Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

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	03/25/2025

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 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45844 Based on observation, interview, and document review, the facility failed to ensure resident advance directives were accurately documented in the clinical record to reflect the resident's current wishes which affected 1 of 30 residents (R9) reviewed for advanced directives. This deficient practice resulted in an immediate jeopardy (IJ) for R9 who would have received cardiopulmonary resuscitation (CPR), contrary to their wishes, in the absence of a pulse or respirations. The IJ began on [DATE], when R9's electronic health record (EHR) banner and orders identified R9 was to have CPR however, R9's updated physician's order for life sustaining treatment (POLST) signed on [DATE], identified R9's wishes of do not resuscitate (DNR). The administrator, assistant administrator and director of nursing (DON) were notified of the IJ on [DATE], at 5:49 p.m. The IJ was removed on [DATE], at 11:35 a.m., when the facility had implemented corrective action, however non-compliance remained at the lower scope and severity level of D, isolated with no actual harm but potential to cause more than minimal harm. Findings include: R9's admission Minimum Data Set (MDS) dated [DATE], identified R9 was cognitively impaired and had diagnoses which included dementia, asthma, and hypertension (elevated blood pressure). Identified R9 was dependent on staff for activities of daily living (ADLs) which included bed mobility, toileting, and transfers. R9's current POLST signed by family member (FM)-A on [DATE], identified R9's wishes were DNR. The POLST was scanned into her EHR and signed by her medical provider on [DATE]. Review of R9's current EHR Order Summary Report signed by her medical provider on [DATE], identified R9 had an order for CPR even though R9's POLST identified DNR. Review of R9's EHR banner on [DATE] at 1:12 p.m., identified R9 wanted CPR. Review of R9's face sheet in the EHR undated identified R9 was admitted to the facility on [DATE]. Identified R9 wanted CPR. R9's care plan revised [DATE], identified R9 wanted CPR. Identified the POLST would be reviewed quarterly and as needed. (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 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a facility report sheet dated [DATE] -[DATE], located at the nurses station identified R9 wanted CPR. During an interview on [DATE] at 2:39 p.m., FM-A stated she had signed the POLST on [DATE], stating that R9's wishes were to be DNR. During an interview on [DATE] at 4:19 p.m., licensed practical nurse (LPN)-A indicated in the event a resident did not have a pulse or respirations, she would refer to the EHR banner and would have proceeded accordingly. LPN-A verified R9's banner identified R9 wanted CPR. LPN-A verified there was was a discrepancy between R9's banner and the POLST. During an interview on [DATE] at 4:22 p.m., registered nurse (RN)-A indicated in the event a resident did not have a pulse or respirations, she would refer to the report sheet located at the nurses station and would have proceeded accordingly. RN-A verified R9's report sheet identified R9 wanted CPR. RN-A verified there was a discrepancy between R9's report sheet and the POLST. During an interview on [DATE] at 4:24 p.m., RN-B indicated in the event a resident did not have a pulse or respirations, he would refer to the EHR banner and would have proceeded accordingly. RN-B verified R9's banner identified R9 wanted CPR. RN-B verified there was a discrepancy between R9's banner and the POLST. During a joint interview on [DATE] at 4:41 p.m., assistant director of nursing (ADON) and DON stated upon admission, all residents were assigned a full code (CPR) status. ADON and DON stated a POLST was then completed with all residents or resident representatives and sent off to the provider for a signature. ADON and DON confirmed there was a discrepancy with R9's banner and current physician orders which identified R9 was a full code and did not match her current wishes of being DNR. ADON and DON confirmed in the event R9 did not have a pulse or respirations, CPR would have been initiated against R9's wishes. DON indicated she would expect staff to