DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 22, 2020

Administrator
Sacred Heart Care Center
1200 12th Street Southwest
Austin, MN 55912

RE: CCN: 245447
Cycle Start Date: September 23, 2020

Dear Administrator:

On October 14, 2020, we notified you a remedy was imposed. On December 18, 2020 the Minnesota Department 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 6, 2020.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective October 29, 2020 be discontinued as of December 6, 2020. (42 CFR 488.417 (b))

However, as we notified you in our letter of October 14, 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 October 29, 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,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Electronically delivered
November 17, 2020

Administrator
Sacred Heart Care Center
1200 12th Street Southwest
Austin, MN 55912

RE: CCN: 245447
Cycle Start Date: September 23, 2020

Dear Administrator:

On October 14, 2020, we informed you of imposed enforcement remedies.

On October 26, 2020, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the survey findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 29, 2020, will remain in effect.

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

This Department continues to recommend 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 October 29, 2020. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 29, 2020.

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.

As we notified you in our letter of October 14, 2020, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 29, 2020.

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.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

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:

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program

Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

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 - Health Regulation Division 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 March 23, 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

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.

INFORMAL DISPUTE RESOLUTION/ 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.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DIRECTED PLAN OF CORRECTION

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:

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 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.

EQUIPMENT/ENVIRONMENT

- 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 director of housekeeping, director of maintenance, and director of nursing must review policies and procedures regarding disinfecting multiuse/shared equipment/items and/or environmental disinfection to ensure they meet the CDC guidance for disinfection in health care facilities and follow disinfectant product manufacturer directions for use including contact time.

TRAINING/EDUCATION :

- The Director of Housekeeping/Maintenance, and/or Director of Nursing, or Infection Preventionist must train all staff responsible for resident care equipment and environment on the facility policies/practices for proper disinfection, including following manufacturer direction for use. Each staff person must demonstrate competency at the conclusion of the training.

Training and competency testing must be documented. The Minnesota Department of Health (MDH), Center for Disease Control (CDC), and Environmental Protection Agency have education materials that may be used for training.

- CDC: Infection Control Guidelines and Guidance Library. https://www.cdc.gov/infectioncontrol/guidelines/index.html/eic_in_HCF_03.pdf
- MDH COVID-19 Toolkit. https://www.health.state.mn.us/diseases/coronavirus/hcp/ltctoolkit.pdf
- EPA: List N: Disinfectants for Use Against SARS-CoV-2 (COVID-19) https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2-covid-19

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/or other facility leadership will conduct audits for proper cleaning and disinfection of resident use equipment/environmental cleaning, on all shifts every day for one week, then may decrease frequency as determined by compliance.

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.

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	Documentation of the RCA and intervention or corrective action plan based on the results with signatures of the QAPI Committee members.
2	Documentation that the interventions or corrective action plan that resulted from the RCA was fully implemented
3	Content of the training provided to staff, including a syllabus, outline, or agenda, as well as any other materials used or provided to staff for the training
4	Names and positions of all staff that attended and took the trainings
5	Staff training sign-in sheets
6	Summary of staff training post-test results, to include facility actions in response to any failed post-tests
7	Documentation of efforts to monitor and track progress of the interventions or corrective action plan

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

Attach all items into ePOC.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245447	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SACRED HEART CARE CENTER	**1200 12TH STREET SOUTHWEST AUSTIN, MN 55912**

(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 on 10/23/20 and 10/26/20 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 10/23/20 and 10/26/20, 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 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=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		12/6/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 11/24/2020

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245447	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SACRED HEART CARE CENTER	**1200 12TH STREET SOUTHWEST AUSTIN, MN 55912**

(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
F 880	Continued From page 1 §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 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,	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245447	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SACRED HEART CARE CENTER	**1200 12TH STREET SOUTHWEST AUSTIN, MN 55912**

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F 880	Continued From page 2 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. §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 ensure appropriate transmission based precautions were utilized and failed to perform proper hand hygiene to prevent and/or mitigate risks of transmission of COVID-19 disease. This had the potential to effect all 39 residents and staff. Findings Include: During an observation and interview on 10/23/20 at 3:15 p.m., registered nurse (RN)-A was	F 880	Regulation 483.80(a)(1)(2)(4)(e)(f) Tag F880 Infection Prevention and Control Sacred Heart Care Center has established and maintains an infection prevention and control program designed to provide a safe and sanitary environment for the residents and reduce the risk of the development and transmission of communicable diseases and infections. The infection control program includes a system for 1)	

