Electronically delivered

January 21, 2021

Administrator
Redeemer Residence Inc
625 West 31st Street
Minneapolis, MN 55408

RE: CCN: 245520
Cycle Start Date: December 8, 2020

Dear Administrator:

On December 29, 2020 and January3, 2021, we notified you remedies were imposed. On January 19, 2021 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 January 12, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective January 13, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of December 29, 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 was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 13, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on January 12, 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 Therefore, the NATCEP prohibition is rescinded.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,

Kamala Fiske-Downing

Kamala Fiske-Downing

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

Electronically Submitted
December 29, 2020

Administrator
Redeemer Residence Inc
625 West 31st Street
Minneapolis, MN 55408

RE: CCN: 245520
Cycle Start Date: December 8, 2020

Dear Administrator:

On December 8, 2020, survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

## REMOVAL OF IMMEDIATE JEOPARDY

On December 8, 2020, the situation of immediate jeopardy to potential health and safety cited at F805 was removed. However, continued non-compliance remains at the lower scope and severity of D.

## REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective January 13, 2021.

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

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430

through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective January 13, 2021, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 13, 2021, (42 CFR 488.417 (b)).

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

## NURSE AIDE TRAINING PROHIBITION

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

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective January 13, 2021. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

## ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

## DEPARTMENT CONTACT

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

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

## PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

## VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 8, 2021 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

## APPEAL RIGHTS DENIAL OF PAYMENT

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

Tamika.Brown@cms.hhs.gov

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

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

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

## APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

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

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

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

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

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

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

Nursing Home Informal Dispute Process
Minnesota Department of Health

Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

**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.

## 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), the DPOC remedy is effective 15 calendar days from the date of the enforcement letter. The DPOC may be completed before or after that date. A revisit will not be approved prior to receipt of documentation confirming the DPOC was completed. To successfully complete the DPOC, the facility must provide all of the following documentation identified in the chart below.

Documentation must be uploaded as attachments through ePOC to ensure you have completed this remedy.

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.**

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245520 | A. BUILDING _____ B. WING _____ | C 12/08/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **REDEEMER RESIDENCE INC** | **625 WEST 31ST STREET MINNEAPOLIS, MN 55408** |

| (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<br><br>A COVID-19 Focused Infection Control survey was conducted 12/7/20, to 12/8/20, at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.73(b)(6).<br><br>The facility was IN full compliance.<br><br>Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form.<br><br>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<br><br>An abbreviated survey for complaint H5520081C was conducted on 12/7/2020, to 12/8/20, by the Minnesota Department of Health to determine compliance with §483.60(d)(3) Food and Drink.<br><br>The survey results in an immediate jeopardy (IJ) to resident health and safety. An IJ at F805 began on 11/26/20, when it was determined the facility served the wrong food to a resident, resulting in choking, and failed to determine a root cause and educate all facility staff. The director of program services and director of nursing were notified of the IJ at 6:47 p.m. on 12/7/20. The IJ was removed on 12/8/20, at 4:25 p.m., but noncompliance remained at a lower scope and severity level of D which indicated no actual harm but potential for more than minimal harm that is not immediate jeopardy for residents with altered diets. | F 000 | | |

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

Electronically Signed | 01/05/2021

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245520 | A. BUILDING _____ B. WING _____ | C 12/08/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **REDEEMER RESIDENCE INC** | **625 WEST 31ST STREET MINNEAPOLIS, MN 55408** |

| (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 000 | Continued From page 1<br>There was no finding of substandard quality of care (SQC) therefore an extended survey was not conducted.<br><br>A COVID-19 Focused Infection Control survey was also conducted on 12/72020, to determine compliance with §483.80 Infection Control. The facility was determined NOT to be in compliance. As a result, a deficiency was cited at F880.<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance.<br><br>Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form.<br><br>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 805 SS=J | Food in Form to Meet Individual Needs<br>CFR(s): 483.60(d)(3)<br><br>§483.60(d) Food and drink<br>Each resident receives and the facility provides-<br><br>§483.60(d)(3) Food prepared in a form designed to meet individual needs.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to prepare food in accordance with residents need for 1 of 3 residents (R1), whom were on modified diet. R1 choked, became unresponsive and required | F 805 | This Plan of Correction constitutes the facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists | 12/8/20 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245520 | A. BUILDING _____ B. WING _____ | C 12/08/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **REDEEMER RESIDENCE INC** | **625 WEST 31ST STREET MINNEAPOLIS, MN 55408** |

