

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245228	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/30/2024
NAME OF PROVIDER OR SUPPLIER  Avera Morningside Heights Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  300 South Bruce Street Marshall, MN 56258	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>51380</p> <p>Based on observation, interview, and document review, the facility failed to ensure hand hygiene was provided to 1 of 1 resident (R21) prior to mealtime and during morning cares and required staff assistance.</p> <p>Findings include:</p> <p>R21's quarterly Minimum Data Set (MDS) identified R21's cognition was severely impaired, she had continuous inattention and disorganized thinking present. She required set up assistance with eating and was dependent on staff for all other cares. R21 was incontinent of bowel and bladder. R21 had diagnoses of Alzheimer's disease, dementia, anxiety, and depression.</p> <p>R21's 5/10/24, care plan identified she had difficulty making needs known and she was rarely understood. She has a diagnosis of Alzheimer's disease and and Vascular dementia. R21 required her food to be cut up and she needed staff assistance. The nurtion assessment noted resident should not have silverware.</p> <p>Interview on 10/28/24 at 4:21 p.m., with family member (FM)-D identified there were concerns R21 was not getting her fingernails trimmed. FM-D states that R21 ate with her hands and at times had been known to put her hands down her pants.</p> <p>Observation on 10/28/24 at 5:28 p.m., of staff assisting R21 identified R21 had come from the common area where she had been seated in the recliner. Her hands were on the recliner and then placed on the EZ stand by staff as they moved her to the wheelchair. R21 placed her hands on the wheelchair arms and was wheeled to the dining room table. There was no observation of hand hygiene assistance despite R21 touching the recliner, wheelchair, and table area. R21 was provided with a grilled cheese ripped into pieces along with a bowl of grapes. R21 used both hands to feed herself the sandwich pieces and eat the grapes. Intermittently, R21 was observed touching her wheelchair, pushing herself away from the table with her hands, then pushed back in by staff, where she resumed eating. While she ate, R21 would set one hand on the tabe to rest and then would use that same hand again to feed herself. R21 alternates using each hand. R21 nails were observed to be longer that the finger and had some darker debris under the nails. It is unclear the dark debris was food particles or other contaminants.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 10/29/24 at 12:58 p.m., R21 during meal service identified she was at the table using her hands to eat a take-out meal the facility ordered-in for residents. She had orange chicken and noodles. There were chunks of chicken all over her bib and it appeared she struggled to pick up the noodles as they were hard to pick up with her hands. There was no silverware there and no staff assisting.</p> <p>During an interview with (NA)B 10/29/24 at 1:27 p.m., she shared that R21 is only allowed one dish as she will get confused and she is not provided with silverware. She is set up with the dish and R21 eats with her hands.</p> <p>Observation on 10/30/24 at 9:52 a.m., of nursing assistant (NA)-A completing morning cares with R21 in the bathroom where NA-A washed R21's face, her back, under her arms, and lastly her personal area. NA-A did not wash R21's hands during morning cares before leaving R21's bathroom and room. NA-A then proceeded to take R21 to the dining room for breakfast. NA-A obtained R21's breakfast and placed it in front of her at the table. She was provided scrambled eggs, bacon, and a pastry with a glass of juice. R21 was encouraged to start to eat. No staff provided hand hygiene to R21 prior to her eating her meal. R21 was placed in her wheelchair and NA-A proceeded to assist with dressing, pulling her arms through the holes, but grabbing her hands. Once dressed, NA-A pushed R21 to dining room as R21 placed hands on the wheelchair arm rests. NA-A stated they wash wheelchairs once a week.</p> <p>Interview on 10/30/24 at 10:20 a.m., with NA-A revealed she normally only washed R21's hands with a wipe or washcloth after she eats as that is when R21 has dirty hands. NA-A confirmed she had not washed R21's hands during morning cares or prior to her being served her breakfast. Therefore, R21 went from bed, hands in sheets (which were changed while R21 was in bathroom), to dining room, to eating with her hands without having any hand hygiene.