follow the POLST, resident wishes and the facility policy. Review of a facility policy titled Code Status Policy revised [DATE], identified the facility would follow a policy regarding a resident's right to request, refuse, and/or discontinue medical treatment and to formulate an advance directive. Identified the POLST would have been documented in the EHR. Further identified the code status would have been reviewed with Care Conferences at least quarterly and documented in the medical record. The IJ was removed on [DATE] at 11:35 a.m., when the facility developed and implemented a systemic removal plan which was verified by interview and document review: -All residents' records were reviewed to ensure the POLST form, the electronic medical records were updated to ensure resident's wishes for advance directives, were accurate on [DATE]. -R9's EHR record was updated to match the current POLST. -All current licensed staff were educated on the policy for advance directives, updating the POLST and the EHR to reflect the resident's wishes on [DATE], as evidenced by the education sign in sheet and interviews. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-A process was implemented to assure all other nursing staff completed mandatory education prior to the start of their next shift on [DATE], by notification of required education via phone/text. All staff would sign off once education had been completed. -The advance directive policy was reviewed and determined no changes were required.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48583 Based on observation, interview and document review, the facility failed to ensure cleaning chemicals were secured away in a locked cabinet or cart, which had the potential to affect all residents residing on the B-wing (8 rooms - B-39, B-40, B-41, B-42, B-43, B-44, B-45, B-46). Additionally, it had the potential to affect 2 of 30 (R22 and R10) who were observed walking down the hallway. Findings include: R22's quarterly Minimum Data Set (MDS) dated [DATE], identified R22 was severely cognitively impaired and had diagnoses which included dementia, traumatic brain injury (TBI) and alcohol dependence. Identified R22 was independent with transfers and mobility. R22's care plan revised 3/23/25, identified R22 had wandering behaviors. R10's annual Minimum Data Set (MDS) dated [DATE], identified R10 was severely cognitively impaired and had diagnoses which included dementia, depression, and glaucoma (difficulty with vision). Identified R10 was independent with transfers and mobility. R10's care plan revised 3/6/25, identified R10 had wandering behaviors. During observations the following was observed: -3/23/25 at 11:45 a.m., the tub/shower room door was propped open with the white trash can. Sitting to the right of the tub on the floor were two full bottles of vindicator+ (disinfectant/cleaner) one with no cap and the other closed with a cap. Sitting on the green rolling cart with hygiene supplies was one bottle of QT-TB (disinfectant/cleaner) 3/4 full in a spray bottle. Sitting on the tan rolling cart with hygiene supplies was a one bottle of Quarternary (Barrier II) based sanitizer 3/4 full in a spray bottle. The storage room B-50's door was open and one full bottle of pine liquid odor control was sitting on the floor in front of the wooden toiletry shelf. No staff were present down the hallway or ar the nurses' station. -3/23/25 at 2:10 p.m., both doors remained open and chemicals remained in the same place. -3/24/25 at 8:38 a.m., tub/shower room door continued to be propped open with the white trash can. Sitting to the right of the tub on the floor was one full bottle of vindicator+ and one empty bottle. Sitting on the white wire shelf above the tan rolling care was one bottle of QT-TB 3/4 full. The storage room B-50's door was open and one full bottle of pine liquid odor control was sitting on the floor in front of the wooden toiletry shelf. No staff were present down the hallway or ar the nurses station. -3/24/25 at 11:11 a.m., both doors remained open and chemicals remained in the same place. R22 walked down the hallway past both open doors to the exit. R22 remained at the exit door for approximately two minutes and walked back down the hallway past both open doors to another part of the facility. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-3/24/25 at 1:39 p.m., both doors remained open and chemicals remained in the same place. -3/24/25 at 1:48 p.m., both doors remained open and chemicals remained in the same place. Nursing staff left the B-wing. - 3/25/25 at 7:25 a.m., tub/shower room door continued to be propped open with the white trash can. Sitting to the right of the tub on the floor was one full bottle of vindicator+ and one empty bottle. Sitting on the white wire shelf above the tan rolling care was one bottle of QT-TB 3/4 full. The storage room B-50's door was open and one full bottle of pine liquid odor control was sitting on the floor in front of the wooden toiletry shelf. No staff were present down the hallway or ar the nurses station. -3/25/25 at 12:56 p.m., both doors remained open and chemicals remained in the same place. R10 wheeled in R10's wheelchair down the hallway past both open doors to the exit door. R10 remained at the exit door for approximately five minutes. R10 wheeled R10's wheelchair back down the hallway past both open doors to another area in the facility. -3/25/25 at 1:12 p.m., both doors remained open and chemicals remained in the same place. R22 walked down the hallway past both open doors to the exit. R22 remained at the exit door for approximately two minutes and walked back down the hallway past both open doors to another part of the facility. During an interview on 3/25/25 at 1:20 p.m., nursing assistant (NA)-A stated nursing staff cleaned and disinfected the tub after a resident had received a bath and before another resident would enter the tub. NA-A indicated both doors were to be shut after staff were finished cleaning and disinfecting the tub or getting supplies out of the storage area. When NA-A was finished talking with surveyor, NA-A left the B-wing and both doors remained open. During an interview on 3/25/25 at 1:55 p.m., director of nursing (DON) confirmed the above findings and stated the doors to both rooms were to be closed at all times. DON indicated neither room had a lock on the door and chemicals were not locked in a storage area. DON further indicated even if the doors were closed the chemicals would not be stored properly. DON stated having chemicals sitting out could have the potential for a harmful situation. During an interview on 3/25/25 at 2:14 p.m. administrator confirmed the above findings and stated her expectations were chemicals were to be locked up and both doors were to be closed. The [NAME] material safety data sheet (MSDS) for Vindicator+ revised 2/4/21, indicated the disinfectant/cleaner was hazardous to a person's health. The MSDS indicated to health hazards with exposure to eye, skin, or ingestion. The MSDS further indicated to seek immediate medical attention if ingestion or eye or skin contact occurred. The [NAME] MSDS for QT-TB revised 8/12/21, indicated the disinfectant/cleaner was hazardous to a person's health. The MSDS indicated to health hazards with exposure to eye, skin, or ingestion. The MSDS further indicated to seek immediate medical attention if ingestion or eye or skin contact occurred. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The [NAME] Chemical Company MSDS for Barrier II revised 4/9/20, indicated the disinfectant/cleaner was hazardous to a person's health. The MSDS indicated to health hazards with exposure to eye, skin, or ingestion. The MSDS further indicated to seek immediate medical attention if ingestion or eye or skin contact occurred. The Genlabs MSDS for Pine Odor Control revised 11/4/20, indicated the disinfectant/cleaner was hazardous to a person's health. The MSDS indicated to health hazards with exposure to eye, skin, or ingestion. The MSDS further indicated to seek immediate medical attention if ingestion or eye or skin contact occurred. Facility policy titled Hazard Communication and Employee Right-to-Know dated 9/23, was to educate the employees of the hazardous substances, physical and infectious agents that may endanger their health and well-being while at work. Chemicals, through the different steps from their production to their handling, transport and use, may be a real danger for human health and the environment. People of any ages, from children to elderly, using many different languages and alphabets, belonging to various social conditions, including illiterates, were daily confronted to dangerous products (chemicals, pesticides, etc.)

