STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245454	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandstone Health Care Center	109 Court Avenue South Sandstone, MN 55072

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to develop care plans to include enhanced barrier precautions (EBPs) for 2 of 3 residents when nursing assistant (NA)-A was observed lacking required personal protective equipment (PPE) while performing high contact care for R2 who required EBPs.Findings include: During observations on 3/4/26 at 1:05 p.m., an Enhanced Barrier Precautions sign was observed on the door for R2's room, with a personal protective equipment (PPE) cart outside the door. NA-A was observed at the side of R2's bed, wearing only gloves and a mask as PPE. Registered Nurse (RN)-A, an agency nurse, entered the room with a mask, gloves, and a gown. RN-A failed to inform NA-A a gown was also required as a part of the necessary PPE during high-contact cares for R2. NA-A proceeded to assist RN-A with positioning R2. NA-A reached over R2 to turn her to her right side, as R2 did not participate in her own bed mobility. NA-A held R2 on her side while RN-A performed wound care to her coccyx (tailbone area). R2's admission minimum data set (MDS), dated [DATE], indicated R2 had diagnoses of Alzheimer's Disease and a stage IV pressure ulcer. Her MDS also indicated she had severely impaired cognition, was dependent on staff for all cares and mobility. R2's care plan, dated 2/17/26, directed assistance of 1-2 staff for all cares, but lacked direction to use EBPs with high-contact care. During an interview on 3/4/26 at 9:52 a.m., nursing assistant (NA)-A, an agency aide, stated she was provided with verbal instructions to properly care for each resident when she started at the facility on 2/23/26. NA-A stated she had not been shown how to access each residents' care plans. During an interview on 3/4/26 at 1:20 p.m., RN-A stated, I should have probably told her to gown up, when asked if NA-A was lacking required PPE during R2's care. During an interview on 3/4/26 at 1:25 p.m., NA-A stated she noticed RN-A entered the room with a blue gown on but did not know she was supposed to wear a gown. NA-A stated she did not see the EBP sign on R2's door. She stated she saw the PPE cart, in the hall next to R2's door, but was not aware it was intended for R2. NA-A stated she was aware of the EBP practice and knew it was to reduce the spread of germs. During an interview on 3/4/26 at 1:35 p.m., the ADON/infection control nurse stated EBPs should be used for residents identified when performing high-contact cares, including gown and gloves. She stated the RN should have said something to the NA regarding the need to wear a gown. She stated the NA's are to reference the Kardex (developed from the care plan) to determine care and precautions required for each resident. ADON stated she missed adding EBPs to the care plan for R2. A facility policy, Enhanced Barrier Precautions (EBPs), dated 1/26 directed EBPs was an infection control intervention designed to reduce transmission of multi-resistant drug organisms (MDROs) that employs targeted gown and glove use during high contact resident care activities. Further the policy indicated the use of EBPs within the facility was recommended by the Center for Disease Control (CDC). A facility policy, Care Plans Comprehensive Person-Centered, dated 2/2025 directed the comprehensive, person-centered care plan will: incorporate identified problem-areas and incorporate risk factors associated with identified problems. The policy indicated that the care plan must reflect currently recognized standards of proactive for problem areas and conditions and identify problem areas and their causes and develop interventions that are targeted and meaningful to the residents.

