DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 17, 2020

Administrator
Wabasso Rehabilitation & Healthcare Center
660 Maple Street
Wabasso, MN 56293

RE: CCN: 245400
Survey Start Date: April 21, 2020

Suspension of Survey/EnforcementActivities

Dear Administrator:

On May 1, 2020, we notified you a remedy was imposed. On June 3, 2020 the Minnesota Department(s) of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of May 11, 2020. Per the CMS Memo QSO-20-20-All, enforcement remedies have been suspended and will be evaluated at a later date.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Electronically delivered
May 1, 2020

Administrator
Wabasso Rehabilitation & Healthcare Center
660 Maple Street
Wabasso, MN 56293

SUBJECT: SURVEY RESULTS
CCN: 245400
Cycle Start Date: Cycle Start Date: April 21, 2020

Dear Administrator:

SUSPENSION OF SURVEY AND ENFORCEMENT ACTIVITIES

The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with Memorandum QSO-20-20-All, CMS is suspending certain Federal and State Survey Agency surveys, and delaying revisit surveys, for all certified provider and supplier types.

During this time, CMS is prioritizing and conducting only the following surveys: focused infection control surveys, investigations of complaints and facility-reported incidents that are triaged at the Immediate Jeopardy (IJ) level, and revisit surveys for unremoved IJ level deficiencies. With the exception of unremoved IJs, CMS will also be exercising enforcement discretion during the suspension period. For additional information on the prioritization of survey activities please visit https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0.

SURVEY RESULTS

On April 21, 2020, a survey was completed at your facility by the Minnesota Department of Health completed a COVID-19 Focused Survey at Wabasso Rehabilitation & Healthcare Center to determine if your facility was in compliance with Federal requirements related to implementing proper infection prevention and control practices to prevent the development and transmission of COVID-19. The survey revealed that your facility was not in substantial compliance. The findings from this survey are documented on the electronically delivered CMS 2567.

PLAN OF CORRECTION

You must submit an acceptable plan of correction (POC) for the enclosed deficiencies that were cited during the April 21, 2020 survey. Wabasso Rehabilitation & Healthcare Center may choose to delay submission of a POC until after the survey and enforcement suspensions have been lifted. The

provider will have ten days from the date the suspensions are lifted to submit a POC. An acceptable POC will serve as your allegation of compliance. Upon receipt of an acceptable POC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. Please note that if an onsite revisit is required, the revisit will be delayed until after survey and enforcement suspensions are lifted. The failure to submit an acceptable POC can lead to termination of your Medicare and Medicaid participation.

To be acceptable, a provider's POC 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; and
- The date that each deficiency will be corrected.

The POC must be signed and dated by an official facility representative. Please send your POC by fax or email to:

Nicole Osterloh, Unit Supervisor
Health Regulation Division
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230 Cell: 218-340-3083

INFORMAL DISPUTE RESOLUTION

You have one opportunity to dispute the deficiencies cited on the April 21, 2020 survey through Informal Dispute Resolution (IDR) in accordance with 42 CFR § 488.331. To receive an IDR, send (1) your written request, (2) the specific deficiencies being disputed, (3) an explanation of why you are disputing those deficiencies, and (4) supporting documentation by fax or email to:

Nicole Osterloh, Unit Supervisor
Health Regulation Division
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230 Cell: 218-340-3083

An IDR may not be used to challenge any aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

An IDR, including any face-to-face meetings, constitutes an informal administrative process that in no way is to be construed as a formal evidentiary hearing. If you wish to be accompanied by counsel for your IDR, then you must indicate that in your written request for informal dispute resolution.

Wabasso Rehabilitation & Healthcare Center may choose to delay a request for an IDR until after the survey and enforcement suspensions have been lifted. The provider will have ten days from the date the suspensions are lifted to submit a request for an IDR in accordance with the instructions above.

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES

The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at https://qioprogram.org/. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at https://qioprogram.org/locate-your-qio.

Sincerely,

Kamala Fiske-Downing

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Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245400	A. BUILDING _____ B. WING _____	04/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WABASSO REHABILITATION & HEALTHCARE CENTER	**660 MAPLE STREET WABASSO, MN 56293**

(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 4/20/20 through 4/21/20, 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 facilty acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control survey was conducted on 4/20/20 through 4/21/20, 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	Infection Prevention & Control	F 880		5/11/20

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

Electronically Signed | 05/08/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 880 SS=F	Continued From page 1 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; (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	F 880		

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F 880	Continued From page 2 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 actively screen staff in accordance with Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control (CDC) guidelines for COVID-19. Additionally, the facility failed to have up-to-date infection control surveillance with ongoing analysis to ensure patterns and trends of all potential infections, including viral infections were promptly identified and acted upon. This had the potential to effect	F 880	COVID -19 risk assessment tool was reviewed by DON and ED. A line was added for assessor's signature. Past employee assessment records were reviewed, and active surveillance by another staff member prior to entrance to the facility was implemented immediately. All residents have the potential to be affected in this area. All staff have been educated on the	

