STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245360	A. Building B. Wing	01/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glenoaks Senior Living Campus	100 Glen Oaks Drive New London, MN 56273

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43080 Based on interview and document review, the facility failed and maintains improper dietary practices surrounding the use of kitchen equipment used to clean and sanitize dishes by not removing the use of a dishwasher when sanitizing cycles did not meet temperature requirements despite policies and procedures, along with manufacturer guideline's identified alternative instructions when temperatures were out of range. This had the potential to impact all 35 residents in the facility. A Comment Entry Point (CEP) report was submitted to the State Agency (S.A.) on 1/18/23 and identified the dish washing system failed to heat properly for about two weeks, in which the temperature only heated to 155-157 degrees Fahrenheit (F.) instead of the required 180 degrees F. The report identified the complainant went to the Facility Manager and updated them about the heating issue, and in response the complainant was instructed to inform the Head Chef. The report identified the dishwasher was eventually fixed. A [NAME] AM Select Dishwashers Instruction manual form 35320, dated 6/18, identified the operating temperatures for the sanitizing mode for all models are as follows: minimum wash temperature of 150 degrees F., minimum rinse temperature of 180 degrees F. The manual directed to contact service for adjustment or repair if the water temperatures were incorrect. During observation and interview, on 1/27/23, at 1:19 p.m. dietary aide (DA)-A stated she primarily processed dirty dishes and explained she was required to test the dishwasher temperatures with each meal time she worked, and if there were issues she was to follow the instructions on a sheet of paper she pointed to, that was taped to the wall, and then she would do as instructed by the dietary manager (DM)-A or the maintenance director (MD)-A. DA-A confirmed the dishwasher was fixed earlier in the month; however, she was unable to state exactly what the issue was. DM-A denied DM-A, MD-A, or other dietary staff instructed her to not use the dishwasher during that time and thus she continued to use it. DA-A explained she checked the wash and the rinse water temperatures (observed to register on the front lower right side of the dishwasher) in the middle of the cycle for the best reading and it was important to make sure the temperatures were within required ranges in order to kill whatever is on [the dishes]. DA-A denied she had conversed with DM-A or MD-A related to any temperature concerns and she denied any recent training instructions were provided to her for when the dishwasher failed to maintain required temperatures. (continued on next page)

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 - Few	-The paper sheet taped to the wall identified a Dish Washer Temperature log. The log identified it was for January and allowed for Wash and Rinse temperature documentation each day at Breakfast, Lunch, and Supper. The log indicated Minimum Standards for Wash was 150 degrees F. and the Rinse as 180 degrees F. Instructions at the bottom of the log identified the following: If the dish machine temperatures fall below 150 [degrees F.] for WASH and 180 [degrees F.] for RINSE, stop doing dishes immediately and notify your FSD [food safety director] or Maintenance right away. The log identified documented below required rinse temperatures on 1/1/23 and each day that proceeded through 1/16/23. Identified below required wash temperatures were documented on the following days: 1/5/23, 1/6/23, 1/9/23, 1/10/23, 1/15/23, 1/16/23. The log identified one missed meal temperature check on each of the following days: 1/1/23, 1/4/23, 1/14/23, 1/20/23 and 1/23/23. When interviewed on 1/27/23, at 1:41 p.m. DM-A confirmed the dishwasher periodically had issues, with a recent dishwasher temperature issue that lasted about two to three days before it was fixed. She explained the rinse was not meeting required temperatures. She identified the wash cycle worked as required during that time, and staff had not updated her otherwise, and thus, We ran [the dishwasher] as the wash temperature was hot enough. She stated she reviewed the temperature log right after she was updated by maintenance of the dishwasher issues; however, she denied she reviewed them again after, when the facility waited for parts, or after the dishwasher was fixed. When questioned on the directed processes for staff when the dishwasher was not maintaining required temperatures, DM-A stated if both wash and rinse temperatures were below required temperatures staff were required to sanitize the dishes by hand using the three sink method, and as long as one of [the cycles were] correct it would be okay to continue to use the dishwasher. DM-A stated, after the dishwasher was fixed, she did not audit the staff or the dishwasher to ensure continued fix and she did not educate staff on temperature documentation [based on missed temperature log entries] and expected processes when the dishwasher temperatures were not at required readings. During interview