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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.

49620

Based on observation, interview and document review, food was not served in a sanitary manner for 30 residents who dined in the dining area observed during dining services and who received an afternoon snack. In addition, the facility failed to maintain the ice machine and the coffee machine in a sanitary manner to prevent potential illness for 30 residents who currently received ice from the ice machine and or coffee from the coffee machine in the dining area. Further, the facility failed to maintain proper holding food temperatures for cole slaw that was to be served during the evening meal for all residents in the dining room. These deficient practices had the potential to affect all 30 residents residing in the facility.

Findings include:

FOOD SERVICE

During an observation on 3/23/25 at 11:51 a.m., activities aide (AD)-A was serving beverages in the dining room. AD-A was not observed to wash her hands and was not wearing gloves. AD-A picked up a glass off the table holding the top rim with her fingers, poured tomato juice into the glass and placed the glass on the table. AD-A picked up another glass holding the top rim with her fingers and poured water. AD-A picked up a coffee cup holding the top rim with her fingers and carried the cup over to the hot water for tea. AD-A then placed a clothing protector around a resident's neck and touched the resident's skin while closing the snaps on the back of the clothing protector around the residents neck. AD-A proceeded to pick up a glass holding the top rim with her fingers and poured milk. AD-A picked up three prefilled thickened glasses off of the beverage cart of milk and two juices. AD-A removed the plastic wrap off of the top rim of the three glasses with her fingers, held onto the top rim and placed each glass on the table.

During an interview on 3/23/25 at 12:52 p.m., AD-A stated she usually poured the beverages at lunch time. AD-A confirmed she picked up the glasses and coffee cup holding the top rim with her fingers. AD-A stated she had not received any specific training on handling glasses and did not perceive handling the top rim of the glasses as a concern.

