

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245253	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2025
NAME OF PROVIDER OR SUPPLIER Paynesville Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 200 First Street West Paynesville, MN 56362	

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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47638</p> <p>Based on observation, interview, and record review, the facility failed to ensure proper use of personal protective equipment (PPE) for 1 of 2 residents (R249) during high contact cares. In addition, the facility failed to ensure PPE use while providing wound care for 1 of 2 residents (R249) reviewed for enhanced barrier precautions (EBP).</p> <p>Findings include:</p> <p>R249's quarterly Minimum Data Set (MDS) dated [DATE], indicated R249 was cognitively intact and had acute osteomyelitis (bone infection) on the right ankle and foot and had recently undergone orthopedic surgery for right below the knee amputation, phantom limb syndrome with pain (real pain in a missing limb after amputation), peripheral vascular disease (PVD) (narrowed arteries reduce blood flow to the arms and/or legs), type II diabetes mellitus (DM), hypertension (elevated blood pressure), hyperlipidemia (high cholesterol), neuropathy (nerve pain, tingling, or numbness), and was a carrier or suspected carrier of Methicillin-susceptible Staphylococcus aureus (MSSA) (type of staph bacteria that can cause infections on the skin or other parts of the body).</p> <p>R249's care plan dated 2/26/25, indicated R249 was on EBP due to MSSA, PICC line with six weeks of antibiotics, and chemotherapy medication. Interventions included posting clear signage on the exterior of resident's door with the required PPE, provide education to residents and visitors, PPE available outside of the room, use gown and gloves with high-contact resident care activities.</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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During observation on 3/17/25 at 3:26 p.m., registered nurse (RN)-A along with an unidentified nursing assistant (NA) assisted R249 from his manual wheelchair into his recliner to perform wound care. Neither NA or RN-A wore gown or gloves while assisting R249 with transfer. NA exited the room after assisting with the transfer. R249's legs were elevated using the recliner. RN-A gather the supplies to complete dressing changes then sat in R249's wheelchair to perform R249's wound care. RN-A donned gloves to both hands, but failed to don a gown prior to procedure. RN-A then removed Prevalon boot (heel protectant boot) from R249's left heel wound. RN-A noted there was no dressing in place, she then lifted R249's left leg and foot and placed R249's ankle on her right leg above the knee to provide support while painting the wound with betadine per the provider order. After bandaging the left heel RN-A removed her gloves and discarded the used supplies. RN-A returned to sit in the wheelchair and applied a glove to her right hand. She removed the dressing from R249's right below the knee surgical wound with gloved hand, noted there was no drainage and was seen painting the site with a betadine swab. RN-A redressed, dated and initialed the tape used to secure the gauze wrap, and applied the limb protector with gloved hand. RN-A removed her glove and discarded the used supplies. Signage, PPE supply cart and disposal bin were observed on resident's door and just inside of the door. RN-A was not wearing a gown to protect R249 nor herself from pathogens during this procedure.</p> <p>Interview on 3/17/25 at 3:46 p.m., RN-A stated that she had worn gloves. RN-A confirmed she had not worn a gown during resident high contact cares, she stated I forgot. Unable to complete interview at this time.</p> <p>Interview on 3/17/25 at 3:48 p.m., R249 stated she [RN-A] never wears a gown.</p> <p>Interview on 3/19/25 at 3:02 p.m., RN-A stated when a resident required EBP there should be a sign on the resident's door to alert them. In the resident's plan of care there is a stop sign that indicated the precaution, and if hovered over, it showed the type of precaution specifically. RN-A confirmed R249 did have EBP signage posted on exterior of his door and that there was a PPE cart and disposal bin located inside his doorway. RN-A did not recall receiving any specific EBP training, and stated she may not have been there for it. RN-A stated gown and gloves should be worn for, anything up close and personal where concerns for infection are possible, like peri cares, all personal cares and wound care. RN-A was not aware high contact care included transfers. RN-A stated PPE use was important to prevent infection for the resident with whatever I could be carrying, to keep as clean as possible and not introduce anything new to him.</p> <p>Interview on 3/19/25 at 3:20 p.m., with case manager (CM) and director of nursing (DON). DON stated staff were able to tell which residents were on EBP in the residents EHR, it was flagged on their face page, on the care plan, signage on their door, as well as on the huddle board (white board) in the breakroom that lists all residents on precautions. CM stated they also had supply bins and disposal containers in the residents' rooms. CM also stated they go through the residents on EBP in their morning huddle daily, during shift reports and pass on. DON stated precautions were put into PCC like a medication order, when it was time for wound care to be completed, it alerted the nurse. CM stated training on EBP was provided to care staff at their annual skills fair. DON stated many different audits had been completed, and gown and gloves were expected for all wound care. Both CM and DON agreed they would expect orders to be followed, infection control practices followed, and if there was a question, staff would ask for clarification as they had many tools and resources available to them. DON and CM were not specific on the expectation of staff to wear PPE during high contact cares, including transfers.</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 - Few</p>	<p>A policy effective 3/2025, titled Enhanced Barrier Precautions indicated the policy is in place to reduce the transmission of multidrug-resistant organisms (MDROs). Enhanced barrier precautions is defined as an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. PPE used for these high-contact resident care activities as dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, and wound care of any skin opening requiring a dressing.</p>		