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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(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 follow established infection control practices for 3 of 3 residents (R1, R2, R3) on enhanced barrier precautions (EBPs) while performing high-contact care.Findings include: During an observation on 3/4/26 at 7:05 a.m., licensed practical nurse (LPN)-A and the director of nursing (DON) performed wound care for R1.- The DON removed two dressings on R1's left foot, discarded them and removed her gloves. The DON failed to perform hand hygiene prior to applying new gloves. She used wound cleanser and gauze to clean the stage II (partial thickness skin loss) left heel wound. She applied calcium alginate (a highly absorbent dressing that creates a moist healing environment) and covered with a bordered foam dressing. Following the application of the dressings to the left heel, the DON changed her gloves but failed to perform hand hygiene.- The DON cleansed the stage III (full thickness skin injury that involves full-thickness skin loss, resulting in exposure of the fatty tissue beneath) left lateral foot wound using wound cleanser and gauze. She measured the wound. She failed to change her gloves and perform hand hygiene. The DON proceeded to complete the treatment using skin prep, applied collagen to the wound bed, and covered with a bordered foam dressing. The DON changed her gloves and performed hand hygiene.- The DON observed R1's foley catheter (a flexible indwelling tube inserted into the bladder to drain urine) lying in her bed. The DON discarded her gloves and applied sterile gloves but failed to perform hand hygiene, before attempting to place the foley catheter into R1's urethra (the tube-structure that transports urine from the bladder to outside of the body) with her right hand, as she used her left hand to position R1's genitalia. When there was no urine return, she removed the sterile gloves, opened a new catheter kit, and applied sterile gloves without performing hand hygiene. The DON used her right hand to attempt to place the foley catheter into R1's urethra and her left hand to position R1's genitalia again but was unsuccessful. The DON discarded her gloves and opened a new catheter kit without performing hand hygiene prior to applying the sterile gloves. The DON placed the Foley catheter and inflated the balloon intended to maintain its placement in the bladder.- The DON failed to change her gloves and perform hand hygiene before she removed the abdominal (ABD) pad and gauze packing from R1's stage IV coccyx wound and her stage IV left gluteal (buttocks) fold wound. She discarded the dressings, changed her gloves, and washed her hands.- Then the DON held the paper tape measure to the coccyx wound to determine measurements, then moved the tape measure to the bedside table with the backside of the tape measure touching the table four times, as she documented the wound measurements with the marker. The DON failed to change her gloves or perform hand hygiene, then used another paper tape measure to assess the left gluteal fold wound.- The DON moved all the used paper tape measures on top of an open box of facial tissues. Then she used wound cleanser and gauze to clean the coccyx wound and left gluteal fold wound, failing to change her gloves or perform hand hygiene between cleaning the two wounds. After cleaning the wounds, she discarded her gloves and washed her hands. She applied new gloves and packed the coccyx wound with gauze and covered with a new ABD pad, securing it in place with tape. The DON then placed all the used paper tape measures on the flap of the open box of ostomy bags (medical appliance bags used to collect stool through an opening in the abdominal wall). Then the DON removed her gloves and performed hand hygiene.- The nurses failed to disinfect the over the bed table where the soiled paper tape measures had been placed before exiting the room. R1's quarterly MDS dated [DATE] indicated she had diagnoses of Type 2 Diabetes Mellitus, paraplegia, encephalopathy and had two stage III pressure ulcers, one stage IV pressure ulcer, and one deep tissue injury. Her MDS indicated she was cognitively intact and was dependent on staff for all cares and mobility. R1's care plan dated 2/12/25 indicated R1 was on EBP's per CDC recommendations for wounds with a goal to remain free of multidrug-resistant organisms (MDRO). During an observation on 3/4/26 at 1:05 p.m., an Enhanced Barrier Precautions (EBP) sign was observed on the door for R2's room, with a personal protective (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	equipment (PPE) cart outside the door. NA-A was observed standing at the edge of R2's bed, wearing only gloves and a mask as PPE. Registered Nurse (RN)-A, an agency nurse, entered the room with a mask, gloves, and a gown. RN-A failed to inform NA-A that a gown was also required as a part of the necessary PPE during high-contact cares for R2. NA-A proceeded to assist RN-A with positioning R2, as NA-A's scrubs were in contact with R2/s bedding and handrail. NA-A reached over R2 to turn her to her right side, as R2 was unable to participate in her own bed mobility. NA-A held R2 on her side while RN-A performed wound care to her coccyx (tailbone area). R2's admission minimum data set (MDS), dated [DATE], indicated R2 had diagnoses of Alzheimer's Disease and a stage IV (severe, full thickness wound extending to exposed muscle, tendon, or bone) pressure ulcer. Her MDS also indicated she had severely impaired cognition, was dependent on staff for all cares and mobility. R2's care plan, dated 2/17/26, directed assistance of 1-2 staff for all cares, but lacked direction to use EBPs with high-contact care. During an interview on 3/4/26 