on 1/27/23, at 2:21 p.m. MD-A stated he was made aware on either 1/4/23 or 1/5/23 the dishwasher rinse temperatures were not within required ranges. After a part was ordered, it was fixed on 1/16/23. MD-A stated the wash was always working; however, denied he reviewed the temperature log at that time to identify temperatures. MD-A stated the dishwasher functioned without issues after it was fixed based on staff had not come to him with complaints. He denied he formally audited the dishwasher temperatures or reviewed the temperature log documentation to ensure proper functioning. MD-A explained he understood that if the wash cycle worked properly, but the rinse did not, it was still safe to use the dishwasher, as the chemicals were still getting on the dishes and the rinse cycle was a precautionary backup, thus he never instructed the staff to not use the dishwasher before it was fixed. He added if both the wash and rinse failed to maintain temperatures then he expected staff to wash the dishes by hand. MA-A was unable to explain the process for washing dishes by hand. After the interview, MD-A walked to the kitchen and confirmed the dishwasher was a [NAME], model AM15 with a serial number of 23-1102-204. He denied he had a manufacture's manual. When interviewed on 1/27/23, at 2:57 p.m. registered nurse (RN)-A confirmed she was the infection preventionist (IP). She denied knowledge the dishwasher failed to function properly earlier in the month. She stated she expected if any cycle of the dishwasher failed to function staff would follow their processes for alternative washing to ensure the dishes were sanitized correctly and not contaminated. She explained if staff did not follow any facility policy or process related to the dishwasher issue, there was possible risk of microbe transmission that we do not want transmitted to the residents. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/30/23, at 10:30 a.m. DA-B stated the dishwasher was fixed a couple weeks ago as it failed to maintain temperatures as required. She explained everyone who did dishes knew it was not functioning; however, We just ran it. DA-B stated she felt the rinse was [hot] enough and sanitizing [the dishes] enough as the dishes went into the dishwasher without any food on them and if the water was hot enough, it sanitized. She identified dishes were sanitized when the wash water reached 150 degrees F. and the rinse reached 180 degrees F. She explained she would only use the three sinks process if both cycle temperatures were off. She denied any recent training instructions were provided to her for when the dishwasher failed to maintain required temperatures. During a follow up interview on 1/30/23, at 2:56 p.m. MD-A stated he was unable to remember who instructed him that if only one dishwasher cycle functioned that it was still okay to use the dishwasher. He denied knowledge of the dishwasher manufacturer guidelines, or facility policy, on the use of the dishwasher when the temperatures were not within requirements, or alternative washing instruction(s). When interviewed on 1/30/23, at 3:31 p.m. the administrator stated he was updated on the dishwasher issue initially on 1/27/23. He stated he expected dietary staff to continue to monitor the dishwasher for temperatures and to update DM-A and MD-A when issues were noted. In addition, he stated he expected DM-A and MD-A to follow the facility policy when the dishwasher temperatures were not within requirements. A dietary policy Dishwashing Procedures, dated 12/11/08, directed for mechanical hot water sanitizing dishwashing the water temperature was to be maintained at 150 degrees F. or above for the washing cycle and at 180 degrees F for the rinsing and sanitizing cycle. The policy directed if temperatures were below the minimum standards, immediate action was to be taken. In addition, the policy directed if the final rinse temperature on the dishwasher read below180 degrees, the temperature was to be checked using a holding thermometer or temperature strips to test that the surface contact point was at 160 degrees to ensure proper operation. Maintenance was to be notified and all dishwashing was to be halted as soon as the problem was identified and resumed when standard temperatures were again being maintained. The policy directed, when necessary, disposable dishware and/or hand sanitizing of dishes was to be performed, and further directed all food service staff were to follow the dishwashing operation policy and procedures. A dietary policy Dishwashing Temperature Monitoring Logs, undated, identified the policy was to ensure the wash and rinse temperatures were properly monitored and controlled in which a log was to be completed by those we were directly involved in the dishwashing process. Entries were to be made daily according to health department regulations and quality assurance standards. The policy directed that wash and rinse temperatures where to be logged every meal by the operator during dishwashing and if the temperature was below required levels the FSD was to be immediately notified for additional instructions before dishwasher use continued. In addition, the policy indicated it was the responsibility of the FSD to monitor the logs daily for completion.

