DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 3, 2021

Administrator
Providence Place
3720 23rd Avenue South
Minneapolis, MN 55407

RE: CCN: 245271
Cycle Start Date: November 4, 2020

Dear Administrator:

On November 30, 2020, we notified you a remedy was imposed. On December 22, 2020 the Minnesota Department(s) of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of December 18, 2020.

As authorized by CMS the remedy of:

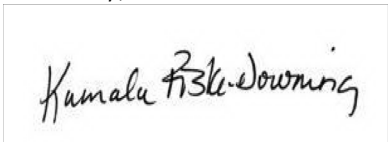
- Discretionary denial of payment for new Medicare and Medicaid admissions effective December 15, 2020 be discontinued as of December 18, 2020. (42 CFR 488.417 (b))

As we notified you in our letter of November 30, 2020, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from December 15, 2020. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,



Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit

Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

Electronically Submitted
November 30, 2020

Administrator
Providence Place
3720 23rd Avenue South
Minneapolis, MN 55407

RE: CCN: 245271
Cycle Start Date: November 4, 2020

Dear Administrator:

On November 4, 2020, survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted immediate jeopardy to resident health or safety. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted immediate jeopardy (Level K) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On November 4, 2020, the situation of immediate jeopardy to potential health and safety cited at F880 was removed. However, continued non-compliance remains at the lower scope and severity of E.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective December 15, 2020.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective December 15, 2020 (42 CFR 488.417 (b)), (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 15, 2020, (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective November 15, 2020. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Susan Frericks, Unit Supervisor
Metro D District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
PO Box 64990
St. Paul MN 55164-0900
Email: susan.frericks@state.mn.us
Mobile: (218) 368-4467

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 4, 2021 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with

which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900

St. Paul, Minnesota 55164-0900

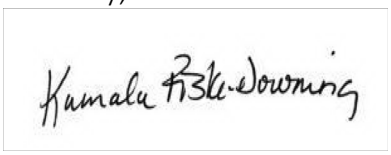
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,



Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

A Directed Plan of Correction (DPOC) is imposed in accordance with 42 CFR § 488.424. Your facility must include the following in their POC for the deficient practice cited at F880:

- In order to assist with identifying appropriate corrective actions and implementing systemic changes, the facility must contract with an infection control consultant to provide consultation and oversight for infection prevention and control within the facility.

- The consultant shall exercise independent judgement in the performance of all duties under the consultant contract. The consultant shall meet the independent judgement requirement if the consultant is not presently and has not within a five (5) year period immediately preceding June 1, 2020 directly or indirectly affiliated with the facility, facility's owner(s), agent(s), or employee(s).

- The consultant shall have completed infection prevention and control training from a recognized source, such as the Centers for Disease Control and Prevention or American Health Care Association.

- The consultant will be contracted to work with the facility for a minimum of two (2) months.

- The consult will assist the facility in completing the CMS infection control self-assessment. If this assessment was completed prior to the June 4, 2020 survey, the assessment should be reviewed to determine if it is an accurate reflection of the facility's infection control program. The self-assessment can be found in the CMS publication QSO-20-20-All: Prioritization of Survey Activity: https://www.cms.gov/files/document/qso-20-20-all.pdf,

Infection control consultant responsibilities must include, but are not limited to, the following:

- Work with the facility to conduct a Root Cause Analysis (RCA) to identify and address the reasons for noncompliance identified in the CMS-2567.
- The facility's Infection Preventionist, Quality Assurance and Performance Improvement (QAPI) committee, must participate in the completion of the RCA. Information regarding RCAs can be found in the CMS publication Guidance for Performing Root Cause Analysis (RCA) with Performance Improvement Projects (PIPs):

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/GuidanceforRCA.pdf.

- Take immediate action to implement an infection prevention plan consistent with the requirements at 42 CFR § 483.80 for the affected residents impacted by the noncompliance identified in the CMS-2567 to include identification of other residents that may have been impacted by the noncompliant practices. This plan must include but is not limited to implementation of procedures to ensure:

PERSONAL PROTECTIVE EQUIPMENT (PPE)

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

POLICIES/PROCEDURES/SYSTEM CHANGES:

- The facility's Quality Assurance and Performance Improvement Committee must conduct a root cause analysis (RCA) to identify the problem(s) that resulted in this deficiency and develop intervention or corrective action plan to prevent recurrence.

The Infection Preventionist and Director of Nursing, shall complete the following:

- Review policies and procedures for donning/doffing PPE for TBD and during COVID-19 with current guidelines to include crisis standard of care, contingency standard of care and standard care.
- Develop and implement a policy and procedure for source control masks.
- Review policies regarding standard and transmission based precautions and revise as needed.

TRAINING/EDUCATION:

As a part of corrective action plan, the facility must provide training for the Infection Preventionist, the Director of Nursing, all staff providing direct care to residents, and all staff entering resident's rooms, whether it be for residents' dietary needs or cleaning and maintenance services. The training must cover standard infection control practices, including but not limited to, transmission-based precautions, appropriate PPE use, and donning and doffing of PPE.

- The training may be provided by the Director of Nursing, Infection Preventionist, or Medical Director with an attestation statement of completion.
- The training must include competency testing of staff and this must be documented.
- Residents and their representatives should receive education on the facility's Infection Prevention Control Program as it related to them and to the degree possible/consistent with resident's capacity.
- Online infection prevention training courses may be utilized. The CDC and MDH websites have several infection control training modules and materials.