| (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 805 | Continued From page 2<br>immediate Heimlich maneuver by staff.<br><br>The immediate jeopardy (IJ) began on 11/26/20, when the facility failed to provide appropriate texture modifications for R1 who required pureed textures. The facility fed R1 a regular diet of a hot dog instead of pureed which caused R1 to choke on 11/26/20. The director of nursing (DON) and administrator were notified of the immediate jeopardy on 12/7/20 at 6:47 p.m.. The immediate jeopardy was removed on 12/8/20, at 4:25 p.m., but noncompliance remained at the lower scope and severity level of D, which indicated no actual harm with potential for more than minimal harm that is not IJ.<br><br>Findings include:<br><br>R1's facesheet printed 12/8/20, identified diagnoses of functional quadriplegia, anoxic brain damage (lack of oxygen to the brain which resulted damage), epilepsy (condition in the brain causing seizures), and dysphagia (swallowing difficulty).<br><br>R1's annual Minimum Data Set (MDS) dated 9/3/20, identified severe cognitive impairment and indicated R1 required total assistance from staff with eating.<br><br>R1's annual Care Area Assessment (CAA), dated 9/8/20, indicated R1 required total dependence of staff for bed mobility, transfers, locomotion on the unit, dressing, eating, toilet use, grooming and bathing; required a therapeutic and mechanically altered diet; and indicated R1 had problems with communication, function problems that affected her ability to eat and had been at risk for choking and aspiration. | F 805 | or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law.<br>It is the policy of Redeemer Health and Rehab to comply with (F805)-Providing Food in Form to Meet Individual Needs. Historically there have been no other similar occurrences involving meal verification resulting in a choking instance.<br><br>Education: On 11/27/2020, all staff on the unit where R1 resided were immediately re-educated on tray ticket and diet order verification. In addition to the unit staff, all dietary cooks and dietary aides responsible for plating food were re-educated on how to ready a meal ticket and to ensure the ticket matches the diet order and the food being plated. The dietary aides scheduled for 11/30, 12/1 and 12/4, received the same re-education prior to their shifts on those dates. Education on 12/8/20 was again completed for all staff involved with meal service. Actions were taken to identify other potential residents having similar occurrences. This education occurred prior to their shift or prior to providing meal assistance and included Root Cause Analysis, proper diet verification of tray cards, proper diet consistencies; double-check of meals being provided and ramifications of improper procedures.<br><br>Monitoring and auditing to ensure compliance:<br>On 12/2/2020, the Dietary Manager and Dietician began monitoring and auditing | |

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| F 805 | Continued From page 3<br><br>R1's quarterly Nutrition Assessment dated 12/4/20, indicated R1 required a mechanically altered diet of pureed food textures and nectar thick liquids.<br><br>R1's physician visit note dated 12/1/20, stated R1's functional quadriplegia was related to anoxic brain damage and she had been totally dependent of staff for all cares.<br><br>R1's care plan dated 12/4/20, indicated R1 required a mechanically altered diet which included thickened liquids related to dysphagia (swallowing difficulties). R1 was at risk for nutrition alteration and was dependent on staff for eating and drinking and directed staff to make decisions for R1's safety due to her cognition.<br><br>R1's nursing assistant (NA) care card undated, identified R1 required a pureed diet, nectar thick liquids and assist at all meals.<br><br>R1's Progress Note on 11/26/20, at 9:33 p.m. indicated R1 choked on food during dinner time. R1 had to gasp for air and 911 had been called. The progress note writer and two nurses assisted to dislodge food from R1's airway.<br><br>During an observation on 12/7/20, at 12:45 p.m. staff brought R1 in her wheelchair to the table in the main dining room. Nursing assistant (NA)-B began to assist R1 with her meal which consisted of mashed potatoes, pureed vegetables, pudding, pureed kielbasa, nectar thick orange juice and nectar thick water. NA-B had to provide total assistance for R1 to consume her meal.<br><br>During an interview on 12/7/20, at 1:51 p.m. NA-A | F 805 | resident meals including those who had altered/textured diets and are at possible risk for not receiving the proper food form and/or diet order. 7 audits were conducted starting 12/3. 52 Audits conducted the week of 12/14. 40 audits conducted week of 12/21; and 20 audits conducted week of 12/28. Audits will continue for dietary compliance and ensuring resident safety for the duration as determined by the QAPI committee. Altered Diet Reference boards were created and are posted in the kitchenettes to ensure proper compliance with diets. Responsible person for compliance: Dietary Manger/Designee. | |