</p> <p>Interview on 10/30/24 at 3:21 p.m., with nurse supervisor (NS)-A identified her expectation was that staff would provide hand hygiene to residents who are dependent for cares, prior to meals, after toileting, and as needed throughout the day.</p> <p>Review of 11/21/23, Hand Hygiene policy identified staff were to encourage residents to perform hand hygiene before activities, before eating, and after using the rest room. R21 is dependent on staff for all ADL's.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34083</b></p> <p>Based on observation, interview, and document review, the facility failed to ensure appropriate infection control technique was followed during 1 of 1 meal service. This had the potential to affect all 20 residents residing on the Gardens unit.</p> <p>Findings include:</p> <p>Observation on 10/28/24 of the supper meal served on the Gardens unit identified at:</p> <p>1) 5:30 p.m., it was noted The meal being served by cook-A. During serving of the meal, cook-A demonstrated multiple incidents of potential cross-contamination and lack of appropriate hand hygiene as he plated the meal for residents. Cook-A was noted to have facial hair that was uncovered as he was dishing food items from the steam table and moving about the kitchenette, obtaining various food items and placing them onto plates.</p> <p>2) 5:32 p.m., cook-A returned to the steam table wearing the same gloves with which he had opened cabinets to retrieve serving items, and opened the refrigerator and freezer doors to obtain items to place onto trays. Upon returning to the steam table, cook-A placed a plate on the counter in front of the steam table, picked up a grilled cheese sandwich with his same gloved hands, place it onto the plate, used a knife to cut the sandwich, and separated the half's with his gloved hands. He then picked up a bowl and ladled soup into the bowl and placed it onto the plate between the sandwich halves. He then turned to a counter behind him and dished up coleslaw into a cup and placed it onto the tray. While still wearing the same gloves, cook-A opened the freezer, and moved a cardboard box with his gloved hand to obtain an ice cream sandwich. He then brought the sandwich to the serving line and placed it on the tray. The meal was then delivered to the resident by dietary staff.</p> <p>3) 5:33 p.m., cook-A was still wearing his same contaminated gloves. Cook-A went to a cabinet, opened the cabinet, obtained a divided plate, placed it on the steam table and continued the same process.</p> <p>4) 5:34 p.m., still wearing his unchanged gloves, he moved to a clipboard lying on the counter, and picked up a pen and made a notation. Still with no glove change or hand hygiene cook-A repeated the same process of handling sandwich's with his gloved hands, and then touching cabinets, the refrigerator and various other items on the counter.</p> <p>6) 5:38 p.m. cook-A continued serving wearing his unchanged gloves, as he dished a bowl with [NAME] slaw with his thumb inside the dish coming in contact with the with [NAME] slaw, he wiped his hand on a napkin and turned to write a note on the clip board.</p> <p>7) 5:40 p.m. cook-A picked up a small bowl, that had a black mark on the inside, he touched the black area, which did not rub off and stated it looked like ink, he set the bowl aside and continued to serve food , no hand hygiene or glove change. [NAME] A was also observed to be a wearing a braided bracelet on his right wrist, (uncovered by his glove), as he reached into the steam table to pick up sandwich's.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44645</b></p> <p>Based on observation, interview and document review the facility failed to appropriately discard personal protective equipment (PPE) after use inside the resident's room and perform appropriate hand hygiene with soap and water, and put on new gloves when carrying infection waste to the soiled utility room for 1 of 2 residents (R12) with a highly infectious disease (Clostridium Difficile (C-Difficile)). This practice had the potential to affect 8 of 73 residents who resided on the wing. Furthermore, the facility failed to ensure Enhanced Barrier Precautions (EBP) PPE use was followed for 1 of 1 resident (R19), who had an open scalp wound due to a drug resistant bacteria. That had the potential to affect 18 of 19 other residents who resided on that wing. The facility also failed to ensure gloves were discarded and hand hygiene occurred after touching multiple surfaces and before administration of an eye ointment for 1 of 1 resident (R32) during medication pass observation.