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F 880	Continued From page 3 all 79 residents. Findings include: Observation on 4/20/20 at 8:30 a.m., identified the designated entrance to the facility for staff was through the back employee door. A sign on the door directed people entering the facility to ring the bell and wait for staff. A table was in the entry way. Face masks, a thermometer, disinfecting wipes, and clipboards with a temperature log and symptom screen logs was on the table. Interview on 4/20/20 at 9:45 a.m., with occupational therapist (OT)-D identified she screened herself when she entered the facility. OT-A would take her own temperature and documented her own results on the COVID-10 screening logs. No facilty staff would be present to actively screen OT-A. Interview on 4/20/20 at 9:50 a.m., with nurses aid (NA)-A identified she completed her own health screening and took her own temperature when she came to work. The facility had no staff present at the entrance to actively screen staff. NA-A identified it was her responsibility to notify the nurse at the desk and wait for further guidance if she had an elevated temperature or other symptoms. Interview on 4/20/20 at 10:00 a.m., with maintenance director (M) -A identified no staff were present at the designated staff entrance to observe staff for signs of COVID-19. She measured her own temperature and documented her answers to the questions on the form at the entrance.	F 880	updated process by 5/08/2020, which include the need for “active surveillance” by another staff member before entering the work floor. Staff educated on ringing the doorbell or calling ahead to the facility, to gain entrance as the entrance door is locked. Staff were educated to notify DON for temperatures above 99.0 for steps on further assessment to be done prior to entry to the work floor. Staff was educated that if they are absent or off work for 3 days or longer, a new COVID 19 assessment plus and active screening must be completed by “assessor” prior to entrance to the floor. INFECTION PREVENTION SERVEILANCE DOCUMENTATION: The MDS coordinator was designated as facility IP on 4/20/20. Proper training for IP was completed by this RN on 4/26/2020. DON will complete CDC Infection Prevention training by 5/29/20. The DON or designee will review and follow up on the employee screenings logs weekly x 4 weeks, then monthly x 2 months with the results of the audit reported to the monthly QAPI meeting for further recommendations. The QAPI committee has the right to discontinue an audit once compliance has been reached. Compliance date: 5-11-2020	

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F 880	Continued From page 4 Interview on 4/20/20 at 11:15 a.m., with director of nursing (DON) identified staff completed their own screening which included taking and measured their own temperatures. The entrance was not monitored by a staff member to actively screen staff entering the facilty for COVID-19 symptoms. No staff were trained to actively screen for COVID-19. Interview on 4/20/20 at 1:44 a.m., with the administrator (A)-A identified today was her first day of hire. Upon entrance, she now was met by a staff member. She was asked to complete the risk assessment tool. Staff had not actively taken her temperature. A informed the staff that she would not sign the questionnaire as she had not been appropriately screened. A instructed the staff member her temperature needed to be taken by that staff. Her expectation was staff should be actively screened at the point of entry. Going forward, she would ensure staff would be trained in completing the active screening process. Review of the 4/16/20, COVID-19 Facility Guidelines identified all staff must be screened prior to each shift. If a tested temperature is higher than 99.0 degrees F (Fahrenheit), access "MUST" be restricted. All staff were required to be screened prior to each shift. Temperatures were to be logged on a staff temperature log. Anyone with a temperature above 99.0 degrees F, should be turned away. There was no mention employees are to be actively screened by a trained person prior to each shift. Review of the facility's undated COVID-19 Employee/Visitor Log, documented employee and	F 880		

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F 880	Continued From page 5	F 880		

visitor temperatures, presence of loss of taste or smell, and if they were sent home.

Review of the undated Risk Assessment Tool, also to be used in addition to the Employee/Visitor Log identified risk factors included:
1) Persons presenting with fever and symptoms of cough and/or shortness of breath.
2) Persons presenting with acute respiratory symptoms of unknown cause.
3) Persons who traveled to a restricted country within the past 14 days.
4) Persons who had close contact with a person who traveled to a restricted country in the last 14 days.
5) Persons who had been in close contact with a person who had a confirmed case of COVID-19.
6) Persons having two or more risk factors required further investigation and evaluation.