at 1:20 p.m., RN-A stated, I should have probably told her [NA-A] to gown up, following R2's care. During an interview on 3/4/26 at 1:25 p.m., NA-A stated she noticed RN-A entered R2's room with a blue gown but did not know she was supposed to wear a gown as well. NA-A stated she had been providing care for R2 for a couple of weeks and had never worn a gown. She stated she did not see the EBP sign on R2's door. She stated she saw the PPE cart, in the hall next to R2's door, but was not aware it was intended for R2. NA-A stated she was aware of the EBP practice and knew it was intended to reduce the spread of germs. During an observation on 3/5/26 at 9:06 a.m., the DON performed wound care, with the assistance of the ADON for her wounds to R3's stage III coccyx wound and her stage IV left gluteal wound. The DON held the paper measuring tape to the coccyx wound, then wrote the measurements with a marker on the tape. Red liquid was observed on the back of the paper measuring tape. The DON placed the tape directly on R3's bedside table, touching her water mug. The DON changed her gloves but failed to perform hand hygiene before she measured the left gluteal wound with a new paper tape measure. She wrote the measurements with a marker. At the completion of the wound care, the DON picked up the marker and paper tape measures with her bare hands and placed the marker and soiled tape measures in the right pocket of her scrubs. The nurses failed to disinfect the bedside table following the wound care. The DON placed the marker and soiled paper tape measures directly on the treatment cart, next to the laptop in the hallway. R3's was admitted on [DATE]. Her minimum data set MDS was incomplete. R3's care plan dated 3/4/26 indicated R3 was on EBP's per CDC recommendations for wounds with a goal to remain free of multidrug-resistant organisms (MDRO). During an interview on 3/4/26 at 9:52 a.m., nursing assistant (NA)-A, an agency aide, stated she was provided with verbal instructions to properly care for each resident when she started at the facility on 2/23/26. NA-A stated she had not been shown how to access each residents' care plan. During an interview on 3/4/26 at 1:35 p.m., the ADON/infection control nurse stated EBPs should be used for residents identified to require EBPs when performing high-contact cares, including gown and gloves. She stated the RN-A should have said something to the NA-A regarding the need to wear a gown. She stated the NA's are expected to reference the Kardex (developed from the care plan) to determine care and precautions required for each resident. The ADON stated she missed adding EBPs to the care plan for R2 when she was admitted with a wound. During an interview on 3/5/26 at 9:30 a.m., the ADON and infection control nurse stated the soiled tape measures had the possibility to spread infection and should not be placed on the treatment cart. She stated hand hygiene should be performed between glove changes, after cleansing each wound, after measuring each wound, and before providing care to the next wound to reduce the spread of infection. During an interview on 3/5/26 at 9:35 a.m., the DON stated it was necessary to change gloves after cleaning each wound and between treatments for each wound. She stated there was potential for contamination from one wound to the other. She stated placing the used tape measures on the treatment cart that could contaminate the surface with germs. During an interview on 3/5/26 at 11:03 a.m., the medical director (MD) stated the importance of infection control measures such as appropriate hand hygiene and proper use of PPE to prevent the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	spread of infection. A facility policy, Handwashing/Hand Hygiene, dated 9/2025, directed this facility considers hand hygiene the primary means to prevent the spread of infections. Use of an alcohol-based hand rub containing at least 62% alcohol; or alternatively soap and water before performing and non-surgical procedures, before and after handling an invasive device, before donning sterile gloves, before handling clean or soiled dressings, before moving from a contaminated body site to a clean body site during resident care, after handling used dressings or contaminated equipment, after removing gloves. Further, the policy indicated the use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections. A facility policy, Personal Protective Equipment (PPE), dated 1/2026, directed gloves are changed as necessary, during the care of a resident to prevent cross-contamination from one body site to another. After gloves are removed, wash hands immediately to avoid transfer of microorganisms to other residents or environments. Wash hands after removing gloves (Note: Gloves do not replace handwashing.) A facility policy, Enhanced Barrier Precautions (EBPs), dated 1/2026 directed EBPs was an infection control intervention designed to reduce transmission of multi-resistant drug organisms (MDROs) that employs targeted gown and glove use during high contact resident care activities. Further the policy indicated the use of EBPs within the facility was recommended by the Center for Disease Control (CDC).EBPs are indicated for residents with any of the following:1. Infection or colonization with a CDC targeted (MDRO when Contact Precautions do not otherwise apply; OR2. Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO.EBP of utilizing a minimum of a gown and glove use will be initiated for high-contact resident care activities. Examples of high-contact resident care activities requiring gown and glove use for EBP include Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator and wound care for stage 2 pressure ulcers, diabetic ulcers, venous stasis ulcers, arterial ulcers, open surgical wounds.