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F 880	Continued From page 3 observed to be checking pulse oximeter reading on resident who is on oxygen and wearing a mask in the hallway. RN-A then placed the pulse oximeter on side of medication cart without disinfecting it and continued on to other tasks at the medication cart. Surveyor interrupted RN-A and asked when equipment used on residents should be disinfected and what product is used. RN-A replied to disinfect after use and they use the purple top PDI wipes but was not sure the contact time. Surveyor pointed out to RN-A she did not disinfect the pulse oximeter after using it and was seen just placing it on the cart. RN-A stated "oh yeah" and got the disinfectant wipes to wipe down the pulse oximeter and placed back on side of cart to air dry. During an observation and interview on 10/23/20 at 3:30 p.m., RN-A was observed assisting resident in wheelchair into her room then adjusted nasal oxygen tubing on the resident face and hooked up oxygen tubing from portable tank on wheelchair to the room tank. RN-A exited resident room and returned to computer on medication cart without performing hand hygiene. Surveyor intervened by asking RN-A when hand hygiene should be performed and asked if she had performed hand hygiene after assisting the resident. RN-A had replied to perform hand hygiene in and out of resident room and noted she had not performed hand hygiene and then used hand sanitizer. During an observation and interview on 10/23/2020, at 3:31 p.m. nursing assistant (NA)-A started to assist with passing out linens to resident rooms. NA-A was observed to go into resident room without sanitizing hands, delivered the towels exited the room without sanitizing	F 880	identifying, reporting, investigating, controlling, and preventing infections in the facility 2) determining the appropriate procedures, if any, that will be implemented (such as isolation) for each resident with an infectious disease and 3) maintaining a record of incidences of infections and tracking any corrective actions taken. There is an ongoing system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility and procedures for required reporting of communicable disease and infections. Procedures also address standard and transmission-based precautions to prevent spread of infections, when and how isolation should be used for a resident, the circumstances under which the facility prohibits employees with a communicable disease from direct resident contact, and staff hand hygiene procedures. In accordance with the Center of Disease Control (CDC) and MDH recommendations, the facility has implemented comprehensive policies and procedures to minimize the risk of COVID-19 transmission. Based on updated information from the World Health Organization, the CDC and the MDH, COVID-19 related policies will continue to be reviewed and revised as necessary. The facility currently has no staff or	

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F 880	Continued From page 4 hands and picked up a stack of towel to deliver to another resident room. Resident (R1) was sitting in the hallway in her wheelchair and stood up. NA-A was observed to touch the R1's wheelchair and R1 in attempts to have R1 sit back down in the wheelchair. NA-A took the stuffed animal from R1 and set it down on the clean towels on the cart. NA-A was able to assist R1 to sit back in her wheelchair. NA-A then picked up the stuffed animal from the cart and placed it in R1's room. NA-A then went to the cart and picked up a clean stack of towels. Surveyor intervened and interviewed NA-A. NA-A verified she had not completed hand hygiene after touching R1, R1's wheelchair, R1's stuffed animal and verified she had placed the stuffed animal on the clean towels on the cart, returned the stuffed animal to R1's room and returned to the cart to pick up a stack of towels. During an observation and interview on 10/26/20 at around 11:50 a.m., NA-B was observed to be wearing personal eyeglasses with no eye protection. NA-B was wearing a surgical facemask. NA-B agreed he was not wearing any eye protection, stated he was sure he was supposed to and stated he had worn one when he worked in the COVID unit area. During a follow up observation and interview on 10/26/20 at 12:45 p.m., NA-B was observed to be wearing his personal eyeglasses with no other eye protection. RN-B stated staff should absolutely be wearing eye protection other than personal eyeglasses and directed NA-B to get eye protection. NA-B had stated he was not provided any and left hallway. NA-B returned immediately wearing face shield.	F 880	residents with confirmed cases of COVID-19; staff and residents are routinely tested according to state guidelines. Compliance with the infection control regulatory requirements and facility policies will positively impact the safety of all residents and support them in attaining and maintaining their highest practicable physical, mental and psychosocial well-being. The infection preventionist has received positive feedback from the staff on the administrative focus of providing services/education/support to promote the safety and well-being of the residents and staff in controlling the transmission of COVID-19. On November 23 and 24, 2020, the Administrator, Director or Nursing, Infection Preventionist, Quality Assurance Coordinator, Infection Control Consultant and the Health Information/Quality Assurance Consultant met to analyze the root cause of breaches in the infection control protocols. A spread sheet has been developed by the Infection Control Consultant to assist the staff in investigating/analyzing of the root cause of infection control breaches, interventions to improve infection control practices/protocols, and options for measuring the success of the interventions. The current infection control policies and procedures were reviewed and felt to be appropriate. To assist in determining the root cause,	

