DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: F66J

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00183

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245322**
2.STATE VENDOR OR MEDICAID NO.
(L2)

3. NAME AND ADDRESS OF FACILITY
(L3) **COVENANT LIVING OF GOLDEN VALLEY CARE & REHAB**
(L4) **5825 ST CROIX AVENUE**
(L5) **GOLDEN VALLEY, MN** (L6) **55422**

4. TYPE OF ACTION: **7** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/28/2021** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 04 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
01/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **88** (L18)
13.Total Certified Beds **70** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
70				
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Kathleen Lucas, District Supervisor 05/26/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 06/15/2021 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
07/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 17, 2021

CMS Certification Number (CCN): 245322

Administrator
Covenant Living Of Golden Valley Care & Rehab Ctr
5825 St Croix Avenue
Golden Valley, MN 55422

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare program.

Effective May 21, 2021 the above facility is certified for:

70 Skilled Nursing Facility Beds

Your facility's Medicare approved area consists of all 70 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 17, 2021

Administrator
Covenant Living Of Golden Valley Care & Rehab Ctr
5825 St Croix Avenue
Golden Valley, MN 55422

RE: CCN: 245322
Cycle Start Date: April 22, 2021

Dear Administrator:

On May 6, 2021, we notified you a remedy was imposed. On May 28, 2021 the Minnesota Department(s) of Health and Public Safety 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 May 21, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective June 5, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of May 6, 2021, 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 was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 5, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on May 21, 2021, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, 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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: F66J

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(L4) **5825 ST CROIX AVENUE**
(L5) **GOLDEN VALLEY, MN** (L6) **55422**

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3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
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5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

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FISCAL YEAR ENDING DATE: (L35)
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X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

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18 SNF	18/19 SNF	19 SNF	ICF	IID
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(L37)	(L38)	(L39)	(L42)	(L43)

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16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Nicole Sassen, HFE - NE II 05/26/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 06/15/2021 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

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3. Both of the Above :

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07/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
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(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
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05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
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07-Provider Status Change
00-Active

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(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
May 6, 2021

Administrator
Covenant Living Of Golden Valley Care & Rehab Ctr
5825 St Croix Avenue
Golden Valley, MN 55422

RE: CCN: 245322
Cycle Start Date: April 22, 2021

Dear Administrator:

On April 22, 2021, a survey was completed at your facility by the Minnesota Department(s) 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.

This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

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(ies) 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 June 5, 2021.

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

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective June 5, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 5, 2021.

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.

This Department is also recommending that CMS impose:

• 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.

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.

If you have not achieved substantial compliance by June 5, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Covenant Living Of Golden Valley Care & Rehab Ctr will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 5, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable 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:

Kathleen Lucas, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: kathleen.lucas@state.mn.us
Office: (320) 223-7343 Mobile: (320) 290-1155

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 October 22, 2021 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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 (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 electronic 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.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag) i.e., the plan of correction, request for waivers, should be directed to:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245322	A. BUILDING _____ B. WING _____	C 04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT LIVING OF GOLDEN VALLEY CARE & REHAB CTR	**5825 ST CROIX AVENUE GOLDEN VALLEY, MN 55422**

(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 On 4/19/21-4/22/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a 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 On 4/19/21-4/22/21, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED H5322055C (MNN68115) and H5322063C (MN71475), however NO deficiencies were cited due to actions implemented by the facility prior to survey. The following complaints were found to be UNSUBSTANTIATED: H5322060C (MN66991), H5322061C(MN71749). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/14/2021

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
	245322	A. BUILDING _____ B. WING _____	C 04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 000	Continued From page 1 Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 880 SS=E	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 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;	F 880		5/21/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245322	A. BUILDING _____ B. WING _____	C 04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT LIVING OF GOLDEN VALLEY CARE & REHAB CTR	5825 ST CROIX AVENUE GOLDEN VALLEY, MN 55422

(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 2 (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. §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 staff were wearing appropriate personal protective equipment (PPE), specifically eye protection per	F 880	It is the policy of Covenant Living of Golden Valley Care & Rehabilitation Center to establish and maintain an infection prevention and control program	