CDC RESOURCES:

Infection Control Guidance: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html
CDC: Isolation Precautions Guideline:
https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007): https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Personal Protective Equipment: https://www.cdc.gov/niosh/ppe/
Healthcare Infection Prevention and Control FAQs for COVID-19:
https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control-faq.html

MDH RESOURCES:

Personal Protective Equipment (PPE) for Infection Control:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/ppe/index.html
MDH Contingency Standards of Care for COVID-19: Personal Protective Equipment for Congregate Care Settings (PDF): https://www.health.state.mn.us/communities/ep/surge/crisis/ppegrid.pdf
Interim Guidance on Facemasks as a Source Control Measure (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/maskssource.pdf
Interim Guidance on Alternative Facemasks (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/masksalt.pdf
Aerosol-Generating Procedures and Patients with Suspected or Confirmed COVID-19 (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/aerosol.pdf
Droplet Precautions:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html
Airborne Precautions:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html

MONITORING/AUDITING:

- The Director of Nursing, the Infection Preventionist, and other facility leadership will conduct audits of donning/doffing PPE with Transmission Based Precautions i.e. Droplet precautions.
- The Director of Nursing, Infection Preventionist, and other facility leadership will conduct routine audits on all shifts four times a week for one week, then twice weekly for one week once compliance is met. Audits should continue until 100% compliance is met on source control masking for staff, visitors and residents.
- The Director of Nursing, Infection Preventionist, and other facility leadership will conduct real time audits on all aerosolized generating procedures to ensure PPE is in us.
- The Director of Nursing, Infection Preventionist, or designee will review the results of audits and monitoring with the Quality Assurance Program Improvement (QAPI) program.

HAND HYGIENE

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

POLICIES/PROCEDURES/SYSTEM CHANGES:

- The facility's Quality Assurance and Performance Improvement Committee must conduct a root cause analysis (RCA) to identify the problem(s) that resulted in this deficiency and develop intervention or corrective action plan to prevent recurrence.

The Infection Preventionist and Director of Nursing, shall complete the following:

- Review hand hygiene policies and procedures to ensure they meet CDC guidance, and revise as

needed.

TRAINING/EDUCATION:

- As a part of corrective action plan, the facility must provide training for the Infection Preventionist, the Director of Nursing, all staff providing direct care to residents, and all staff entering resident's rooms, whether it be for residents' dietary needs or cleaning and maintenance services. The training must cover standard infection control practices, including but not limited to, transmission-based precautions and adequately caring for and disinfecting shared medical equipment. Findings of the RCA should also be incorporated into staff training.
- The Infection Preventionist, Director of Nursing and Clinical Education Coordinator must implement competency assessments for staff on proper hand hygiene and develop a system to ensure all staff have received the training and are competency
- Online infection prevention training courses may be utilized. The CDC and MDH websites have several infection control training modules and materials.

https://www.health.state.mn.us/people/handhygiene/ (MDH)
Hand Hygiene (MDH) https://www.health.state.mn.us/people/handhygiene/index.html
Hand Hygiene for Health Professionals (MDH)
https://www.health.state.mn.us/people/handhygiene/index.html
Cleaning Hands with Hand Sanitizer (MDH)
https://www.health.state.mn.us/people/handhygiene/clean/index.html
CDC: Guideline for Hand Hygiene in Health-Care Settings (CDC)
https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5116a1.htm
WHO Guidelines on Hand Hygiene in Health Care (WHO)
https://apps.who.int/iris/bitstream/handle/10665/44102/9789241597906_eng.pdf;jsessionid=A770590E49844880F6F3E1D8F22F0841?sequence=1
Hand Hygiene in Outpatient and Home-based Care and Long-term Care Facilities (WHO)
https://www.who.int/gpsc/5may/hh_guide.pdf

CDC RESOURCES:
Infection Control Guidance: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html
CDC: Isolation Precautions Guideline:
https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007): https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Personal Protective Equipment: https://www.cdc.gov/niosh/ppe/
Healthcare Infection Prevention and Control FAQs for COVID-19:
https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control-faq.html

MDH RESOURCES:
Personal Protective Equipment (PPE) for Infection Control:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/ppe/index.html
MDH Contingency Standards of Care for COVID-19: Personal Protective Equipment for Congregate Care Settings (PDF): https://www.health.state.mn.us/communities/ep/surge/crisis/ppegrid.pdf
Interim Guidance on Facemasks as a Source Control Measure (PDF):

https://www.health.state.mn.us/diseases/coronavirus/hcp/maskssource.pdf
Interim Guidance on Alternative Facemasks (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/masksalt.pdf
Aerosol-Generating Procedures and Patients with Suspected or Confirmed COVID-19 (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/aerosol.pdf
Droplet Precautions:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html
Airborne Precautions:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html

MONITORING/AUDITING:

- The Director of Nursing, the Infection Preventionist and other facility leadership will conduct audits on all shifts, every day for one week, then may decrease the frequency based upon compliance. Audits should continue until 100% compliance is met.
- The Director of Nursing, Infection Preventionist or designee will review the results of audits and monitoring with the Quality Assurance Program Improvement (QAPI) program.

COHORTING RESIDENTS/TRANSMISSION BASED PRECAUTION "ISOLATION"

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

POLICIES/PROCEDURES/SYSTEM CHANGES:

- The facility's Quality Assurance and Performance Improvement Committee must conduct a root cause analysis (RCA) to identify the problem(s) that resulted in this deficiency and develop intervention or corrective action plan to prevent recurrence.

