STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245537	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Minnewaska Community Health Services	605 Main Street Starbuck, MN 56381

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 appropriate personal protective equipment (PPE) was worn to prevent the spread of infection for 1 of 1 residents (R5) observed for enhanced barrier precautions (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) In addition, the facility failed to ensure proper hand hygiene was provided to prevent the spread of infection for 1 of 1 residents (R5) observed while receiving wound care.Findings Include:R5's quarterly Minimum Data Set (MDS) dated [DATE], identified R5 had severe cognitive impairment and diagnoses which included: dementia, arthritis and psychotic disorder. R5 required assistance with activities of daily living (ADLs) and had one venous ulcer with applications of non-surgical dressings and ointments or medications other than to feet.R5's care plan revised 11/10/25, identified R5 required assistance with bathing, dressing, grooming and transfers. R5 had potential for impaired skin integrity with interventions including monitor wound left foot and follow facility protocol for treatment of skin injury. R5 required enhanced barrier precautions (EBP) related to wounds. Gown and gloves would be worn by staff during high-contact care activities. Signage would be posted notifying staff of needs for EBP. During observation on 11/10/25 at 10:14 a.m., R5 was seated in a wheelchair, dressed in street clothes in the hallway outside her door. R5's room did not have any signage up notifying staff of R5's EBP, and a dresser was at the end of the hallway with PPE supplies in it. R5's room had a normal small trash can, with no trash can placed by exit of doorway. During observation on 11/10/25 at 10:58 a.m., registered nurse (RN)-A knocked, entered R5's room, washed his hands, then applied a mask and gloves. RN-A removed R5's dressings to R5's left foot. R5 had two small open dark areas on top of left foot near her toes, and a large open area on the bottom of her left foot. RN-A then wet a hand towel in the bathroom, applied soap to towel, then washed and dried R5's wounds. RN-A removed gloves, then applied new gloves and applied new dressings to R5's left foot. RN-A removed gloves, then applied gauze wrap, then gripper socks to R5's left foot. RN-A washed his hands, applied gloves, then removed R5's Tubi-grip (compression stocking material) from R5's right leg. RN-A left R5's room for additional supplies, sanitized hands, then returned with washcloths. RN-A applied gloves, wet the washcloth, then washed R5's right leg and foot. RN-A removed gloves, applied new gloves, then applied an antifungal cream to R5's right leg. RN-A removed gloves, then applied new gloves, and put a new Tubi-grip stocking onto R5's right leg. RN-A did not apply a gown prior to R5's wound care as part of EBP. RN-A did not complete hand hygiene after removing gloves and prior to applying new gloves during R5's wound cares.During interview on 11/10/25 at 12:45 p.m., RN-A verified R5 required wound cares and he had applied a mask and gloves prior to wound care for R5. RN-A stated he had worn the mask because of wound care, to prevent spread of infection. RN-A stated he was not required to wear a gown during wound cares. RN-A indicated EBP were for residents who had a catheter or infection in a wound. RN-A then reviewed R5's electronic medical records and verified R5's orders and care plan both identified R5 was on EBP. RN-A indicated he was unaware R5 was on EBP, and stated EBP was important to prevent spread of infections. RN-A indicated usual facility process was to be notified of residents on (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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	EBP through report and their care plan. RN-A stated he should have checked R5's care plan prior to wound care. RN-A also indicated the usual facility practice was to put EBP signage up with instructions when residents were on EBP, and was not aware why R5 did not have signage for EBP posted. RN-A also verified he had not completed hand hygiene after removing gloves and prior to applying new gloves during wound care. RN-A indicated he should have sanitized hands between glove use, but there was no hand sanitizer in R5's room. During observation on 11/10/25 at 12:45 p.m., director of nursing (DON) walked in hallway near dining room and was heard telling a nursing assistant to remember purple stars means gowns. Then at 1:02 p.m. DON applied a purple star to R5's nameplate near R5's door, then moved the dresser with PPE from the end of the hall and placed it next to R5's door. During interview on 11/10/25 at 1:12 p.m., DON verified R5 had wounds and was on EBP. DON stated her expectation was gowns and gloves be worn during personal cares and wound cares for R5. DON indicated the facility used purple stars to notify staff residents were on EBP. DON confirmed R5 did not have a purple star up until she applied one that afternoon, and she had put purple stars up and PPE outside other residents' rooms that day who were also on EBP. DON further stated her expectation was that staff complete hand hygiene after remove gloves, prior to applying new gloves to prevent spread of infection. The facility policy titled Enhanced Barrier Precautions, undated, identified EBP was for the prevention of transmission of multidrug resistant organisms. The facility would have the discretion on how to communicate to staff which residents required the use of EBP, as long as staff were aware of which residents required the use of EBP prior to providing high-contact care activities. Gowns and gloves would be available immediately near or outside a resident's room and to ensure alcohol-based hand rub was in every resident room, ideally both inside and outside of the room. Position a trash can inside resident's room and near the exit for discarding PPE after removal. The facility policy titled Hand Hygiene Policy, undated, identified all staff would perform proper hand hygiene to prevent spread of infection to other personnel, residents, and visitors. The policy identified if task required gloves, to perform hand hygiene prior to donning gloves, and immediately after removing gloves. The facility policy titled Clean Dressing Change, undated, identified facility to provide wound care in a manner to decrease potential for infection and/or cross-contamination. Instructions included to wash hands and put on gloves. After removing the soiled dressing, remove gloves, wash hands and put on clean gloves. Clean wound, measure wound, remove gloves, then wash hands and put on new gloves. Apply ointments or creams, and secure dressing, mark and initial, then dispose of gloves, and wash hands.