</p> <p>R12</p> <p>Review of the 4/3/24, US Centers for Disease Control and Prevention (CDC) Transmission-Based Precautions guidelines, located at <a href="https://www.cdc.gov/infection-control/hcp/basics/transmission-based-precautions.html">https://www.cdc.gov/infection-control/hcp/basics/transmission-based-precautions.html</a>, identified staff were to use Contact Precautions for patients with known or suspected infections that represent an increased risk for contact transmission by:</p> <p>1) Using PPE appropriately, including gloves and gown. Staff (and visitors) were to wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment. Donning [putting on] PPE upon room entry and properly discarding before exiting the patient room is done to contain pathogens.</p> <p>Review of the 3/5/24, CDC: C. Diff: Facts for Clinicians guidelines, located at <a href="https://www.cdc.gov/c-diff/hcp/clinical-overview/index.html#:~:text=If%20a%20patient%20has%20had%20three%20or%20more,Reassess%20appropriateness%20of%20antibiotics%20in%20C.%20diff%20patients">https://www.cdc.gov/c-diff/hcp/clinical-overview/index.html#:~:text=If%20a%20patient%20has%20had%20three%20or%20more,Reassess%20appropriateness%20of%20antibiotics%20in%20C.%20diff%20patients</a>, identified:</p> <p>1) C. diff sheds in feces. Any surface, device or material that becomes contaminated with feces could serve as a reservoir for the C. diff spores. C. diff spores can transfer to patients by the hands of healthcare personnel who have touched a contaminated surface or item.</p> <p>2) Staff were to wear gloves and a gown when treating residents with C. diff, even during short visits. Gloves are important because hand sanitizer doesn't kill C. diff.</p> <p>R12's quarterly Minimum Data Set (MDS) dated [DATE], indicated R12 had moderate cognitive impairment and required extensive assistance with toileting hygiene.</p> <p>R12's Hospital Discharge Summary dated 9/30/24, identified R12 was hospitalized from 9/27/24 to 9/30/24, for sepsis (life threatening infection) secondary to C. difficile colitis (inflammation in the intestines). R12 presented from the facility with 1 to 2 weeks of diarrhea, and hospital stool studies were positive for C. difficile.</p> <p>Observation on 10/28/24 at 12:47 p.m., a Contact Enteric Precautions sign was posted on the outside of R12's door. Also outside R12's door was a container for PPE and a waste bin.</p> <p><i>(continued on next page)</i></p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Observation and interview on 10/28/24 at 12:54 p.m., with nursing assistant (NA)-C exiting R12's room identified NA-C removed their gloves and gown in the hallway outside R12's room into a waste bin. Without removing her PPE inside the room as appropriate or washing her hands, NA-C gathered the full bag of trash from the trash bin with her bare hands and disposed of it in the soiled utility room. NA-C exited the soiled utility room and used alcohol-based hand rub (ABHR) from the touch-less wall unit on her hands. When NA-C was asked if soap and water had been used after caring for R12, NA-C stated, No, I used sanitizer. NA-C further stated staff only needed to wash their hands with soap and water after hand sanitizer had been used 3 times. It was facility practice to have all PPE discarded outside a resident's room.</p> <p>Interview on 10/28/24 at 3:11 p.m., infection preventionist (IP) identified staff were expected to use soap and water for hand hygiene after caring for a resident with C. difficile, and because C. difficile was a spore releasing bacteria. Hand sanitizer would not kill the microbes completely as it does not kill the bacteria. Soap and water was most effective at prevention of transmission.</p> <p>Review of the 3/14/23, Nurse-driven Protocol for Screening hospitalized Patients for Clostridium Difficile Infections policy identified C. difficile spores could survive for long periods of time in the environment, and the bacteria could be transmitted to others through contact with the contaminated environment and equipment or indirectly on unwashed hands of health care workers.</p> <p>Review of the 11/21/23, Hand Hygiene policy identified staff were to complete hand hygiene with soap and water, not alcohol-based hand rub (ABHR), after caring for a resident with known C. difficile.