The Infection Preventionist and Director of Nursing shall complete the following:

- COVID-19 residents, non-COVID-19 suspected residents).
- Confine symptomatic residents and exposed roommates to their rooms. If they must leave their room, ensure the resident is wearing a mask.
- Provide dedicated equipment for areas, as able.

When a resident is placed on transmission-based precautions, the staff should implement the following:

- Clearly identify the type of precautions and the appropriate PPE to be used.
- Place signage in a conspicuous place outside the resident's room (e.g., the door or on the wall next to the door) identifying the CDC category of transmission-based precautions (e.g., contact, droplet, or airborne), instructions for use of PPE, and/or instructions to see the nurse before entering. Ensure that signage also complies with residents' rights to confidentiality and privacy.

- Make PPE readily available near the entrance to the resident's room.
- Don appropriate PPE upon entry into the environment (e.g., room or cubicle) of resident on transmission-based precautions (e.g., contact precautions).
- Use disposable or dedicated noncritical resident-care equipment (e.g., blood pressure cuff, bedside commode). If noncritical equipment is shared between residents, it will be cleaned and disinfected following manufacturer's instructions with an EPA-registered disinfectant after use.
- Clean and disinfect objects and environmental surfaces that are touched frequently (e.g., bed rails, over-bed table, bedside commode, lavatory surfaces in resident bathrooms).

TRAINING/EDUCATION:

- Provide education to residents (to the degree possible/consistent with the resident's capacity) and their representatives or visitors on the use of transmission-based precautions.
- Refer to CDC Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings. https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
- Refer to MDH COVID-19 Infection Prevention and Control and Cohorting in Long-term Care. https://www.health.state.mn.us/diseases/coronavirus/hcp/ltcipchohort.pdf
- MDH: Interim Guidance for Hospital Discharge to Home or Admission to Congregate Living Settings and Discontinuing Transmission-Based Precautions. https://www.health.state.mn.us/diseases/coronavirus/hcp/hospdischarge.pdf

CDC RESOURCES:
Infection Control Guidance: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html
CDC: Isolation Precautions Guideline:
https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007): https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Personal Protective Equipment: https://www.cdc.gov/niosh/ppe/
Healthcare Infection Prevention and Control FAQs for COVID-19:
https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control-faq.html

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MDH Contingency Standards of Care for COVID-19: Personal Protective Equipment for Congregate Care Settings (PDF): https://www.health.state.mn.us/communities/ep/surge/crisis/ppegrid.pdf
Interim Guidance on Facemasks as a Source Control Measure (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/maskssource.pdf
Interim Guidance on Alternative Facemasks (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/masksalt.pdf
Aerosol-Generating Procedures and Patients with Suspected or Confirmed COVID-19 (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/aerosol.pdf
Droplet Precautions:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html
Airborne Precautions:

https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html

MONITORING/AUDITING:

- The Director of Nursing, the Infection Preventionist and other facility leadership will verify the placement of each new admission and location and audit for transmission based precautions are being appropriately implemented.
- Conduct a Root Cause Analysis (RCA) which will be done with assistance from the Infection Preventionist, Quality Assurance and Performance Improvement (QAPI) committee and Governing Body. The RCA should be incorporated into the intervention plan. Information regarding RCAs can be found in the document: Guidance for Performing Root Cause Analysis (RCA)with Performance Improvement Projects (PIPs)
https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/GuidanceforRCA.pdf

In accordance with 42 CFR § 488.402(f), this remedy is effective 15 calendar days from the date of the enforcement letter. The DPOC may be completed on or after that date. The effective date is not a deadline for completion of the DPOC. However, a revisit will not be approved prior to receipt of documentation confirming the DPOC was completed. To demonstrate that the facility successfully completed the DPOC, the facility must provide all of the following documentation. Documentation should be uploaded as attachments through ePOC.

Imposition of this DPOC does not replace the requirement that the facility must submit a complete POC for all cited deficiencies (including F880) within 10 days after receipt of the Form CMS 2567.

Item	Checklist: Documents Required for Successful Completion of the Directed Plan
1	Consultant name and credentials meeting the criteria outlined above
2	Executed contract with the consultant
3	Documentation demonstrating that the RCA was completed as described above
4	List of facility policies and procedures reviewed by the consultant.
5	Infection control self-assessment
6	Summary of all changes as a result of the RCA and consultant review – to include a summary of how staff were notified and trained on the changes
7	Content of the trainings provided to staff to include a Syllabus, outline, or agenda as well as any training materials used and provided to staff during the training
8	Names and positions of all staff to be trained
9	Staff training sign-in sheets
10	Summary of staff training post-test results, to include facility actions in response to any failed post-tests
11	Summary of follow-up employee supervision and work performance appraisal to include when employees were observed, what actions were observed, and an evaluation of the effectiveness of any new policies and procedures.

In order to speed up our review, identify all submitted documents with the number in the “Item” column.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING _____ B. WING _____	11/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A COVID-19 Focused Infection Control survey was conducted 11/3/20, and 11/4/20, at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.73(b)(6). The facility was IN full compliance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control survey was conducted on 11/3/20, and 11/4/20, at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was determined NOT to be in compliance. The survey resulted in findgings of immediate jeopardy (IJ), pattern, when it was determined the facility failed to implement 14 days of quarantine with full PPE: gown, gloves, mask, and eye protection per the Centers for Disease Control and Prevention (CDC) COVID-19 guidelines. Staff were observed providing direct cares and repositioning residents without wearing gowns. Staff were also observed not practicing hand hygiene when entering and exiting rooms between quarantine and non-quarantine rooms. The administrator and director of nursing (DON) were notified of the IJ on 11/3/20, at 6:51 p.m.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/10/2020

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.