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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 - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43080 Based on observation, interview, and document review the facility failed to ensure standards of practice for hand hygiene was completed between residents, and residents' rooms, to prevent the spread of infection, and to maintain infection control measures, for 5 of 5 residents (R1, R6, R7, R8, R9) observed during the passing of meal trays. In addition, the facility failed to ensure appropriate source control was utilized by contracted staff in accordance with national standards for 4 of 4 residents (R2, R3, R4, R5) observed during exercise programming. Findings include: The CDC (Centers for Disease Control and Prevention) website, dated 9/23/22, identified When SARS-CoV-2 Community Transmission levels are high, source control [well-fitting face mask] is recommended for everyone in a healthcare setting when they are in areas of the healthcare facility where they could encounter patients. The CDC Covid Data Tracker website, reviewed on 1/27/23, identified Kandiyohi County (county where facility resides) had a high SARS-CoV-2 community transmission level. During observation on 1/27/23, at 10:00 a.m. a side-table was directly positioned to the left side of the corridor after one passed through the entry vestibule. Signage was taped to the table which identified the facility was currently in outbreak status which ended on 2/3/23. In addition, additional signage indicated the facility's community transmission level was high and face masks were required. During the entrance conference on 1/27/23, at 10:05 a.m. the director of nursing (DON) identified R1 required contact transmission-based precautions (TBP) due to a bacteria. No other residents were identified on TBP. In addition, she identified the facility was free of COVID-19 positive/symptomatic residents or staff, and neither resident or staff were quarantined or off of work related to COVID-19. On 1/27/23, at 10:41 a.m. R1 was observed to have a three drawer plastic bin outside of his room which contained personal protective equipment (PPE - gowns/gloves/masks), along with a bottle of hand sanitizer on top of the bin. R1's room door and surrounding area lacked any signage which indicated R1 required TBP or which designated the type of TBP required. At the time of the observation, R1 walked with staff inside his room. The staff wore a gown, gloves, and mask. When the staff exited R1's room on 1/27/23, at 10:45 a.m. physical therapist (PT)-A stated R1 required contact precautions as R1 had an infection, not related to COVID. R1's Admission Assessment Tool Fast Track, dated 1/5/23, identified R1 required isolation related to VRE (Vancomycin [antibiotic] resistant enterococcus infection). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R1's admission Minimum Data Set (MDS) dated [DATE], identified R1 was moderately cognitively impaired and diagnosed with acute on chronic respiratory failure and liver (solid organ) transplant status, along with mental health conditions and heart disease. R1's Order Summary Report, printed 1/30/23, indicated R1 received CellCept (immunosuppressant medication) twice a day. The CDC website, COVID-19 - People Who Are Immunocompromised (have a weakened immune system), dated 1/26/23, identified persons who received a solid organ transplant and took immunosuppressant medications were moderately to severely immunocompromised and were more likely to get sick with COVID-19 or would be sicker longer. The CDC website, COVID-19 - People with Certain Medical Conditions, dated 1/26/23, identified persons with the following medical conditions were more likely to get sick with COVID-19 or were at higher risk of severe illness from COVID-19: chronic kidney disease (CKD), chronic lung disease(s) (e.g. asthma/COPD), diabetes, dementia, obesity, mental health conditions, heart disease and/or stroke. R2's admission MDS dated [DATE], identified R2 was moderately cognitively impaired and diagnosed with dementia, CKD, and a mental health condition. R3's annual MDS dated [DATE], identified R3 was moderately cognitively impaired and diagnosed with diabetes, obesity, mental health conditions, and heart diseases. R4's quarterly MDS dated [DATE], identified R4 was cognitively intact and diagnosed with respiratory failure, diabetes, COPD, mental health diseases, and heart disease. R5's annual MDS dated [DATE], identified R5 was cognitively intact and diagnosed with dementia, CKD, mental health conditions, and heart disease. R6's annual MDS dated [DATE], identified R6 was cognitively intact and diagnosed with CKD, diabetes, obesity, heart disease with