STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. Building B. Wing	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pelican Valley Health Center	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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure enhanced barrier precautions (EBP) were implemented in accordance with Centers for Disease Control (CDC) guidelines for 1 of 3 (R8) residents who were reviewed for enhanced barrier precautions.CDC guidelines dated 8/12/22, identified EBP are an infection control intervention designed to reduce transmission of resistant organisms that employ targeted gown and glove use during high contact resident care activities. EBP may be indicated (when Contact Precautions do not otherwise apply) for residents with any of the following: Wounds or indwelling medical devices, regardless of MDRO colonization status. CDC guidelines updated 6/28/24 identified examples of indwelling medical devices include, but are not limited to, central vascular catheters (including hemodialysis catheters, peripherally inserted central catheters (PICCs)), indwelling urinary catheters, feeding tubes, and tracheostomy tubes. R8's Significant Change Minimal Data Set (MDS) dated [DATE], identified R8 had mild cognitive impairment. R8 had a diagnosis that included heart failure, end-stage renal disease, and diabetes. R8 required maximuml assistance with personal hygiene and dressing, and needed touching assistance with toilet transfers. R8's Care Area Assessment (CAA) dated 2/20/26, identified R8 required staff assistance with toileting needs. Staff assists with toileting every two hours as needed. R8's care plan revised on 2/9/26, directed staff to use EBP due to venous access site for dialysis. R8 needs hemodialysis related to renal failure. Monitor dialysis access site daily. Resident had an IJ tunnel catheter (IJC) placed. Dialysis center to change dressing. R8 required assistance of one staff for personal hygiene and dressing. R8 received dialysis. R8's ADL report sheet, not dated, revealed R8 needed assistance to transfer to the toilet and was on EBP. During an observation/ interview on 3/23/26 at 10:24 a.m., R8 reported having dialysis stopped the previous week as her dialysis port was not working. R8 had a large, tan, non-transparent renal dressing on the upper right chest; the external limbs of the catheter were not showing. During an observation on 3/24/26 at 9:43 a.m., nursing assistant (NA)-A, went into R8's room and transferred R8 onto the toilet. R8's room did not have an EBP sign on the door, and no gowns were located outside the door or in R8's room. During an observation and interview on 3/24/26 at 9:45 a.m., NA-A knocked on R8's door and asked if R8 was done on the toilet. NA-A transferred R8 from the toilet to the wheelchair. NA-A verified she did not wear a gown when R8 was toileted as there were no signs on the door or gowns to identify R8 was on EBP. NA-A indicated there were gowns next to the door and a sign on the door indicating R8 was on EBP when R8 was receiving dialysis, but the sign and gowns were removed when R8 dialysis was put on hold, and a dressing covered the dialysis site. During an interview on 3/23/26 at 5:02 p.m., registered nurse (RN)-A indicated R8 had an internal jugular catheter (IJC) for hemodialysis, and the port was occluded (blockage) and was not receiving dialysis at this time. During an interview on 3/25/26 at 8:30 a.m., infection preventionist (IP) indicated R8's IJC is covered by a dressing applied by the dialysis unit, and staff were not to change the dressing unless the dressing comes off. Dialysis was stopped the previous week. The plan was to monitor labs and remove the IJC the following week. IP indicated a staff member removed the EPB sign and gowns last week when the IJC was covered, and dialysis was stopped. IP verified R8 should have been on the EBP, as R8 continued to have the (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	IJC. IP verified R8 did not have a sign on the door or gowns by the room on 3/23/26 and 3/24/26. IP verified staff should have been wearing gowns when toileting resident, and during all high contact care. IP verified the EPB sign and gowns were replaced on 3/24/26 after becoming aware of being removed. IP indicated EPB were important to protect staff and residents from multidrug resistant organisms (MDROs). During an interview on 3/25/26 at 9:08 a.m., director of nursing (DON) verified staff should have used EBP when performing high contact activities, such as toileting, as R8 had an IJC. EBP precautions were important to protect staff and residents from MDROs. Review of facilty policy titled enhanced barrier precaution policy dated 4/11/24, revealed Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in conjunction with contact precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multidrug-resistant organisms (MDROs) to residents. EBPs employ targeted gown and glove use during high-contact resident care activities when contact precautions do not otherwise apply. Gloves and a gown are applied prior to performing the high-contact resident care activity (as opposed to before entering the room). Personal protective equipment (PPE) is changed before caring for another resident. Face protection may be used if there is also a risk of splash or spray. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.); and, wound care (any skin opening requiring a dressing). In general, gowns and gloves would not be recommended when performing transfers in common areas such as dining or activity rooms, where contact is anticipated to be shorter in duration. EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization. Wounds generally include chronic wounds, not shorter-lasting wounds, such as skin breaks or skin tears covered with an adhesive bandage (e.g., Band-Aid(R)) or similar dressing. Examples of chronic wounds include, but are not limited to: pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, venous stasis ulcers. Indwelling medical device examples include: central lines, urinary catheters, feeding tubes, and tracheostomies. A peripheral intravenous line (not a peripherally inserted central catheter) is not considered an indwelling medical device for the purpose of EBP. Staff are trained prior to caring for residents on EBPs. Signs are posted in the door or wall outside the resident room indicating the type of precautions and PPE required. PPE will be available outside of the resident rooms, and alcohol-based hand rub is readily accessible to staff. Residents, families and visitors are notified of the implementation of EBPs throughout the facility.