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F 000	Continued From page 1 The IJ was removed on 11/4/20, at 4:55 p.m., but noncompliance remained at a lower scope and severity level of E: pattern which indicated no actual harm with potential for more than minimal harm that is not IJ. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, a revisit of your facility will be conducted to validate substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 880 SS=K	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections	F 880		12/18/20

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F 880	Continued From page 2 and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 880		

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F 880	Continued From page 3 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement appropriate COVID-19 infection control practices related to the appropriate utilization of personal protective equipment (PPE) when providing personal care and treatment to residents and failed to quarantine for 12 (R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R12) of 22 recently admitted residents. These practices resulted in an immediate jeopardy (IJ) due the potential risk to affect all 22 residents residing in the transitional care unit (TCU). In addition, staff were not practicing hand hygiene, not ensuring social distancing in the smoking area, not wearing appropriate PPE or following infection control practices at the screening station. The IJ began on 11/3/20, when it was determined the facility failed to implement 14 days of quarantine with full PPE: gown, gloves, mask, and eye protection per the Centers for Disease Control and Prevention (CDC) COVID-19 guidelines. Staff were observed providing direct cares and repositioning residents without wearing gowns. Staff were also observed not practicing hand hygiene when entering and exiting rooms between quarantine and non-quarantine rooms. The administrator and director of nursing (DON)	F 880	F880: The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: 1. Facility assessed R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11 and R12 for respiratory symptoms or changes in status warranting intervention with none noted. Facility placed all residents on step down unit within 14 observation period in enhanced precautions, posted signage on doors and added gowning for all direct cares into updated guidelines. 2. Facility reviewed all residents active screening logs with twice daily assessments for acute health changes on December 1, 2020. All residents are	

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F 880	Continued From page 4 were notified of the IJ on 11/3/20, at 6:51 p.m. The IJ was removed on 11/4/20, at 4:55 p.m., but noncompliance remained at a lower scope and severity level of E: pattern which indicated no actual harm with potential for more than minimal harm that is not IJ. Findings include: RESIDENT CARE PPE USE: R2 Admission Face Sheet dated 11/4/20, indicated R2 was admitted on 10/22/20, from an acute care hospital. R2's Care Area Assessment (CAA) dated 11/3/20, indicated R2 was frequently incontinent of urine due to urge incontinence, required extensive assist for bed mobility and total assist with toileting. R2's Diagnosis Report dated 11/4/20, indicated R2 had diagnoses that included bacteremia, unspecified streptococcus and cutaneous abscess of left foot. R2's initial care plan was requested but not provided by facility at the time of the findings. During an observation on 11/3/20, at 1:49 p.m. nursing assistant (NA)-A performed hand hygiene and entered R2's room. NA-A donned gloves, removed an incontinent product, and provided perianal care. Upon completion of cares, NA-A removed gloves and proceeded to the bathroom and washed hands. NA-A had on face mask, face shield and gloves while providing high contact care to R2, however, a gown was not used during this time.	F 880	screened twice daily for symptoms and clinical leadership reviews daily. There were no identified areas of concern. 3. All Residents care plans were reviewed and updated to reflect at risk for Covid-19 infection with need for quarantine a minimum of 14 days upon admission to facility per Centers for Disease Control guidelines. 4. Facility□s QAPI committee completed a root cause analysis with contracted consultant on December 4, 2020, regarding area of concern. 5. The Infection Preventionist and Director of Nursing reviewed policy and procedure for donning and doffing PPE during COVID-19. Reviewed and updated facility guidelines for source control mask, face shield use and gown when in direct contact with others. Reviewed facility guideline regarding standard and transmission based precautions. 6. All staff will be reeducated on facility guidelines for standard infection control practices, including transmission-based precautions, PPE during direct contact, disinfecting equipment, and donning and doffing of PPE by December 18, 2020. The training included a return demonstration to ensure staff competency, and information utilized from current CDC and MDH guidelines. All residents and their representatives will receive education on the facility□s infection control program.	

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F 880	Continued From page 5 On 11/3/20, at 1:54 p.m. NA-A stated he had returned to R2's room to apply rash prevention topical cream to perianal area. NA-A had on a face mask, and face shield, performed hand hygiene, donned gloves and then applied topical cream to R2's perianal area. NA-A then doffed gloves, and performed hand hygiene. R2 did not use a gown for these cares. During an observation on 11/3/20, at 1:57 p.m. NA-A and NA-C entered R2's room to reposition R2 in bed. NA-A and NA-C both had on face masks and face shields. NA-A and NA-C performed hand hygiene and donned gloves. NA-A then explained to R2 that they would be moving R2 up in bed. NA-A and NA-C used the draw sheet under R2 to reposition up in bed. After repositioning, both staff doffed gloves and performed hand hygiene. Neither NA-A nor NA-C wore gowns for these cares. During an interview on 11/3/20, at 2:15 p.m. NA-C stated R2 was a new admit but NA-C was not assigned to R2. NA-C stated she went into the room to assist NA-A with repositioning R2 since they needed 2 staff for repositioning in bed. NA-C also stated that for new admits, staff are only required to wear face mask, face shield, or goggles and wear gloves when providing personal cares. When interviewed at 2:21 p.m. on 11/3/20, NA-A stated R2 is a new admit. She stated gown usage was not for everyone, however face mask, face shield, or goggles are used for all residents. If a resident is on contact precautions then gowns are used only when providing direct care. NA-A further explained that she only need to wear a	F 880	7. Director of Nursing or designee will complete four times weekly PPE audits x 1 week, then twice weekly times one week or once 100% compliance is reached. Director of Nursing or designee will complete hand hygiene daily audits x 1 week, then decrease frequency based on compliance until 100% compliance is met. Staff are audited for expectations of hand hygiene and PPE use when in direct contact with others. The Director of Nursing or designee will complete real time audits on all aerosolized generating procedures to ensure PPE is in use. The Director of Nursing and Infection Preventionist will review the results of the audits and monitoring with the facility□s QAPI program.	