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F 880	Continued From page 5 During an interview on 10/26/20, at 1:19 p.m. the director of nursing (DON) stated she expected staff to put the stuffed animal in R1's room not on the clean linen cart. The DON stated the staff member should have completed hand hygiene after she touched the resident, their wheelchair and prior to touching the clean linen. The DON stated everyone should be wearing eye protection and it should not be their regular glasses. The DON indicated the staff member observed to not be wearing eye protection had already had COVID. The DON stated her expectation was all staff were to complete hand hygiene prior to entering and exiting resident rooms. The DON verified staff should perform hand hygiene after touching resident oxygen tubing and facemask of residents. DON also verified equipment such as the pulse oximeter should be disinfected after use. MDH Responding to and Monitoring COVID-19 Exposures in Health Care Settings dated 4/21/2020, included MDH and health care organizations are cooperating to identify, manage, and monitor health care workers (HCW) with workplace exposures to persons with confirmed COVID-19 disease. This approach calls for timely identification of these persons who have contact with coworker, patient, or long term care resident beginning 48 hours before onset of symptoms. Then a structured risk assessment is conducted, with individual employees receiving recommendations for health monitoring, voluntary quarantine, and social distancing, as relevant. If facilities have exhausted all options to continue targeted contact identification and exclusion, they should strengthen efforts to identify recognized exposures (PPE breaches) ...The guidelines also included, "Institute eye protection during all	F 880	the staff involved in the infection control breaches were interviewed to identify knowledge gaps, extenuating circumstances (breach occurred when assisting a resident who unexpectedly assumed unsafe posturing), or other reasons for noncompliance with facility procedures. As documented on the Record of Education form, the involved staff were counseled on the importance of complying with infection control protocols and were provided resources and education to reduce the risk of subsequent noncompliance. All staff will be reeducated on the facility's heightened infection control program required to reduce the risk of COVID-19 transmission. The following will be addressed: 1) hand hygiene after resident contact; 2) appropriate use of eye protection; 3) cleansing of equipment used by multiple residents; 4) following manufacturer instructions for disinfectant use; and 5) sanitary transport and distribution of linen. The facility will provide reference sheets for staff addressing the disinfectant manufacturer's recommendation for contact time needed for disinfection. When appropriate, containers of disinfectant will be labeled with the manufacturer's recommended contact time.	

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F 880	Continued From page 6 patient care providers as a way to reduce COVID-19 exposure risk. Eye protection is recommended for all routine encounters when PPE supply allows.	F 880	The staff will be encouraged to communicate to their supervisor any challenges with use of personal protective equipment such as poor fit, lack of accessibility, discomfort with use, health concerns, etc. The importance of working as a team to keep the care givers and residents safe will be emphasized, including being sensitive to infection control protocols and reminding peers when breaches are observed. The following audits of staff infection control techniques will continue to be routinely conducted and documented: 1) appropriate use and the donning/doffing sequence of gowns and gloves, use of face masks and eye protection, and hand hygiene with resident contact (with competency tests); and 2) unannounced hand hygiene observations. The facility has implemented an additional audit form which will address donning/doffing of gloves, gowns, masks and eye protection as well as linen transport/distribution and disinfecting of shared medical equipment such as mechanical lifts, pulse oximeters, blood glucose machines, blood pressure cuffs and thermometers. For residents who frequently have their oxygen saturation level monitored, the facility plans to use resident-specific pulse oximeters. The Infection Preventionist and other	

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F 880	Continued From page 7	F 880	licensed nurses will continue to complete the infection control audits daily for one week, two to three times per week for four weeks, and randomly thereafter. Frequency of audits will increase if there are residents who test positive for COVID-19. If breaches in infection control protocols are observed, immediate staff counseling/training will be done and the Infection Preventionist and the Director of Nursing will decide the need for an investigation of root cause and further staff education. The Director of Nurses/designee will monitor compliance by review of the audit tools weekly for four weeks. If noncompliance is noted, additional auditing and staff education will be done. During the COVID-19 pandemic, compliance with the infection control policies as well as the investigation of root cause of the infection control breaches will continue to be comprehensively reviewed during the monthly infection control Quality Assurance and Performance Improvement (QAPI) subcommittee meetings and addressed during the December 2020 quarterly QAPI Committee meeting. DPOC In addition to the plan of correction actions taken, Sacred Heart Care Center will implement the Directed Plan of Correction (DPOC) in accordance with the directive by MDH. In keeping with the completion date of our previous DPOC, this additional DPOC will be completed by	

