tables after eating in between serving residents their food by dipping the same wash rag into a bucket of water and unknown contents to wash the tables. During an interview on September 19, 2023, at 1:02 p.m., RN-A stated she completed hand-washing audits with staff but had not completed audits of PPE use. The licensee policy titled Infection Disease Guidelines, dated May 2023, indicated an outbreak refers to two or more persons present	0 510		

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0 510	Continued From page 15 with the same group of symptoms. The licensed nurse is responsible to report infection disease among staff and residents as required by regulation. The facility shall establish CDC guidelines, standards and practices to support timely identification of potentially infectious disease and control against spread. After an outbreak is confirmed, all resident family and responsible party, physicians, and local health department will be notified. Written notice will be posted at the facility main entrance for visitors and talk with residents about the virus/symptoms and recommended practice for the outbreak. TIME PERIOD OF CORRECTION: IMMEDIATE	0 510		
02340 SS=I	144G.91 Subd. 6 Participation in care and service planning Residents have the right to actively participate in the planning, modification, and evaluation of their care and services. This right includes: (1) the opportunity to discuss care, services, treatment, and alternatives with the appropriate caregivers; (2) the right to include the resident's legal and designated representatives and persons of the resident's choosing; and (3) the right to be told in advance of, and take an active part in decisions regarding, any recommended changes in the service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to inform residents of a highly contagious bacterial infection identified within the facility to provide residents the opportunity to discuss their care and treatment options with	02340		

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02340	Continued From page 16 appropriate caregivers for 166 out of 167 residents. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: FIRST INFECTIOUS CASE R1's medical record was reviewed. R1 resided in the memory care unit. R1's service plan dated November 1, 2022, indicated R1 required assistance with all activities of daily living (ADLs), medication administration and assistance with transfers. R1's progress note dated November 18, 2022, indicated the hospice aide identified a new sacrum wound and reported to nursing. Nursing implemented weekly dressing changes. On December 8, 2022, R1 developed an infection, cellulitis, and required an antibiotic. On January 1, 2023, a urine analysis indicated positive for the bacteria E. Coli. On January 3, 2023, written by licensed practical nurse (LPN)-D, R1's urine culture showed ESBL resistant organism and organism was in critical levels. She also developed a new wound to her right lower leg. LPN-D updated hospice, the physician and registered nurse (RN)-B. The Minnesota Department of Health (MDH) lab report dated January 9, 2023, indicated	02340		

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02340	Continued From page 17 Carbapenemase detected, and positive for NDM (New Dehli Metallo-beta-lactamase). The Center for Disease Control (CDC) webpage titled, Tracking CRE (Carbapenemase-resistant Enterobacterales) in the United States, reviewed January 2, 2020, indicated New Delhi Metallo-beta-lactamase (NDM) is a less common carbapenemase in the United States but concerning because it can be resistant to even more antibiotics than more common CRE variation. An MDH epidemiology email date January 11, 2023, indicated due to movement of residents in the memory care unit, colonization screening of NDM should be considered. The licensee nurse manager, RN-B said the staff use gloves, but not gowns while providing care to the residents with these types of organisms. MDH infection control preventionist indicated the staff should be using personal protective equipment (PPE) to include gowns and should have those readily available. The plan was to communicate appropriate PPE use with the facility staff and plan an infection control onsite visit to the facility. An MDH epidemiology email dated January 12, 2023, indicated RN-B was updated about the precautions to include glove and gown use. RN-B indicated R1 had been using a communal shower and at this point in time will complete bathing in her own room. R1's progress notes dated January 13, 2023, indicated R1 died. MDH infection control preventionist conducted an onsite visit on February 10, 2023 from 10:00 a.m. to 12:00 p.m. The agenda included training and	02340		

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02340	Continued From page 18 education on the organisms of concern, training, auditing, hand hygiene, transmission-based precautions, and environmental services (cleaning). The licensee was provided an Infection Control Assessment and Response (ICAR) program action plan specific for the licensee. The ICAR action plan included implementing a process for all transfers and admissions to inform the receiving facility of the infection and colonization and transmission based precautions for any residents transferred out of the facility, screening of all new admissions, develop a process for tracking all employee ill calls, tracking ill residents, develop an outbreak policy and procedure, review disinfection guidelines, staff training on PPE use and review CDC enhanced barrier precautions resources. RN-B and RN-A, the director of nursing, participated in the ICAR visit. The licensee policy titled Infection Disease Guidelines, dated May 2023, indicated an outbreak refers to two or more persons present with the same group of symptoms. The licensed nurse is responsible to report infection disease among staff and residents as required by regulation. The facility shall establish CDC guidelines, standards and practices to support timely identification of potentially infectious disease and control against spread. After an outbreak is confirmed, all resident family and responsible party, physicians, and local health department will be notified. Written notice will be posted at the facility main entrance for visitors and talk with residents about the virus/symptoms and recommended practice for the outbreak. SECOND INFECTIOUS CASE R2's medical record was reviewed. R2's service plan dated May 31, 2022, indicated R2 required	02340		

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02340	Continued From page 19 assistance with all ADLs, transfer assistance, escorts and medication administration. R2's progress note dated July 10, 2023, indicated R2 presented more confused than normal and a urine analysis was obtained. On July 13, 2023, R2's urine culture was positive and sent the specimen to the MDH lab. R2's lab report dated July 13, 2023, indicated the urine culture was positive for ESBL bacteria, possible carbapenemase producer and sent to MDH lab for testing. R2's progress note dated July 17, 2023, indicated R2 stated an antibiotic to treat ESBL and "infection control complete." On August 11, 2023, written by RN-A, indicated there was no symptoms related to ESBL infection, R2 remained on enhanced barrier precautions. During an interview on September 19, 2023, at 10:45 a.m., MDH epidemiology stated the facility was made aware of the second NDM case of R2 through direct contact from epidemiology on July 19, 2023 with the facility staff. MDH conducted a phone conference on September 1, 2023, with the licensee leadership. MDH provided again education on NDM and recommendation to screening the residents per CDC recommendation. Licensee leadership indicated they needed to discuss an action plan. Additional resources emailed to the licensee by MDH epidemiology included CDC containment strategy, CRE technical information, antibiotic threats report and interim guidance for public health response to contain Multidrug-resistant Organisms (MDRO's).	02340		

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02340	Continued From page 20 The CDC Interim guidance for a Public Health Response to Contain Novel or Targeted Multidrug-resistant Organisms (MDRO's), updated December 2022, indicated initial response by the facility included identity affected patients (residents) by colonization screening. MDH emailed the licensee on September 5, 2023, to inquire if they were ready to move forward with testing. The licensee indicated they were meeting on September 8, 2023, to discuss. The licensee failed to communicate further with MDH between September 8 through September 18, 2023. On September 19, 2023, at 10;15 a.m., an onsite complaint visit was initiated. At 10:25 a.m., RN-A stated no residents have been notified of NDM or a CRE infection identified within the facility. RN-A stated there was no plan to conduct colonization screening of the residents, that was "in corporate's hands." TIME PERIOD OF CORRECTION: IMMEDIATE	02340		