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F 880	Continued From page 6	F 880		

face mask, face shield or goggles are required when entering R2's room. Gloves are only worn when providing direct personal cares.

On 11/3/20, at 2:35 p.m. during an interview, the infection preventionist (IP) indicated new admits are placed in the back half of the transition care unit (TCU) for fourteen days and are monitored for respiratory symptoms, temperature and oxygen saturation monitoring, signs and symptoms monitoring and tested weekly during the facility wide Covis-19 testing. IP further indicated, staff are expected to wear a face mask and eye protection at all times for all resident but are not required to wear gowns for newly admitted residents during cares or entry into their rooms as facility has to preserve supplies or would run out.

During interview on 11/3/20, at 4:15 p.m. the director of nursing (DON) indicated all new admits are placed on the Step Down unit on the TCU. DON further explained, when new admits are positive for Covid-19 they are placed on the Covid-19 isolation unit. New admits on the TCU are placed in quarantine for fourteen days on the Step Down unit, however staff are not expected to enter new admittion rooms gloved or gowned, and staff were not required to wear gowns during high contact cares with new admits on quarantine.

R1
R1's face sheet, dated 11/4/20, indicated R1 had been admitted to the facility on 10/29/20.

R1's Diagnosis List, dated 11/4/20, indicated R1 had diagnoses of disseminated herpes zoster (shingles, which is a viral infection caused by the

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F 880	Continued From page 7	F 880		

same virus that causes chicken pox and causes a painful rash; disseminated shingles means it is widespread), hypertension, atherosclerotic heart disease (thickening of the blood vessels of the heart causing them to stiffen and restrict blood flow to the heart), myocardial infarction (heart attack), and hyperlipidemia (high cholesterol).

R1's Progress Note, 10/30/20, indicated R1 was admitted to the facility following a hospital admission for disseminated herpes zoster (shingles). R1's Comprehensive Skin and Positioning Note, dated 11/3/20, indicated R1 had "open lesion(s)" but there was no description of the lesions.

R1's Care Plan, dated 10/31/20, lacked care planning related to use of isolation or quarantine for either the disseminated herpes zoster or for COVID-19 precautions for a new admission.

During an observation on 11/3/20, at 9:00 a.m., R1 had a sign on her room door that read "contact precautions". An isolation cart was inside her room with a box of gloves on top of the cart but no gowns were in the cart.

During an observation on 11/3/20, at 12:42 p.m., R1's room door was open; nursing assistant (NA)-A entered R1's room with a food tray. NA-A's face shield was pushed back on top of his head and his mask was loosely on his beard, not covering his mouth or nose. NA-A did not perform hand hygiene upon entering the room and was not wearing a gown or gloves. NA-A placed the food tray on the bedside table in front of R1, who was not wearing a mask. NA-A did not perform hand hygiene when exiting the room.

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F 880	Continued From page 8 During an interview on 11/3/20, at 12: 45 p.m., NA-A stated he did not know why R1 was on contact precautions. NA-A indicated all new residents were on quarantine but NA-A did not know why there was a sign on R1's door and no other resident's door. NA-A verified there was no gowns in the isolation cart in R1's room and no gloves, but NA-A stated gloves were in the bathroom. NA-A stated they did not need to wear gloves or gowns unless they were providing direct care to a resident. R3 R3's face sheet, dated 11/4/20, indicated R3 had been admitted to the facility on 10/20/20. R3's Diagnosis List, dated 11/4/20, indicated R3 had diagnoses which included human immune deficiency virus (HIV) disease (a disease that interferes with the body's ability to fight infection), chronic obstructive pulmonary disease (COPD, a lung diseases that blocks airflow and make it difficult to breathe), atherosclerotic heart disease (thickening of the blood vessels of the heart causing them to stiffen and restrict blood flow to the heart), and congestive heart failure (when the heart muscle does not pump blood as well as it should causing fluid to back-up in the legs and lungs). R3's "Nursing Assessment: Admission/Readmission + Care Plan - V3", dated 10/30/20, lacked care planning related to COVID-19 precautions for a new admission. During an observation on 11/3/20, at 9:45 a.m. through 9:55 a.m., R3's room door was open; RN-B was at the medication cart preparing	F 880		

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F 880	Continued From page 9	F 880		

medications outside of R3's room. RN-B took medications into R3's room without performing hand hygiene. In addition, there was no sign on the door indicating R3 was in quarantine, and RN-B did not wear gown or gloves. There was no PPE cart near R3's room or inside R3's room. In the process of administering medications to R3, RN-B dropped one of the pills and it fell into the chair's cushion. RN-B left the room without performing hand hygiene, went to the medication cart, retrieved a new pill, and returned to R3's room without performing hand hygiene. RN-B then left R3's room, performed hand hygiene, and returned to the medication cart to prepare medications for R4.