During an observation on 3/23/25 at 2:28 p.m., AD-A had a food cart in the A-wing with individual desserts and beverages. AD-A was visiting with a resident who was in a wheelchair sitting at an even height of the desserts directly next to the food cart. The desserts were observed to be uncovered and individual plastic wrap pieces stacked up sitting next to the tray of desserts. Two staff members were observed to walk past the food cart while AD-A was visiting with the resident. AD-A confirmed the desserts were not covered and she removed the plastic wrap in the kitchen from each dessert prior to bringing the food cart down the hall as it was quicker to serve the desserts. AD-A did not perceive the desserts being uncovered as a concern.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 3/24/25 at 4:31 p.m., assistant director of nursing (ADON) stated the activities staff usually assisted in the dining room and delivered afternoon snacks. ADON was unaware of any specific training the activities staff received on handling glasses or delivering food. ADON confirmed the expectation of staff was to handle the bottom of a glass while serving beverages and not touching the top rim of the glass as the glass would be contaminated with germs and a resident could become ill. ADON further confirmed desserts should be covered while the food cart goes down each hall to prevent germs from others getting on the food and potentially causing foodborne illness to the residents. ICE MACHINE During an observation on 3/23/25 at 11:37 a.m., the hot water spout on the coffee machine in the dining room had a white powder substance build up around the entire spout. In addition, the ice machine in the dining room had a white scaley substance build up around the entire inside of the spout approximately one to two inches in height. During an interview on 3/25/25 at 10:44 a.m., dietary manager (DM) verified the hot water spout on the coffee machine had a white powder substance build up around the entire spout and the ice machine had a white scaley substance build up around the entire inside of the spout. DM stated dietary staff were expected to clean the coffee machine at the end of each evening shift. DM was unaware of any staff cleaning the ice machine. DM stated there was not a log for cleaning the machines. DM verified the white substances could have bacteria present and residents could develop illness as a result. During an interview on 3/25/25 at 10:47 a.m., maintenance director stated he was unaware of cleaning logs for the coffee machine and ice machine and dietary staff were expected to clean them. The maintenance director stated he had not been notified of any white substance build up on the coffee machine or the ice machine. FOOD TEMPERATURE During an observation and interview on 3/24/25 at 12:04 p.m., dietary aide (DA)-A was temping food at the steam table in the dining room. Another dietary aide was writing the food temperatures onto a piece of scratch paper. A large uncovered plastic bin of cole slaw was sitting on the counter next to the steam table. DA-A temped the cole slaw after the hot foods at 12:14 p.m., at 49.5 degrees Fahrenheit (F). DA-A starting to serve the meal and was stopped by surveyor and asked what the cold food holding temperature was supposed to be. DA-A stated she was unaware what the cold food holding temperature should be and asked the dietary manager standing behind her. DM stated the cold food holding temperature should be between 40 and 45 degrees F. DM then removed the cole slaw from the meal service. During a follow up interview on 3/24/25 at 4:10 p.m., DA-A stated temperatures were written on a piece of paper and later transferred to the three ring binder of food temp logs. The food temp logs were observed to have breakfast, noon meal and evening meal entries with the recommended temperature of each food group listed. DA-A stated she was unable to verify food temperatures without use of the log. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 3/24/25 at 4:17 p.m., DM confirmed the cole slaw was at 49.5 degrees F and was unaware cold food holding temperature was 41 degrees F or less. DM verified the food temperature logs state salad 40 to 45 degrees for cold food temperature and that dietary staff usually wrote the temperatures on a piece of paper and transfer to the log book after a meal service. DM stated there was not a policy or procedure for keeping foods cold. DM stated the expectation was dietary staff to know the proper holding food temperatures to prevent the residents from developing food borne illness. The Food and Drug Administration food code identified the danger zone refers to the range of temperatures at which bacteria can grow between 40 degrees Fahrenheit (F) and 140 degrees F. For food safety, keep food below or above the danger zone. A facility policy titled Food Safety Requirements, undated, identified food distribution included holding foods hot on the steam table or under refrigeration for cold temperature control. When meals were assembled in the kitchen and then delivered to resident rooms, covering foods was appropriate, either individually or in a mobile food cart. Food would be covered when traveling a distance (i.e., down a hallway, to a different unit or floor). Food service safety referred to handling, preparing, and storing food in ways that prevent foodborne illness. Foodborne illness referred to an illness caused by the ingestion of contaminated food or beverages. Staff shall monitor food temperatures while holding for delivery to ensure proper hot and cold holding temperatures were maintained. Staff shall refer to the current Food and Drug Administration (FDA) Food Code and facility policy for food temperatures as needed. Foods and beverages shall be distributed and served to residents in a manner to prevent contamination and maintain food at the proper temperature and out of the Danger Zone. A facility policy for the coffee machine was requested and not received. A facility policy titled Ice Machine Policy and Procedure reviewed 10/26/19, identified the ice machine would be washed and wiped down daily at the end of each evening shift, making sure that the storage bin drains were clear and no Lime build up had occurred. If there was lime build up to notify maintenance for descaling. A manufacturer form provided by the facility titled Manitowoc Nugget Ice Machine dated July 2022, identified over time the drip tray and cup rest/spouts may become coated with scale or dirt. They could be removed and scrubbed in a sink. The spouts/chutes and drip tray were to be washed and to use ice machine scale remover if needed to dissolve scale. Recommended cleaning the ice machine every six months and more frequent cleanings may be required based on the mineral content of the water, run time and potential airborne contamination.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 48583 Based on interview and document review, the facility failed to submit complete and accurate direct care staffing information, including information for agency and contracted staff, based on payroll and other verifiable and auditable data, during 1 of 1 quarters reviewed (Quarter 4), to the Centers for Medicare and Medicaid Services (CMS) according to specifications established by CMS. This deficient practice had the potential to affect all 30 residents residing in the facility. Findings include: Review of the Payroll Based Journal Report (PBJ) [NAME] Report 1705 D identified excessively low weekend staffing. During an interview on 3/23/25 at 12:45 p.m., administrator confirmed the above findings and stated the low weekend staffing always happened because contracted staff hours had not been calculated into the system before it was submitted to CMS. Administrator further stated the PBJ would continue to be incorrect because the contracted staff hours would not be received on time from the contract company to accurately submit the facility's information to CMS. During an interview on 3/25/25 at 2:22 p.m., the administrator and chief financial officer (CFO) stated contracted staff hours were gathered from the invoices the facility received from the contract company. CFO further stated the invoices were received after the required submission date of the facilities PBJ information to CMS. CFO indicated contracted staff hours would continue to not be included in the PBJ due to the dates of the invoices and the required submission time of the facility's PBJ information to CMS. Review of facility policy titled Payroll Based Journal undated, It was the policy of this facility to electronically submit timely to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS.

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F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

Provide and implement an infection prevention and control program.