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F 880	Continued From page 3 Centers for Disease Control and Prevention (CDC) requirements. This had the potential to affect all residents residing on the Fireside Unit. In addition, the facility failed to ensure proper hand hygiene when provided during care for 1 of 4 residents (R39) and failed to ensure proper hand hygiene was performed when handling oral medications for 1 of 4 residents (R9). Findings include: During observation on 4/20/21, at 1:19 p.m. nursing assistant (NA)-C and NA-D were observed on Fireside unit exiting resident room 121 wearing an isolation gown, gloves, and surgical mask, however NA-C and NA-D were not wearing eye protection. There were two signs posted outside of room 121's door indicating resident was on both droplet and contact precautions. In addition, there was an isolation cart outside of the door. On 4/20/21, NA-C stated room 121 was "on isolation. She just came to the facility not long ago. We [staff] are required to wear a gown, gloves, mask when we [staff] are in the room." Further, NA-C stated "we [staff] also wear eye protection." However, when asked why NA-C was not wearing eye protection, NA-C stated "I can't see if I don't wear my glasses. I will fall." In addition, when asked why the use of proper PPE is important, NA-C stated "even though [room 121] does not have COVID-19, you [staff] have to use protection" On 4/20/21, at 1:40 p.m. NA-D indicated when a resident is newly admitted to the facility, the resident is placed on a 14 day quarantine. When asked what PPE is required to be worn in room	F 880	designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident R39, R9 and the additional two residents listed did not sustain any adverse events related to the observations noted during survey. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected by the alleged deficiency. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: The facility□s Quality Assurance and Performance Improvement Committee with assistance from the Infection Preventionist and Governing body have conducted a root cause analysis to identify the problem and developed interventions to prevent recurrence. This meeting was held on May 12, 2021. Hand hygiene competencies of staff are being completed by DON and IP. All staff will be trained on principles of infection control, PPE use including the use of eye protection and hand	

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F 880	Continued From page 4 121, NA-D stated "gown, mask, gloves and a faceshield. I have a faceshield, but I left it in the breakroom and forgot it in there from break." NA-D stated the importance of wearing the appropriate PPE is "protect yourself if the person [resident] has it, you [staff] shouldn't come in contact with it." On 4/20/21, at 1:53 p.m. NA-C continued to not have eye protection on, in resident care areas. On 4/20/21, at 2:44 p.m. registered nurse (RN)-B indicated when a resident is newly admitted to the facility, the resident is placed on a 14 day quarantine. RN-B stated "we [staff] have to wear gloves, gown, mask, goggles or a faceshield when providing cares." In addition, RN-B indicated staff were expected to wear eye protection and "if staff have prescription glasses then there are bigger goggles that go over them or the face shield. The prescription glasses don't substitute for the goggles." Facility document titled Coronavirus- (COVID-19) dated 4/16/20, indicated "Full PPE should be worn per CDC [Centers for Disease Control and Prevention] guidelines for the care of any resident with known or suspected COVID-19 per CDC guidance on conservation of PPE." Further review of facility document, indicated PPE includes: gloves, isolation gowns, facemasks and "eye protection that covers both the front and sides of the face." CDC guidance titled Interim Infection Prevention and Control Recommendations for Healthcare Personnel during the Coronavirus Disease 2019 (COVID-19) Pandemic dated 2/10/21, "eye protection should be worn during patient care	F 880	hygiene expectations; any needed accommodations to PPE will be offered. The trainings will be held on May 13th and staff who do not attend will be trained at the all staff meeting on May 21st. An employee roster is utilized to ensure staff completion of the training and competencies. The Coronavirus Disease (Covid-19) Prevention and Control, Handwashing/ Hand Hygiene, Contingency Standards of Care and Transmission Based Precautions will be reviewed by the DON and IP and updated if needed. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur: The DON, Infection Preventionist or designee will complete infection control audits for eye protection and appropriate hand hygiene on every shift for one week then may decrease the frequency based on compliance and until 100% compliance is met. The results of the infection control audits will be reviewed at the monthly QAPI committee meetings who will determine when compliance is achieved. The date that the deficiency will be corrected: The deficiency will be corrected by May 21, 2021. The DON and/or designee is responsible for maintaining compliance with this requirement.	

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encounters to ensure the eyes are also protected from exposure to respiratory secretions." Further review of CDC guidance, states "the PPE recommended when caring for a patient with suspected or confirmed COVID-19 includes the following: respirator, eye protection, gloves, and gowns."

During an observation on 4/21/21, at 7:30 a.m. resident room 104 had signage which indicated PPE was necessary prior to entering. Further, there was a cart outside the door containing clean PPE and disinfecting spray.

During an observation on 4/21/21, at 8:23 a.m. nursing assistant (NA)-B was wearing a surgical mask and regular glasses however, no face shield or goggles. NA-B donned gown and gloves, retrieved the room tray and entered room 104. When questioned, NA-B stated she was not able to wear the eye protection because it gave her a headache and was given permission by administration to not wear it.

