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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245373	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2025
NAME OF PROVIDER OR SUPPLIER: Pelican Valley Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 211 East Mill Avenue, Pelican Rapids, MN 56572	

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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48740 Based on observation, interview, and document review, the facility failed to maintain the ice machines located in the kitchen and on the 300 wing in a sanitary manner to prevent potential illness. This deficient practice had the potential to affect all 32 residents who received water from the ice machines. Findings include: During an observation on 1/6/25 at 10:13 a.m., the ice machine in the dining room had a thick white hard powder substance approximately one-fourth of an inch in height around the entire inside and outside of the ice spout. During an observation on 1/6/25 at 11:33 a.m., the ice machine on the 300 wing had a thick white hard powder substance approximately one-fourth of an inch in height around the entire inside and outside of the ice spout. The drip pan drain below the ice and water spouts had a thick white hard powder substance. During an observation on 1/7/25 at 4:15 p.m., the ice machine on 300 wing continued to have the white hard powder substance around the ice spout and drain. The ice machine in the dining room appears to have been cleaned and no longer had a thick white hard powder build-up. During an observation on 1/8/25 at 7:20 a.m., the ice machine on the 300 wing continued to have the white hard powder substance around the ice spout and drain. During an interview on 1/6/25 at 11:47 a.m., the dining director confirmed the build-up on the ice machine in the dining room had a thick hard white powered substance buildup. The dining director indicated the kitchen staff were not responsible for the cleaning of the ice machines. (continued on next page)

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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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 1/6/25 at 4:41 p.m., the environmental services director (ESD) verified a thick, white, hard, powder substance was present on the outside and inside of the ice machine in the dining room. The ESD verified there was a thick, white, hard, powder substance present on the outside and inside of the ice machine on the 300 wing. The ESD indicated the ice machine on the 300 wing had a continuous water drip. The ESD stated the water spouts were removed and cleaned monthly. The ESD indicated the water spouts would still have build-up even after being cleaned. The ESD printed out an ice machine cleaning log identifying the spouts that were cleaned monthly and the entire ice machines that were cleaned inside and out every three months. ESD verified keeping the waterspouts clean was important since residents drank the water that came out of the machines. During an interview on 1/8/25 at 12:11 p.m., the infection preventionist (IP) indicated he expected staff to clean the ice machines more frequently when needed. IP verified maintenance was responsible for the cleaning of the ice machines. Keeping the ice machines clean was important as it is was the source of drinking water for the residents. IP indicated a resident could become ill if there was a build-up as it could cause food-borne illness. During an interview on 1/8/25 at 12:11 p.m., the director of nursing (DON) indicated housekeeping was responsible for cleaning the ice machines. DON indicated her expectation was the ice machines would have been kept clean and sanitary, as that was where the residents obtained their drinking water from. DON indicated a resident could become ill if there was a build-up present as it could be a source for food-borne illness. Review of the ice machines cleaning and service spreadsheet titled 2024 ice machine cleaning and service, recorded the ice machines had been fully cleaned every three months. The exterior of the ice machines had been cleaned monthly along with the shower head and faucets. Review of the ice machine manual titled Scotsman ice systems installation and user's manual for meridian ice maker dispenser's models HID312, HID625, and HID 540 dated 2015, revealed steps to clean the ice machine, along with time to clean was when the clean light was on when unit had not been cleaned for at least six months. Water drips from spout may be normal, a few drops per minute is normal. Maintenance and cleaning wash out the drip tray and dispense chutes. Use ice machine scale remover if needed to dissolve scale.