48583

Based on observation, interview and document review, the facility failed to establish an on-going infection control program which included comprehensive surveillance of resident infections. In addition, the facility failed to ensure hand hygiene was completed for 6 of 30 residents (R7,R10, R14, R22, R28, R31) observed during the afternoon water pitchers being delivered. These deficient practices had the potential to affect all 30 residents who resided in the facility.

Findings include:

SURVEILLANCE

A review of the facility's infection control surveillance log titled Peerlytics dated October - December 2024 and January - March 2025, revealed the following:

-Facility map included resident's room number and the resident's room was highlighted if the resident had a diagnosed infection.

- The facility's current surveillance log lacked tracking necessary data which included: signs and symptoms for each infection, dates cultures were obtained, when the antibiotic was completed, when the antibiotic was discontinued, and when symptoms resolved.

During an interview on 3/24/25 at 4:39 p.m., director of nursing (DON) and assistant director of nursing (ADON) indicated the facility used Peerlytics infection map to track resident's with diagnosed infections. DON and ADON stated the mapping document only included illnesses that were diagnosed and did not track signs and symptoms, culture results, or the antibiotic being used.

49620

HAND HYGIENE DURING WATER PITCHER PAS

During an observation on 3/24/25 at 2:30 p.m., nursing assistant (NA)-B and NA-C pushed a cart of water pitchers from C-wing to A-wing. NA-B entered R7's room with a water pitcher from the cart and removed the used water pitcher from R7's room and placed on the middle shelf of the cart. NA-C entered R28's room with a water pitcher from the cart and removed the used water pitcher from R28's room and placed on the middle shelf of the cart. NA-B repeated the process for R10 and R14. NA-C repeated the process for R31 and R22. Three staff and two residents were observed to walk past the water pitcher cart. NA-B and NA-C did not sanitize their hands prior to entering a resident room or after touching the used water pitchers.

During a joint interview on 3/24/25 at 2:35 p.m., NA-B and NA-C confirmed they did not sanitize their hands during the entire water pitcher delivery service. Both NA-B and NA-C stated they should have sanitized their hands to prevent the spread of infection.

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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	03/25/2025

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 - Many	During an interview on 3/24/25 at 4:31 p.m., assistant director of nursing (ADON) verified the expectation of staff would be to sanitize their hands in between the new and used water pitchers being delivered to prevent the spread of germs and possible illness to the residents. During a follow up interview on 3/24/25 at 5:36 p.m., DON and ADON confirmed the facility did not have a process for tracking and trending infections within the facility. DON and ADON further confirmed the mapping only showed current resident infections. DON and ADON indicated they were unaware all signs and symptoms needed to be tracked for every resident. DON and ADON further indicated the facility had not had an outbreak therefore there would have not been a need to track signs or symptoms for every resident. During a follow-up interview on 3/25/25 at 2:06 p.m., DON and registered nurse (RN)-A provided spreadsheets for tracking and trending of residents infections for October - December 2024 and January - March 2025. DON and RN-A stated the spreadsheets were filled out the night before. DON further stated the spreadsheets should have been used before for tracking and trending. During an interview on 3/25/25 at 2:17 p.m., administrator confirmed the above findings and indicated she was unaware tracking and trending was not being completed. Administrator stated her expectations were trending and tracking of residents signs and symptoms of an infection were completed. Administrator further stated she would expect staff to completed contract tracing and utilize the facility software to help reduce/prevent an illness outbreak in the facility. Administrator indicated tracking and trending of infections was important to keep residents safe and healthy. Facility policy on infection control surveillance was requested, however one was not provided. A facility policy titled Hand Hygiene, undated, identified all staff would perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. Hand hygiene would be performed after handling contaminated objects.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245537	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/25/2025
NAME OF PROVIDER OR SUPPLIER: Minnewaska Community Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE: 605 Main Street Starbuck, MN 56381	