history of a stroke, and mental health conditions. R7's admission MDS dated [DATE], identified R7 was moderately cognitively impaired and diagnosed with obesity, diabetes, a mental health condition, and heart disease. R7's progress notes, dated 1/27/23, at 11:53 a.m. and 3:13 p.m. respectively, identified R7 received antibiotic treatment for a urinary tract infection (UTI) and required medication to assist with an upset stomach and loose stools. R8's significant change MDS dated [DATE], identified R8 was cognitively intact and diagnosed with mental health conditions and heart disease. R9's admission MDS dated [DATE], identified R9 was cognitively intact and diagnosed with pneumonia, respiratory failure and COPD. During continued observation on 1/27/23, from 11:11 a.m. to 11:41 a.m. a contracted wellness staff (CWS)-A led an exercise session with eight residents in the main dining room. CWS-A lacked the use of any sort of face protection/source control. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 11:12 a.m. R2 started to cry. CWS-A approached R2 and crouched to her level which placed their faces in direct line with each other, less than one foot apart, and they conversed with each other. R2 lacked the use of a source control mask. -At 11:15 a.m. R2 started to cry. CWS-A approached R2, crouched to her level, aligned her face less than a foot from R2's face, and they conversed. -At 11:16 a.m. CWS-A passed R4 on her way to get R2 a Kleenex. CWS-A bent at her waist, aligned her face within approximately two feet of R4's face, and they conversed. R4 lacked the use of a source control mask. -At 11:17 a.m. CWS-A approached R3. She bent at the waist and aligned her face within an approximate foot of R3's face and they conversed. R3 lacked the use of a source control mask. -At 11:18 a.m. CWS-A adjusted her chair placement to accommodate R4 within the group circle. This placed CWS-A approximately two to three feet from R4 and three to four feet from R5. R4 was on CWS-A's left side and R5 on her right. R5 lacked the use of a source control mask. -From 11:18 a.m. to 11:35 a.m. CWS-A verbalized exercise instructions in which she often looked at R4 and R5 when she spoke. -At 11:35 a.m. CWS-A approached R2 as R2 wheeled her wheelchair into the middle of the group. CWS-A crouched to R2's level, aligned her face less than a foot from R2's face, and they conversed. CWS-A brought R2 back to her previous place, bent at the waist, aligned her face less a foot from R2, and they conversed. CWS-A returned to her spot and continued with verbalizing exercise instructions. -At 11:27 a.m. activity aide (AA)-A entered the dining room and sat down outside of the group circle and observed the exercise session. AA-A stayed until the end of the session and did not approach CWS-A to instruct her to don a mask. -At 11:29 a.m. CWS-A approached R2, crouched to her level, aligned her face less than two feet from R2's, and they conversed. -At 11:30 a.m. CWS-A returned to her chair and continued the session. -At 11:39 a.m. the session ended and CWS-A approached R2, bent down and aligned her face within approximately a foot, and they conversed. Right after she ended her conversation with R2, CWS-A approached two other residents (unidentified) who were brought in as the session ended, bent at the waist to align her face and theirs, and they conversed. These two residents lacked the use of a source control mask. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	When interviewed on 1/27/23, at 11:41 a.m. CWS-A stated she transitioned to the facility that week to assist with work out classes three times a week. In order to mitigate the spread of infection, she stated just the usual processes were required and explained hand washing and social distancing were important. She stated no one from the facility had informed her face masks were required and thus she thought they were not. She denied she asked staff about face mask expectations and denied she noticed and/or read the mask directive signs at the front entry when she entered. She explained another facility she visited for work out classes did not require face masks; however, her third facility did. CWS-A stated she was unaware of any residents with COVID; however, only as no one had mentioned any positive residents. She confirmed she was unaware of the county's transmission rate or what that would indicate if she did know. She explained she believed the CDC rules were for masks but she thought things may have changed and thus she followed facility processes. CWS-A stated if the facility required face mask use she would be expected to wear one in order to keep residents from getting sick. After the interview, at 11:49 a.m. CWS-A was observed