During an observation on 4/21/21, at 9:05 a.m. speech therapist (ST)-D was wearing a surgical mask and regular glasses, however, no face shield or goggles. ST-D donned gown and gloves then reached to open the door of room 104. ST-D confirmed she was not wearing eye protection and stated her understanding was only when entering a COVID positive room was eye protection required. ST-D stated she would double check with her supervisor before entering the room.

During an interview on 4/21/21, at 11:06 a.m. the infection preventionist (IP) stated staff were expected to wear masks and eye protection when

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doing close contact or cares. Further, IP stated no staff had been given any type of waiver to excuse them from wearing eye protection. Her expectation was any staff going into care areas should wear mask and goggles.

During an interview on 4/21/21, at 1:42 p.m. director of nursing (DON) stated all direct care staff should wear goggles at all times.

During an interview on 4/22/21, at 8:24 a.m. the administrator stated all staff should follow precaution posted on quarantined doors and should always be wearing a mask and eye protection. And stated she was not aware of anyone given a waiver from wearing eye protection.

During an interview on 4/22/21, at 10:25 a.m. the director of rehab services (DPT)-E stated she was responsible for education of all rehab service people. DPT-E stated all staff had been trained to wear appropriate PPE, to follow posted precautions and to always wear a mask and eye protection.

R39's annual Minimum Data Set (MDS) dated 4/9/21, indicated R39 was moderately cognitively impaired and required extensive assistance for bed mobility, locomotion, transfers, dressing, toileting and personal hygiene. R39 had diagnoses of non-traumatic brain dysfunction, Alzheimer's disease, peripheral vascular disease and osteoporosis.

During an observation on 04/21/21, at 8:14 a.m. NA-A assisted R39 with morning cares. NA-A was wearing a face mask, eye protection and gloves during cares. NA-A was observed leaving R39's

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room with a bag of trash in one hand and a bag of soiled linens in the opposite hand. NA-A entered the soiled room and disposed of the bags. While still in the soiled room, NA-A applied liquid soap onto her hands and began rubbing her hands together. While rubbing the soap into her hands, NA-A noted that there were no paper towels in the soiled room. NA-A then exited the soiled room while still rubbing the liquid soap into her hands. NA-A then used a clean paper towel to turn on the water in a sink in the common area. During this time, no lathering was observed on NA-A's hands. The soap on NA-A's hands was visibly gone. NA-A then rinsed off her hands under water. NA-A only rinsed her hands, she did not rub her hands together under the water. NA-A then dried her hands with clean paper towels, used another clean paper towel to turn off the water and disposed of the used paper towels in the trash bin near the sink. Next, NA-A knocked on R39's door, entered the room, knocked on R39's bathroom door, opened the bathroom door, spoke with R39, then closed the bathroom door. R39 was seated on her walker, facing the bathroom sink, with the water running. NA-A then stood outside of R39's bathroom door for approximately two minutes before she opened the bathroom door, entered the bathroom and turned off the bathroom sink water using a clean paper towel. Next, NA-A opened a drawer, took out a comb, closed the drawer and handed the comb to R39. After R39 used the comb, NA-A opened the drawer, placed the comb in the drawer and closed the drawer. Next, NA-A unlocked R39's walker brakes and turned R39, while seated on the walker, around to face the bathroom grab bars. NA-A locked the walker brakes, touched R39's hand and placed it onto the grab bar, and instructed R39 to use the grab

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bar to stand. While R39 was standing, NA-A unlocked the walker brakes, moved the walker to the side of R39, and instructed R39 to take the walker while NA-A guided R39's hand to the walker by R39's elbow. NA-A then used the alcohol-based hand rub (ABHR) before exiting R39's room. NA-A pulled a chair away from a table in the common area and assisted R39 to sit. Next, NA-A was observed putting liquid soap onto her hands and rubbing her hands together until the soap was visibly gone from NA-A's hands. No lathering was noted on NA-A's hands. NA-A then turned on the water with a clean paper towel, rinsed her hands, dried her hands with clean paper towels, used a clean paper towel to turn off the sink, and disposed of the paper towels.

During an interview on 4/21/21, at 8:45 a.m. NA-A confirmed NA-A did not apply water to her hands prior to rubbing her hands together with liquid soap. NA-A confirmed that hand-washing instructions were posted at each sink indicating that hands need to be wet prior to applying soap to lather the hands. Further, NA-A confirmed that she should wet her hands first before stating, "I should follow the rules."