On 11/3/20, at 2:01 p.m. through 2:34 p.m. during continuous observations of R3 in R3's room:
* Occupational therapist (OT)-A entered R3's room without performing hand hygiene, and without wearing gloves or a gown. OT-A was wearing a face mask but her face shield was pushed back to the top of her head and her eyes were not covered.
* NA-A entered R3's room without gown or gloves and did not perform hand hygiene. R3 asked NA-A for coffee and NA-A left the room without performing hand hygiene. NA-A returned with coffee and no hand hygiene was performed upon entrance or exit to the room.
* OT-A asked R3 to wear a face mask for an OT evaluation. Did R3 NOT have a mask on at the beginning of this observation? If so, let's put that above.
* NA-C entered R3's room and R3 asked for pain medication. NA-C did not perform hand hygiene upon entering the room and did not wear gloves or gown but did have on a face mask and eye protection.

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F 880	Continued From page 10 * NA-C left the room and asked OT-A to press the call light to shut it off. OT-A pressed the call light once, reaching over R3. R3 then reached up and pressed the call light three times. RN-B entered R3's room, without gown or gloves and without performing hand hygiene while entering, and pressed R3's call light three times. * OT-A, still not wearing gloves, gave a hand grip to R3 and instructed him to squeeze it three times with his right hand. Once he did this, OT-A took the grip from R3 and wrote numbers on a piece of paper on R3's window sill. OT-A handed the grip to R3 to squeeze with his left hand. OT-A took the hand grip back and wrote on the same piece of paper. * RN-B entered R3's room without performing hand hygiene upon entering and not wearing gown or gloves. RN-B gave R3 a ½ tablet of pain medication and R3 stated that was not enough. RN-B left the room without performing hand hygiene upon exit to check the medication dose. * OT-A gave a sheet of paper and her pen to R3 and asked him to draw a clock. R3 placed the paper on his bedside table and when done, handed the paper and pen back to OT-A. * RN-B entered the room again without performing hand hygiene. RN-B gave R3 a whole pill for pain. RN-B exited the room without performing hand hygiene. * OT-A asked R3 to pull his pants down and then pull them up [testing his ability to do this task]. R3 pulled his pants to his knees, then OT-A handed R3 a grabber so he could use it to pull up his pants. OT-A then moved her face shield down to cover her eyes and donned gloves to assist R3 with putting on his socks. OT-A removed gloves after R3's socks were off. During an interview on 11/3/20, at 2:34 p.m.,	F 880		

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F 880	Continued From page 11 OT-A stated R3 was on isolation for 14 days because he was a new admission. OT-A stated this meant he could not leave his room and they did therapy in the room. OT-A stated this meant he was on standard precautions and gloves were only used for close contact with the resident. R4 R4's face sheet, dated 11/4/20, indicated R4 had been admitted to the facility on 10/29/20. R4's Diagnosis List, dated 11/4/20, indicated R4 had diagnoses which included sick sinus syndrome (an inability of the heart's natural pacemaker to create electrical impulse that trigger the heart muscle to pump), congestive heart failure (when the heart muscle does not pump blood as well as it should causing fluid to back-up in the legs and lungs), hypertension, type 2 diabetes mellitus, and abdominal aortic aneurysm (an enlargement of the largest blood vessel in the body that can lead to rupture). R4's "Nursing Assessment: Admission/Readmission + Care Plan - V3", dated 11/2/20, revealed it lacked care planning related to COVID-19 precautions for a new admission. On 11/3/20, at approximately 9:50 a.m., R4's door was open and RN-B took medications into R4's room without performing hand hygiene. In addition, there was no sign on the door indicating R4 was in quarantine, RN-B did not wear gown or gloves and there was no PPE cart near R4's room or inside R4's room. R5 and R10 R5's face sheet, dated 11/4/20, indicated R5 had	F 880		

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been admitted to the facility on 10/19/20.

R5's Diagnosis List, dated 11/4/20, indicated he had diagnoses which included intracerebral hemorrhage (stroke) and a relevant diagnoses of HIV, hypertension, and hyperlipidemia (high cholesterol, a fat-like substance found in the blood).

R5's "Nursing Assessment: Admission/Readmission + Care Plan - V3", dated 10/19/20, showed the record lacked care planning related to COVID-19 precautions for a new admission or readmission.

R10's face sheet, dated 11/4/20 indicated he was 53 years old and admitted to the facility on 10/7/20.

R10's diagnosis list, dated 11/4/20, indicated R10 had relevant diagnoses of renal failure (gradual loss of kidney function) requiring dialysis (a treatment for kidney failure), diabetes, morbid obesity, vitamin D deficiency, right above the knee amputation, left above the knee amputation, and hypertension (high blood pressure).

Since R10 was not a new admission or readmission within 14 days, R10 did not need to be on any type of quarantine.

During observation on 11/3/20, from 8:30 a.m. until 8:45 a.m. R5's room door was open. RN-A was preparing medications at a medication cart nearby and took R5 medications without performing hand hygiene and there was no sign on the door indicating R5 was in quarantine. Finally, RN-A did not wear a gown or gloves, and

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there was no PPE cart near R5's room or inside R5's room. Throughout this observation, RN-A's face shield was on the top of his head, not covering his eyes.