to directly exit the facility and she failed to review any of the signage located in the facility's entryway. During an interview on 1/27/23, at 11:50 a.m. AA-A stated she currently was expected to wear an N-95 face mask and eye protection, along with resident social distancing, when she worked with resident(s) due to previous COVID positive residents in the facility this month. AA-A confirmed CWS-A lacked a face mask while she observed the exercise session and explained CWS-A was new to the position; however, someone had to have told her she was required to wear a mask. AA-A acknowledged she, should have stood up and said something, and she should have procured a mask for her but she did not want to embarrass her. During continued observation on 1/27/23, from 12:08 p.m. to 12:18 p.m. nursing assistant (NA)-A pushed a metal cart which housed resident meal trays towards the Maple Lane unit. -When they was adjacent to R6's room, they procured a meal tray and entered R6's room. NA-A placed the tray on R6's tray table, removed the insulated meal delivery dome, and then replaced it per R6's directive. NA-A then picked up R6's milk and asked if he desired it opened and replaced it on the tray when he declined. NA-A exited R6's room and closed R6's door. NA-A failed to perform hand hygiene before they entered and after they exited R6's room. -NA-A proceeded to push the cart to R7's room and procured a tray. NA-A entered R7's room and placed the tray on the tray table. NA-A adjusted the tray table in front of R7 and touched a pump bottle that was located on the tray table and exited R7's room. NA-A failed to perform hand hygiene before they entered and after they exited R7's room. -NA-A proceeded to push the cart to R8's room and procured a tray. NA-A entered R8's room, placed the tray on the tray table, and adjusted the tray table closer to him. NA-A exited R8's room and closed R8's door. NA-A failed to perform hand hygiene before they entered R8's room and after exit. -NA-A proceeded to push the cart toward the Oak Lane unit and touched their face mask to adjust it. NA-A failed to perform hand hygiene after they adjusted face mask. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-NA-A stopped pushing the cart when she was adjacent to R1's room. NA-A pulled out a drawer on the plastic PPE bin located outside R1's room, procured a TBP gown, and donned it. NA-A failed to perform hand hygiene before they touched the bin drawer or donned the gown. NA-A donned gloves, moved the cart for ease of access to the trays with a gloved hand, procured a tray, and entered R1's room. NA-A placed the tray on R1's tray table and moved the tray table into position in front of R1. After NA-A removed their PPE, they exited R1's room and used hand sanitizer. NA-A failed to perform hand hygiene before she entered R1's room and failed to change her gloves after she touched the cart. -NA-A proceeded to push the cart to R9's room, procured a tray, and entered R9's room. NA-A placed the tray on the tray table and moved the tray table into position in front of R9. In the process, items fell off the tray table onto the floor in which one item was the television remote. NA-A picked up the items and replaced the back cover of the remote. During the process, NA-A touched their face mask to adjust it. At 12:18 p.m. NA-A exited R9's room, touched their face mask again to adjust it, and proceeded to push the cart down the hallway as there were no more trays on the cart. NA-A failed to perform hand hygiene before and after they entered R9's room, and after she adjusted her face mask. When interviewed on 1/27/23, at 12:19 p.m. NA-A stated she was trained to wear gloves if she needed to touch a resident's food; however, she explained she did not think the facility expected her to use hand sanitizer when she dropped off meal trays despite her verbalization she was expected to use hand sanitizer before she entered a resident's room and when she exited. NA-A confirmed, except for after she exited R1's room, she failed to perform hand hygiene when she entered and exited resident rooms during the observed meal tray delivery. NA-A stated the importance of hand hygiene during meal tray delivery would be to stop the spread of germs. During an interview on 1/27/23, at 2:57 p.m. RN-A confirmed she was the facility's infection preventionist (IP) and identified R1 was on TBP as he was colonized with VRE and was immunocompromised due to his liver transplant status. She explained she expected staff to perform hand hygiene before they entered and after they exited a resident's room and provided an example of before and after passing trays in which staff were to at least use hand sanitizer versus hand washing. RN-A stated staff were recently educated a couple weeks ago on hand hygiene. She stated she expected anyone who worked in the facility who had direct care/interaction with residents, or who were within six feet of a resident, whether the residents were immunocompromised or not, to wear the required face mask per policy. RN-A verbalized she expected staff to approach other staff when face masks were observed to not be worn per policy and remind them as needed to don or adjust. She identified required hand hygiene and face mask use was important to decrease the risk of infection transmission, especially as this time of the year showed increased risk for influenza (flu) and RSV (respiratory virus). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	When interviewed on 1/27/23, at 3:51 p.m. wellness director (WD)-A stated she expected facility and contracted wellness staff to wear face masks per the policy and she further expected staff to remind other staff if face masks were observed to not be worn or to be worn incorrectly. She explained the importance of this was for infection control and if staff did not wear their masks as expected the staff could infect the residents. WD-A acknowledged she did not update CWS-A about facility mask expectations upon CWS-A's initial start that week; however, she identified she reached out to the contracted company this day to have them remind their trainers that face masks were required in the facility, as she observed CWS-A this day without a mask during the wellness activity. She explained she was unsure as to why she failed to approach CWS-A to inform her to don a mask. WD-A stated she expected the contracted company to provide information and education to their staff related to infection control measures; however, she followed-up and stated this was also a role of the facility. During an interview on 1/30/23, at 3:06 p.m. the DON stated she expected staff to perform hand hygiene, either hand washing or sanitizing, before going into or leaving a [resident's] room and provided examples of passing room trays or if picked items up off of the floor. In addition, she stated she expected staff, and contracted staff, to wear and use face masks per the policy. She explained the importance of following the policies was to prevent the spread of infection and to protect the residents and themselves. The DON indicated contracted staff were updated on expectations by word of mouth and signage at the [front entry] door. She expected staff to remind other staff to wear PPE when observed to not be worn, or to provide them with the PPE, and explain why the PPE was required. A policy Handwashing and Hand Hygiene Policy, dated 9/21/21, identified the facility considered hand hygiene the primary means to prevent the spread of infection and expected all staff to follow handwashing and hand hygiene procedures. The policy directed staff to perform hand hygiene before and after direct contact with residents, after contact with objects in the immediate vicinity of residents, and before and after they enter TBP settings. The policy indicated gloves did not replace hand washing/hand hygiene and directed staff to perform hand hygiene before they applied non-sterile gloves. A policy COVID-19 Policy Guidelines, updated 10/24/22, indicated all employees, consultants, and contractors were to be educated on infection control and prevention and identified the level of source control was based on the community transmission levels and if the transmission level was high source control was recommended for everyone in the healthcare setting. The policy identified source control referred to the application of well-fitting masks to cover a person's mouth and nose to prevent the spread of respiratory secretions when they breathed, talked, sneezed, or coughed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245360	A. Building B. Wing	01/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glenoaks Senior Living Campus	100 Glen Oaks Drive New London, MN 56273

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 0882 Level of Harm - Potential for minimal harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 43080 Based on interview and document review, the facility failed to ensure the acting infection preventionist (IP) had completed specialized training in infection prevention and control, failed to ensure the facility assessed the IP hours needed and ensured the IP worked the assessed hours on infection control and prevention to meet the needs of the residents and the facility. This had the potential to affect all 35 residents residing in the facility. Findings include: During the entrance conference on 1/27/23, at 10:05 a.m. the director of nursing (DON) identified RN-A