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 48740 Based on observation, interview and document review, the facility failed to maintain sanitary conditions for mechanical lifts for four (R2, R25, R7, R15) out of five residents observed who used a mechanical lift. Finding include: During an observation on 1/6/25 at 6:59 p.m., nursing assistant (NA)-A assisted R7 into bed with a mechanical lift. NA-A placed the mechanical lift away in the nook without sanitizing the mechanical lift. No sanitizing wipes were in the nook where the lifts were stored. During an observation on 1/7/25 at 8:48 a.m., NA-B took the mechanical lift out of R2's room and placed the mechanical lift in the nook without sanitizing the machine. During an observation on 1/7/25 at 9:15 a.m., NA-C took the mechanical lift out of R25's room, placed it in the corner of the living room, and did not sanitize the mechanical lift. During an observation on 1/7/25 at 9:31 a.m., NA-D took the mechanical lift without sanitizing it before bringing it into R7's room. NA-D and NA-C hooked R7's lift pad to the lift and lifted R7 out of the wheelchair. R7's arms came into contact with the mechanical lift during the transfer. NA-D took the mechanical lift out of the room along with a bag of garbage. The garbage bag touched the mechanical lift as NA-D pushed the mechanical lift to the corner of the living room. NA-D did not sanitize the mechanical lift. During an observation on 1/7/25 at 10:00 a.m., NA-D took the mechanical lift to R25's room. NA-D hooked R25 up to the mechanical lift and lifted R25 out of the wheelchair. R25 grabbed onto the mechanical lift. NA-D laid R25 into bed. NA-D placed the mechanical lift in the living room corner, without sanitizing the mechanical lift. During an observation on 1/7/25 at 3:55 p.m., licensed practical nurse (LPN)-A took the mechanical lift into R15's room. At 4:02 p.m., LPN-A took the mechanical lift out of R15's room and placed it in the nook without sanitizing the lift. After continuous observations at 4:20 p.m., NA-A brought the lift into room R2's room without being sanitized. During an observation on 1/8/25 at 8:10 a.m., LPN-B brought a mechanical lift into R25's room without sanitizing the lift first. At 8:14 a.m., LPN-B brought the mechanical lift to the living room corner and walked away without sanitizing the mechanical lift. During an observation on 1/8/25 at 8:36 a.m., NA-E took the mechanical lift into R7's room without sanitizing the lift. At 8:45 a.m., NA-E brought the mechanical lift out of R7's room and placed the lift in the corner of the living room without sanitizing the lift. During an interview on 1/6/25 at 7:39 p.m., NA-A verified the mechanical lift was not sanitized after use. NA-A's normal practice was not to sanitize mechanical lifts. NA-A believed night shift sanitized and cleaned the mechanical lifts. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/7/25 at 10:16 a.m., NA-B verified the mechanical lift was not sanitized after use in R2's room. NA-B did not sanitize the lift after using it as there were not any sanitizing wipes nearby. During an interview on 1/7/25 at 10:35 a.m., NA-D verified the mechanical lift was not sanitized after being in R25's and R7's rooms. NA-D was not certain when a mechanical lift should have been sanitized. During an interview on 1/7/25 at 4:26 p.m., LPN-A verified the mechanical lift had not been sanitized after being used in R15's room. LPN-A verified mechanical lifts were to be sanitized between each resident. During an interview on 1/8/25 at 11:33 a.m., LPN-B verified she did not sanitize the mechanical lift before or after use in R25's room. LPN-B verified lifts were to be sanitized between residents. During an interview on 1/8/25 at 11:37 a.m., NA-E indicated her normal process was to sanitize the mechanical lifts before use and not after use to ensure the lifts were clean. During an interview on 1/7/25 at 12:20 p.m., infection preventionist (IP) indicated his expectation would be for staff to sanitize mechanical lifts between residents to prevent cross-contamination between residents. During an interview on 1/8/25 at 12:11 p.m., director of nursing (DON) verified mechanical lifts were to be sanitized between residents. The DON's expectation was that sanitizing wipes were to be kept in the cubby next to the lifts. DON verified sanitizing lifts was important to prevent cross contamination. Review of policy titled Cleaning and disinfecting mechanical lifts policy dated 10/27/23, revealed it was the policy of the facility to clean and disinfect mechanical lifts that were shared between residents. Indirect contact transmission- Mechanical lifts may transmit pathogens if devices contaminated with blood or body fluids were shared between residents without cleaning and disinfecting between residents. If a mechanical lift had been used for one resident and must be reused for another resident, the device must be cleaned and disinfected before it can be used for another resident.