After exiting R5's room and performing hand hygiene, RN-A returned to the medication cart and prepared medications for R10. RN-A did not perform hand hygiene upon entering R10's room, and RN-A's face shield remained on top of his head.

During continuous observation on 11/3/20, at 1:46 p.m. through 1:55 p.m., speech therapist (ST)-A was in R5's room with mask and face shield, but no gown or gloves. The door to R5's room was open. ST-A was sitting on the floor within six feet of the resident who was not wearing a mask. ST-A rose and patted R5 on his back and then placed R5's call light near him. ST-A donned gloves to empty R5's urinal, then doffed gloves, but did not perform hand hygiene when she exited the room. ST-A left R5's door open.

R6
R6's face sheet, dated 11/4/20, indicated R6 had been admitted on 1/10/20.

A progress note, dated 10/30/20, indicated R6 was readmitted after treatment for a fractured arm sustained during a fall in the facility.

R6's Diagnosis List, dated 11/4/20, indicated R 6 had relevant diagnoses which included chronic obstructive pulmonary disease (COPD), hypertension, peripheral vascular disease (a disease where fatty deposits and calcium builds up in the walls of the blood vessels and leads to

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narrowing, blockage, or vessel spasms), and chronic kidney disease.

R6's care plan, 1/24/20, showed the record lacked care planning related to COVID-19 precautions for a new readmission.

During an observation on 11/3/20, at 11:23 a.m., R6's room door was open and RN-B was at the medication cart preparing medications. RN-B took medications into R6's room without performing hand hygiene, and without wearing a gown or gloves. In addition, there was no sign on the door indicating R6 was in quarantine. There was no PPE cart near R6's room or inside R6's room. RN-B gave the medications to R6 and performed hand hygiene upon exiting the room.

R7's face sheet, dated 11/4/20, indicated R7 had been admitted to the facility on 8/5/20.

R7's Diagnosis List, dated 11/4/20, indicated R7 was admitted with a primary diagnosis of peripheral neuromuscular disease (a disease affecting peripheral [arms, legs, and torso] nerves on both sides of the body, leading to weakness, numbness, pins-and-needle sensation, and burning pain) and other relevant diagnoses of chronic obstructive lung disease (a lung diseases that blocks airflow and make it difficult to breathe), atherosclerotic disease of coronary arteries (thickening of the blood vessels of the heart causing them to stiffen and restrict blood flow to the heart), hypertension (high blood, usually defined as pressure greater than 140 milligrams of mercury over 80 milligrams of mercury), and peripheral vascular disease (a disease where fatty deposits and calcium builds

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up in the walls of the blood vessels and leads to narrowing, blockage, or vessel spasms).

A progress note, dated 10/23/20, indicated R7 was readmitted to the facility on 10/23/20, after being discharged to the hospital to receive a blood transfusion after sustained nasal bleeding.

R7's care plan, dated 8/28/20, indicated the record lacked care planning related to COVID-19 precautions for a readmission.

R8's face sheet, dated 11/4/20, indicated R8 had been admitted to the facility on 10/27/20.

R8's Diagnosis List, dated 11/4/20, indicated R8 had diagnoses which included closed reduction of fractured (broken) left tibia (bone in lower leg) and fibula (bone in lower leg) with other relevant diagnoses of hyperlipidemia (high cholesterol, a fat-like substance found in the blood), hypertension (high blood, usually defined as pressure greater than 140 milligrams of mercury over 80 milligrams of mercury), and morbid obesity (a condition in which a person has a body mass index (BMI) higher than 35, which is a measure calculated with a simple formula using the resident's height and weight).

R8's "Nursing Assessment: Admission/Readmission + Care Plan - V3", dated 10/27/20, had interventions related to R8's care had interventions of: 1) assistance with dressing and undressing; 2) assistance of an unspecified number of staff for toileting; and 3) assistance of unspecified number of staff for ambulation.

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A review of R8's medical record showed the record lacked care planning related to COVID-19 precautions for a new admission.

R9's face sheet, dated 11/4/20, indicated R9 had been admitted to the facility on 8/4/20.

A progress note, dated 10/24/10, indicated R9 was readmitted to the facility on 10/24/20 after a short hospitalization for sudden onset of weakness.

R9's Diagnosis list, dated 11/4/20, indicated R9 had diagnoses which included traumatic brain injury (brain dysfunction caused by an outside force, usually a violent blow to the head), Parkinson's disease (a progressive nervous system disorder that affects movement), hyperlipidemia (high cholesterol, a fat-like substance found in the blood), diabetes (a metabolic disease that causes high glucose [sugar] in the blood because the pancreas does not create enough insulin), and asthma (a condition in which a resident's lung airways narrow and swell making breathing difficult and triggering coughing, a whistling sound known as wheezing, and shortness of breath).