The COVID-19 Employee/Visitor Log and Risk Factor Tool documentation for all staff identified the following discrepancies:
(1) The 4/14/20, COVID-19 Employee Visitor Log identified NA-B had a temperature of 99.7 degrees Fahrenheit (F). NA-B's Risk Assessment Tool was not included in the 4/14/20, Risk Assessment Tool documention and it was unknown if she was prevented from working, or what steps the facility took to ensure ill staff were not permitted to enter the facility.
2) NA-C's 4/13/20, 4/15/20, and 4/18/20, and 4/19/20, Risk Assessment Tools identified NA-C presented with acute respiratory symptoms with no known cause prior to working those days. The Employee/Visitor Logs identified NA-C was only afebrile, and had no loss of taste or smell and was not sent home. There was no mention staff

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F 880	Continued From page 6	F 880		

had reviewed all the information to determine NA-C should not have worked when presenting with potential COVID symptoms.
3) NA-D's 4/17/20, COVID-19 Employee/Visitor Log identified NA-D's temperature was 99.0. NA-D had no loss of taste or smell and was not sent home. NA-D's COVID-19 Risk Assessment Tool identified NA-D had answered "No" to all risk factor questions. There was no documentation to support the facility had denied entry to the building in the presence of potential COVID-19 symptoms.

Further interview and document review on 4/21/20 at 12:20 p.m., with the DON identified staff were screened for symptoms of COVID-19 by monitoring their own temperatures, presence of respiratory symptoms, and exposure to COVID-19 outside of the facilty. The DON expected staff to report symptoms and elevated temperatures identified during the screening process. She expected staff to self-report anytime staff suspected they had symptoms of COVID-19. Staff were to be sent home if they had two or more symptoms. The DON verified no staff had been sent home for elevated temperatures. Review of the COVID-19 Employee/Visitor Logs, the Risk Assessment Tool, and the COVID-19 Facility Guidelines with the DON identified she was aware:
1) NA-D had an elevated temperature and was not aware of any other staff with elevated temperatures. The DON had no concerns with the COVID-19 screening process. The DON identified NA-D had no additional symptoms, and the elevated temperature she felt was likely due to her pregnancy. NA-D's temperature was checked later in the shift to ensure no elevated temperature continued. The DON had no

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F 880	Continued From page 7	F 880		

additional documentation available to verify NA-D's continued to be monitored for symptoms of COVID-19.
2) NA-B's 4/14/20, Employee/Visitor Log, Risk Assessments identified NA-B had a temperature of 99.7 F and no Risk Assessment had been completed. The DON agreed she should have been notified of the elevated temperature and a symptom screen should have been completed. The DON had no additional documentation available to identify NA-B's Risk Assessment was completed. NA-D should have been sent home due to a temperature above 99.0 F. No additional documentation was available as evidence to ensure NA-A completed a symptoms screen prior to entering the building. The DON agreed without appropriate oversight and active screening, those staff had been allowed entry into the building.

There were no residents symptomatic for COVID-19 at the time of the survey.

Review of the facility's infection prevention surveillance documentation identified no infection surveillance was entered after February, 2020. The facility's former infection preventionist maintained infection surveillance data at the sister facility and had no documentation kept at this facility. When the position was terminated, that data remained at the sister facility. After February, 2020, the DON was responsible to ensure ongoing surveillance of all potential infections occurred. Charge nurses completed an individual resident Infection Treatment/Tracking Form when a resident's infection was treated with antibiotics. There were no viral-like illnesses tracked on any resident form. None of those forms were tracked in a main database for infection surveillance. The DON and the

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F 880	Continued From page 8	F 880		

pharmacist reviewed the infection forms for bacterial illnesses and medication orders on a monthly basis to identify trends for those treated with antibiotics. The nurses were expected to report suspected infections during daily morning meetings, and contact the DON if any infections occurred when she was out of the facilty. Infection surveillance for other types of infections were discussed in daily stand-up, however those infections not treated with antibiotics were not tracked or trended in any way. No process was in place to identify and monitor other types of infections in the facilty. Additionally, only infections treated with antibiotics were included in the monthly QAPI infection reports.

Review of the Quality Assurance and Performance Improvement (QAPI) committee meeting minutes identified in March, 2020, the facility's infection rate was 21 percent (%). The facility's goal was to have an infection rate of 7%. Six residents had received antibiotics in January, 2020. Infections identified included pneumonia, aspiration pneumonia, cellulitis, a urinary tract infection (UTI), and a skin infection. One of six residents was admitted with orders for antibiotics. The minutes made no mention of staff infections, or tracking or trending any non-bacterial infections in the facility.

Interview on 4/21/20 at 12:20 p.m., with the director of nursing (DON) identified the facility's infection preventionist position vacated in February 2020. The DON assumed the position. She had not received infection prevention training, and was unable to receive education due to cancellation of education during COVID-19 restrictions. She was not involved in the hiring process, and was unsure if the facilty planned to

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F 880	Continued From page 9 fill the infection prevention position. Review of the undated Infection Control Guidelines did not include guidelines for surveillance of resident and staff infections in the facilty. A policy was requested for infection surveillance, however, no policy was provided.	F 880		