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F 880	Continued From page 8	F 880	December 21, 2020: 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 will conduct a root cause analysis to identify the problem(s) that resulted in this deficiency and develop interventions or corrective action plan to prevent recurrence. The Infection Preventionist and Director of Nursing, will complete the following: • Review policies and procedures for donning/doffing PPE 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 will provide training for the Infection	

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F 880	Continued From page 9	F 880	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 will cover standard infection control practices, including but not limited to, transmission-based precautions, appropriate PPE use, and donning and doffing of PPE. • The training will be provided by the Director of Nursing, Infection Preventionist, or Medical Director with an attestation statement of completion. • The training will include competency testing of staff and with verifying documentation. • Residents and their representatives will 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 including training modules and materials from the CDC and MDH websites. EQUIPMENT/ENVIRONMENT • 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:	

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F 880	Continued From page 10	F 880	• The facility's QAPI Committee will conduct a root cause analysis to identify the problem(s) that resulted in this deficiency and develop intervention or corrective action plan to prevent recurrence. • The director of housekeeping, director of maintenance, and director of nursing will review policies and procedures regarding disinfecting multiuse/shared equipment/items and/or environmental disinfection to ensure they meet the CDC guidance for disinfection in health care facilities and follow disinfectant product manufacturer directions for use including contact time. TRAINING/EDUCATION: The Director of Housekeeping/Maintenance, and/or Director of Nursing, or Infection Preventionist will train all staff responsible for resident care equipment and environment on the facility policies/practices for proper disinfection, including following manufacturer direction for use. Each staff person will demonstrate competency at the conclusion of the training. Training and competency testing will be documented. Education materials from the Minnesota Department of Health (MDH), Center for Disease Control (CDC), and Environmental Protection Agency may be used for training. MONITORING/AUDITING: • The Director of Nursing, the Infection Preventionist, and other facility leadership	

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F 880	Continued From page 11	F 880	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 use. • The Director of Nursing, Infection Preventionist, or designee will review the results of audits and monitoring with the QAPI Committee. EQUIPMENT/ENVIRONMENT • 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 will conduct a root cause analysis to identify the problem(s) that resulted in this deficiency and develop intervention or corrective action plan to prevent recurrence.	

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F 880	Continued From page 12	F 880	• The director of housekeeping, director of maintenance, and director of nursing will review policies and procedures regarding disinfecting multiuse/shared equipment/items and/or environmental disinfection to ensure they meet the CDC guidance for disinfection in health care facilities and follow disinfectant product manufacturer directions for use including contact time. TRAINING/EDUCATION: The Director of Housekeeping/Maintenance, and/or Director of Nursing, or Infection Preventionist will train all staff responsible for resident care equipment and environment on the facility policies/practices for proper disinfection, including following manufacturer direction for use. Each staff person will demonstrate competency at the conclusion of the training. Training and competency testing will be documented. Materials from the Minnesota Department of Health (MDH), Center for Disease Control (CDC), and Environmental Protection Agency may be used for training. 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.	

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F 880	Continued From page 13	F 880	The Director of Nursing, Infection Preventionist or designee will review the results of audits and monitoring with the QAPI Committee. In accordance with the DPOC Directive, Sacred Heart Care Center will submit the following documents per MDH instruction. “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 will provide all of the following documentation. Documentation will be uploaded as attachments through ePOC.” Imposition of this DPOC does not replace the requirement that the facility will 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. Documentation of the root cause analysis and intervention or corrective action plan based on the results with signatures of the QAPI Committee members.	

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F 880	Continued From page 14	F 880	2. Documentation that the interventions or corrective action plan that resulted from the root cause analysis was fully implemented 3. Content of the training provided to staff, including a syllabus, outline, or agenda, as well as any other materials used or provided to staff for the training 4. Names and positions of all staff that attended and took the training 5. Staff training sign-in sheets 6. Summary of staff training post-test results, to include facility actions in response to any failed post-tests 7. Documentation of efforts to monitor and track progress of the interventions or corrective action plan	