During an interview on 4/21/21, at 9:12 a.m. the unit nurse manager (RN-A) stated staff are expected to perform hand hygiene following the steps posted by each sink. RN-A stated the posted hand hygiene document titled, "Hand Hygiene How To" is posted at every sink. This document directed staff to follow those instructions: 1. Wet, 2. Soap, 3. Wash 20 seconds, 4. Rinse, 5. Dry, 6. Turn off water with paper towel. RN-A stated that staff are expected to follow these steps.

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During an interview on 4/22/21, at 10:01 a.m. the director of staff development/infection preventionist (IP) stated that staff educated on hand washing annually through a Relias computer module, monthly at staff meetings, and periodically during daily huddles. IP stated that hand washing audits have been completed weekly by IP and the unit nurse managers. IP stated the audits are done so that all staff and all shifts are audited. IP stated that IP and the unit nurse managers watched the staff wash their hands during the audits to ensure competency.

Review of facility policy titled Hand Hygiene/Handwashing revised August 2015, indicated that the facility considered hand hygiene the primary means to prevent the spread of infections. Policy indicated that all personnel should follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. Policy indicated the completion of hand hygiene before and after direct contact with residents. Policy indicated the hand washing procedural step, "vigorously later hands with soap and rub them together, creating friction to all surfaces, for a minimum of 20 seconds (or longer) under a moderate stream of running water, at a comfortable temperature."

R9's quarterly Minimum Data Set (MDS) dated 2/5/21, indicated R9's cognition was intact and required extensive assistance for bed mobility, locomotion, transfers, dressing, toileting and personal hygiene. R9 had diagnoses of Alzheimer's disease, congestive heart failure and diabetes.

During an observation on 4/21/21, at 7:20 a.m.

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licensed practical nurse (LPN-A) assisted R9 with medication administration. LPN-A used the alcohol-based hand rub (ABHR) at the med cart. LPN-A then unlocked the med cart, open a drawer, removed five pill bottles and placed the bottles on the med cart. LPN-A then opened a second drawer, removed six medication bubble cards and placed the bubble cards on the med cart. LPN-A then removed each medication tablet, as per the EMAR, and placed each tablet into a medication cup. LPN-A was then observed moving the tablets around in the souffle cup with her ungloved fingers. LPN-A then used her ungloved fingers to transfer the tablets individually from one medication cup to another. LPN-A did not perform hand hygiene prior to handling the medication tablets.

During an interview on 4/21/21, at 8:00 a.m. LPN-A confirmed that she used her fingers to count the medication tablets. LPN-A confirmed that she repeatedly touched R9's oral medications with her fingers. LPN-A stated that she should wear gloves to handle medication tablets.

During an interview on 4/22/21, at 10:00 a.m. IP stated that nurses and trained medication aides (TMA) are taught hand hygiene and when gloves are required. IP stated that the nurses and TMAs have been instructed to wear gloves if they need to touch the medications. IP stated that nurses and TMAs have been taught to use a pill counting tray and wear gloves to count tablets. IP stated that the expectation is that the nurses and TMAs should not touch oral medications with their bare hands.

Review of facility policy titled Hand

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F 880	Continued From page 11 Hygiene/Handwashing revised August 2015, indicated that the facility considered hand hygiene the primary means to prevent the spread of infections. Policy indicated that all personnel should follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. Policy indicated hand hygiene completed before handling medications. Review of facility policy titled Administering Oral Medications revised October 2010, indicated that for tablets or capsules from a bottle, pour the desired number into the bottle cap and transfer to the medication cup. For unit dose tablets or capsules, place packaged medications directly into the medication cup. Policy indicated "do not touch the medication with your hands" as part of the procedure.	F 880		

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Covenant Living of Golden Valley Care & Rehab Center was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and NFPA 99 2012. Covenant Living of Golden Valley is a 1-story building with no basement that was built in 1960 and was determined to be of Type II(000) construction. Additions were built in 1963, 1970, 1976, and 1998 and were all determined to be of Type II(000) construction. This building houses State Licensed only beds that are private pay, but because they are not separated by 2-hour fire rated construction, that portion will be included in the survey. The facility shares a common wall with an assisted living occupancy, but is separated by 2-hour rated construction. This facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is centrally monitored for automatic fire department notification. The facility has a capacity of 88 beds and had a census of 50 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET as evidenced by:	K 000		

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