</p> <p>34083</p> <p>R19</p> <p>R19's 8/21/24, Significant change Minimum Data Set (MDS) assessment identified R19 had severe cognitive impairment. She required total assistance with activities of daily living (ADLS), and was transferred with a sling type lift.</p> <p>R19's printed diagnosis list identified aphasia (a language disorder that affects communication), a surgical wound (complex wound of head with avulsive loss of part of skull and cranial contents-non healing), osteomyelitis (bone infection) of the skull, hemiplegia (paralysis of one side of the body), diabetes, bowel and bladder incontinence, and had been admitted to Hospice services with a terminal diagnosis of respiratory failure with hypoxia.</p> <p>Observation on 10/28/24 at 3:15 p.m. of R19's door identified a bright green sign posted which identified she was on EBP. Staff and visitors must clean their hands before entering and when leaving the room. Providers and staff must also wear gloves and a gown for all the following high-contact resident care activities such as dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care/use, wound care-any skin opening requiring a dressing, or therapy involving high-contact.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Observation on 10/29/24 at 12:31 p.m. when trained medication aide (TMA)-A and nursing assistant (NA)-B retrieved the sling lift and prepared to transfer R19 from her recliner to her bed and then to check and change her incontinent brief. Both TMA-A and NA-B entered the room wearing gloves but no gowns, as indicated by the precautions listed on the door. NA-B retrieved the lift sling and with TMA-A's assistance, shifted R19 forward to place the sling behind her and then beneath her legs. R19 was resting her body against NA-B as she was shifted forward. TMA-A had visible contact against her uniform as she positioned the sling around R19. R19 was then transferred onto her bed. The sling was removed by turning R19 from side to side. NA-A removed R19's pants and change her wet brief . Both NA-A and TMA-A changed their gloves and R19 was redressed. Staff then left R19's room and performed hand hygiene.</p> <p>Interview on 10/29/24 at 12:41 p.m. with NA-B and TMA-A reported R19 was on EBP due to her open head wound and when asked about the sign posted on the door, both NA-B and TMA-A reported they should have been wearing gowns when they provided R19's personal care, but stated they had forgotten.</p> <p>Observation and interview on 10/29/24 at 12:51 p.m. with registered nurse (RN)-A identified staff should have been wearing a gown when transferring and performing brief changes. She reported the sign posted on the door identified both gown and gloves were to be used while providing cares.</p> <p>Interview on 10/29/24 at 1:35 p.m. with the infection preventionist reported EBP was to be in place for residents with any open wounds, lines, drains, with a history of a multi-resistant organisms (MDRO). Staff were expected to use appropriate PPE as indicated on the signage. She reported education on EBP's had been included in the May 24 annual in-service, and reviewed recently.</p> <p>Interview on 10/29/24 at 1:50 p.m. with the director of nursing (DON) confirmed her expectation was for staff to comply with use of PPE when performing personal care for a resident on EBP and that all staff had received training on infection prevention and EBP.</p> <p>Review of the November 2023, LTC-Transmission Based precautions (TBP) and enhanced barrier precautions (EBP) policy identified EBP was utilized when staff were providing high-contact resident care. EBP precautions were to be utilized when a resident had an MDRO with wounds that require dressings, indwelling medical devices such as a central line, a urinary catheter, a feeding tube or a tracheostomy (tube in throat used for breathing). A gown and gloves were indicated when assisting with dressing, bathing/showering, transferring, providing hygiene activities, changing linens, changing briefs or toileting, device care, wound care and therapy services. EBP were indicated to be used throughout a resident's stay in the facility unless the wound heals, the device is no longer used, and the IP had been consulted.</p> <p>47497</p> <p>R32</p> <p>R32's October 2024, Medication Administration Record (MAR) identified R32 was to be administered erythromycin 0.5% ophthalmic eye ointment.</p> <p>(continued on next page)</p>		

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