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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 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. 49620 Based on observation, interview, and document review, the facility failed to ensure the 13 single resident rooms on the A-wing had at least 100 square feet of useable floor space for 10 of 10 residents (R7, R10, R14, R16, R22, R23, R25, R27, R28, R31) who currently resided in those rooms. Findings include: During the entrance conference on 3/23/25, the administrator confirmed the rooms in the hallway A did not have at least 100 square feet of useable floor space as required. During the initial screening for residents on the A-wing on 3/23/25 at 12:15 p.m., the following resident rooms for R7, R10, R14, R16, R22, R23, R25, R27, R28, R31 were observed to not have at least 100 square feet of useable floor space as required. On 3/23/25 at 2:13 p.m., R14 stated she would like a bigger room when one became available but was happy with her room and had no concerns. -at 2:20 p.m., R16 rested in bed, unable to respond to a question regarding room size. -at 2:22 p.m., R25 rested in bed, unable to respond to a question regarding room size. -at 2:25 p.m., R22 stated the room was big enough for him. -at 2:40 p.m., R31 rested in bed, unable to respond to a question regarding room size. -at 2:43 p.m. R7 stated the room was big enough for her. -at 2:45 p.m., R27 stated the room was big enough for him. -at 2:50 p.m., R10 rested in bed, unable to respond to a question regarding room size. On 3/24/25 at 2:33 p.m., R23 stated the room was big enough for him. -at 2:38 p.m., R28 rested in bed, unable to respond to a question regarding room size. R28's daughter stated no concerns with the room size. The following rooms on the A-wing were unoccupied A-30, A-33 and A-34. During an interview on 3/23/25 at 2:30 p.m., nursing assistant (NA)-B stated no residents had complained about the size of their rooms. During an interview on 3/24/25 at 2:35 p.m., maintenance director provided room measurements with surveyor. Maintenance director stated the rooms are less than 100 feet. (continued on next page)

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	245537	A. Building B. Wing	03/25/2025

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F 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/25/25 at 10:13 a.m., director of nursing (DON) stated the facility would move a resident if they were not satisfied with their room. Director of nursing had not heard of any complaints about room sizes. During an interview on 3/25/25 at 10:18 a.m., administrator stated the rooms on the A-wing measured between 95.68 and 96.07 square feet. The administrator planned to apply for a waiver. A facility policy was requested and not received.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45844 Based on observation, interview and document review, the facility failed to ensure call lights were accessible for 1 of 1 residents (R9) reviewed for call light accessibility. Findings include: R9's admission Minimum Data Set (MDS) dated [DATE], identified R9 was cognitively impaired and had diagnoses which included dementia, asthma, and hypertension (elevated blood pressure). Identified R9 was dependent on staff for activities of daily living (ADLs) which included bed mobility, toileting, and transfers. R9's care plan dated 1/28/25, identified R9 was at high risk for falls related to weakness, and age related osteoporosis, with an intervention dated 1/28/25, to be sure call light is within reach and encourage resident to use it for assistance as needed. During an observation on 3/23/25 at 2:00 p.m., R9 was seated in a stationary chair in her room about five ft. from her bed. R9's call light was attached to the bedrail out of R9's reach. During an observation on 3/23/25 at 2:01 p.m., on the bathroom door in R9's room was a sign that stated push call button for help. During an observation on 3/24/25 AT 8:35 A.M. R9 was seated in a stationary chair in her room about five ft. from her bed. R9's call light was attached to the bedrail out of R9's reach. During a joint interview on 3/24/25 at 8:40 a.m., nursing assistant (NA)-A and licensed practical nurse (LPN)-A verified R9's call light was attached to the bed rail and was not within reach of R9. NA-A and LPN-A verified R9 was able to use the call light. LPN-A stated her expectation was that R9's call light would be within reach. During an interview on 3/24/25 at 4:01 p.m., director of nursing (DON) verified R9 was able to use the call light. DON stated her expectations were that resident's call lights were within reach at all times so residents could call for assistance when needed. Review of a facility policy titled Call Lights: Accessibility and Timely Response revised 10/1/24, identified with each interaction in the resident's room or bathroom, staff would ensure the call light was within reach of the resident and secured, as needed.