R9's "Nursing Assessment: Admission/Readmission + Care Plan - V3", dated 4/25/20, had interventions related to R9's care had interventions of: 1) assistance with dressing and undressing; 2) assistance of an unspecified number of staff for toileting; 3) assistance of one staff for transferring; and 4) staff pushing wheelchair, but lacked care planning related to COVID-19 precautions for a readmission. No

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F 880	Continued From page 17 other care plan was produced other than the one mentioned above. R11's face sheet, dated 11/4/20, indicated R11 was 54 years old and was admitted on 10/23/20. R11's diagnosis list, dated 11/4/20, indicated R11 had a primary diagnosis of cerebral vascular accident (stroke) with hemiplegia (loss of the ability to move one side of the body) and hemiparesis (muscle weakness on one side of the body) and other relevant diagnoses of kidney disease, polycystic kidney disease (an inherited disorder causing tiny clusters of sac-like membranes in the kidney), and hypertension. R11's "Nursing Assessment: Admission/Readmission + Care Plan - V3", not dated or signed, had interventions related to R11's care had one intervention of encouraging repositioning during rounds and observing skin during care but lacked care planning related to COVID-19 precautions for a new admission. R12's face sheet, dated 11/4/20, indicated he was 55 years old and was admitted to the facility on 10/27/20. R12's diagnosis list, dated 11/4/20, indicated R12 had a primary diagnosis of lumbar spinal stenosis (a narrowing of the spinal canal in the lower back), and a relevant diagnosis of hyperlipidemia (high cholesterol, a fat-like substance found in the blood).	F 880		

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F 880	Continued From page 18 R12's "Nursing Assessment: Admission/Readmission + Care Plan - V3", dated 10/27/20, had no interventions related to R12's care. A review of R12's medical record showed the record lacked care planning related to COVID-19 precautions for a new admission. SMOKING PATIO: PPE USE AND SOCIAL DISTANCING During an observation of the resident's smoking patio on 11/3/20, at 12:00 p.m., RN-B exited out the dining room door onto the smoking patio where two unidentified residents were smoking. RN-B was not wearing a face mask or eye protection as he walked within three feet of the residents who had their masks under their chins. NURSING STATION: PPE USE During an observation on 11/3/20, at 12:31 p.m., RN-B entered the resident hallway from the dining room without a mask on and RN-B's face shield was pushed back on top of his head, not covering his eyes. RN-B pulled the mask under his nose as he walked into the nursing station, covering his mouth but not his nose. Then RN-B came out of the nursing station with the mask covering his nose and mouth but the face shield was still pushed back on top of his head. SCREENING DESK: PPE USE During an observation on 11/3/20, at 1:30 p.m.,	F 880		

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F 880	Continued From page 19 human resource staff (HR-A) was at the screening desk by the facility entrance without a mask and with eye protection pushed on top of HR-A's head. During interview on 11/3/20, at 8:45 a.m., RN-A stated all residents in the back (motioning with his hands) of the transitional care unit (TCU) were new admissions, and therefore on quarantine. RN-A stated they did not use signs because "everyone just knows." RN-A stated they did not require any additional PPE unless there were performing personal care to residents. RN-A stated, "it's just like standard precautions" and the only difference with the residents on quarantine was they could not leave their rooms and if they did, they had to wear a mask. During interview on 11/3/20, at 12:54 p.m., RN-C stated new admissions were kept in quarantine for 14 days, which meant they were monitored for symptoms of COVID-19, they had to stay in their room, and staff wore masks and face shields when working with the resident in their room. RN-C stated gloves were only used if performing any care but gowns were not required for care. During interview on 11/3/20, at 1:55 p.m., ST-A stated all residents were in isolation during their first 14 days after admission. ST-A stated residents on isolation would stay in their rooms or wear masks outside their rooms. When asked how ST-A would determine if residents were on isolation, ST-A stated they were in the back part of TCU. ST-A also stated they don't do anything different for those in isolation; they use standard precautions and wear gloves if in close contact.	F 880		

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F 880	Continued From page 20 During interview on 11/3/20, at 2:53 p.m., the infection preventionist (IP) stated staff did not use gowns with residents unless the residents were having symptoms of COVID. The IP stated they had to preserve equipment because they only had a week's worth of gowns. The IP stated they were getting the maximum amount from their supplier, McKesson. The IP stated they use redcap (a state emergency system to request PPE when no other resources are available). During interview on 11/3/20, at 4:15 p.m., the director of nursing (DON) stated new admissions went to the TCU, also known as the Stepdown Unit, where they are in quarantine for 14 days. She stated they were preserving gowns because they can't get more than their allotment. She had checked with the coalition and emergency collation, but had not checked recently. The DON stated staff were expected to wear mask and face shield at all times in care areas and gloves when providing direct contact care. The immediate jeopardy that began on 11/3/20, at 6:51 p.m. and was removed on 11/4/20 at 4:55 p.m, when the facility implemented corrected procedures for the appropriate quarantine and use of PPE for newly admitted or readmitted residents. Staff were provided education regarding the infection control procedures and the facility established daily auditing. The facility's Interim Step Down Units for SNFs Guideline (Guideline) dated 6/22/20, indicated staff would use gloves, masks, and face shields or goggles when providing care for the resident. Gowns were to be used for high contact activities: morning and bedtime cares including assisting to	F 880		

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F 880	Continued From page 21 brush teeth, showers or baths, incontinence care including briefs changes and hygienic care, care of an indwelling medical device (IV lines, catheters, tube feedings and tracheostomies) wound care, direct physical contact for turning and repositioning or transfers. This did not include use of gowns for setting up oral care, brushing hair, meal deliveries, medication administration, toileting, and ambulation. Finally, the Guideline indicated the resident door should be closed both during and in between care. The Hand Hygiene policy, dated February 2020, indicated hand hygiene should be performed before donning and after removing gloves. The policy further indicated hand hygiene should be performed after touching a resident or touching the resident's surroundings, which included resident furniture or personal belongings and equipment in the environment.	F 880		