was the facility's IP and identified the facility census was 35. An annual Facility Assessment, dated 12/26/22, identified RN-A was a facility assistant director of nursing (ADON) and the IP. The assessment indicated staffing levels were planned in advance and altered upon census in all departments, along with resident needs and admission and discharge statuses. If the facility was at full census (52 residents), the assessment directed, via a grid, the hours required for each staff type. The grid identified combined hours for Administration, which included the DON, ADON, clinical manager, Minimum Data Set (MDS) nurse, licensed nurses, and IP; however, the grid did not designate specific hours for the IP or other designated roles. The assessment, or grid, did not provide staffing direction(s) when the census was below 52. The assessment identified Staff Key Competencies in which all associates were required to be competent in Infection Control - Hand Hygiene, Isolation, Standard Precautions, Cleaning Equipment; however, competencies specific to the IP role were not identified. When interviewed on 1/27/23, at 2:57 p.m. RN-A identified she was the IP, along with a role of ADON. She acknowledged she was aware of the required specialized infection prevention and control training for the IP role; however, she had only completed three hours of the training since she started the IP role on 10/3/22. RN-A stated she dedicated a few hours a week to the IP role and explained, That [was] not good enough. She explained the IP role, for the facility, required a full time dedicated person. In addition, she explained even if she dedicated half of her hours to IP that would be unrealistic to perform all the IP tasks required effectively. RN-A stated she did not have a lot of time for the IP role as she was dealing with staffing and day to day issues. She explained administration recently removed staff development from her required duties related to her struggle to do all the required IP tasks; however, she still assisted to cover shifts and worked as a floor nurse when required and continued to not have adequate hours for IP. When questioned on a recent facility issue related to the kitchen dishwasher not functioning properly, RN-A confirmed she had no knowledge of the issue; however, felt something of such significance she would have known about if she were able to dedicate more hours to the role. RN-A stated the importance of adequate IP hours was to assist with improved infection surveillance and analysis in order to keep infection transmission down, along with maintained compliance and to ensure the facility and facility staff followed policy and protocols, especially for high risk residents. (continued on next page)

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	245360	A. Building B. Wing	01/30/2023

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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 0882 Level of Harm - Potential for minimal harm Residents Affected - Many	During an interview on 1/30/23, at 3:06 p.m. the DON stated RN-A dedicated at least half of her time on IP; however, she confirmed she had not performed time audits on RN-A's duties, reviewed RN-A's IP work, and/or confirmed with RN-A about the amount of time RN-A spent on infection control. The DON identified RN-A, besides the IP role, assisted with tasks such as admissions, provider order entry, and staffing in which RN-A was required to perform floor nurse duties at times. She stated RN-A was required to work the prior weekend a couple hours one day and then four hours the next as a floor nurse. The DON confirmed RN-A had not completed the specialized infection control required training for the IP role. The DON stated she was unsure how many hours a week were optimal for the IP role based on the resident census. She explained it was very important to spend adequate time on infection control in order to prevent the spread of communicable diseases and infection and to ensure quality control. In addition, she stated continued importance was to ensure the IP stayed on top of wounds and ensured they were improving and to get to the root cause analysis of infection concerns within the facility. When interviewed on 1/30/23, at 3:31 p.m. the administrator stated RN-A was a full time employee; however, he was unaware of the hours RN-A dedicated to the IP role and he explained there are other things [RN-A] does. He confirmed RN-A had yet to complete the specialized infection control training but identified RN-A was going through the course. The administrator stated, you want a dedicated infection preventionist but we all work together. A policy related to the IP was requested; however, was not provided.