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stated staff need to ensure texture and menu items matched what was on the meal ticket before they assist a resident. NA-A was not aware of the last time she received education on textures or the process of meal distribution. NA-A thought it had been at least a year since she received education on diet textures and meal distribution but could watch online training if she wanted to.

During an interview on 12/7/20, at 2:05 p.m. the Registered Dietitian (RD) and Certified Dietary Manager (CDM) stated R1 got the wrong food item for the evening meal on 11/26/20. R1 received a regular hot dog which should have been pureed. The Tray Ticket was correct but R1 had somehow gotten the wrong meal. They were not sure if the cook dished the meal wrong or if the staff on the floor provided the wrong tray. RD and CDM were not aware of where the error occurred.

During an interview on 12/7/20, at approximately 2:10 p.m. RD stated they did follow up with education for Cook (C)-A after the incident related to textures but there had not been in-depth education on diet textures completed with staff for some time. The RD stated training and a roll out of the International Dysphagia Diet (international standardization for dysphagia diets) had been put on hold due to the COVID-19 pandemic. The facility education form dated 11/27/20, to 12/4/20, indicated items discussed with dietary staff included explaining what was on each diet and to "make sure the diet matches ticket" and the "importance of following diet".

During a phone interview on 12/7/20, at 2:20 p.m. LPN-A stated at the time of the incident she heard

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RN-A yell for help and ran to R1's room. RN-A told her that R1 had choked. LPN-A saw tears come out of R1's eyes so she called for LPN-B. LPN-A went to call 911 while RN-A and LPN-B did the Heimlich maneuver. When LPN-A returned back to the room R1 had coughed up a hot dog. LPN-A stated R1 had been given the wrong textures for the evening meal on 11/26/20 and R1 should have had a pureed hot dog but instead got a regular hot dog. LPN-A also stated RN-A had fed the regular hot dog to R1 which caused the choking incident. LPN-A stated the meal had been plated in the kitchen and staff who distribute trays and assist residents are to look at the ticket to ensure they assist with the appropriate texture.

During a phone interview on 12/7/20, at 2:30 p.m. RN-A stated she fed R1 at the time of the incident. RN-A noticed R1 had not been chewing her food and just swallowed the hot dog after each bite as RN-A assisted. After the fourth bite RN-A asked if R1 was ready for another bite, but R1 did not respond. R1 had tears coming out of her eyes and RN-A yelled for help. LPN-B and RN-A did the Heimlich maneuver and were able to get the food out. RN-A stated she did not know R1 was not to have a regular hot dog and was not aware of R1's food texture requirements. RN-A stated she verified the tray ticket was the right room number but did not look at the tray ticket to verify the correct diet for R1.

During an interview on 12/7/20, at 3:50 p.m. the CDM stated R1 the tray ticket was accurate on 11/26/20, but could not verify if it had been plated correctly.

During an interview on 12/7/20, at 4:40 p.m. C-A, who served on 11/26/20, stated he did not

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remember plating R1's meal "exactly". C-A was not sure of the exact reason for the incident. C-A stated, "the incident could have been my fault that she got the regular versus pureed". C-A stated he does get busy which likely could have caused the mistake.

During an interview on 12/7/20, at 4:45 p.m. CDM and C-A stated someone has to double check that each meal provided matched the tray ticket prior to being served to a resident.

The facility had a pureed diet extension form (list of menu items to provide for a pureed diet) for the 11/26/20, evening meal indicated 1 pureed beef hot dog on a bun; 4 oz pureed hash browns, ½ cup pureed baked beans, ½ cup pureed fruit cocktail ½ cup or ½ cup applesauce.

The regular texture diet extension for 11/26/20, evening meal indicated 1 beef hot dog on a bun, 1 oz potato chips or ½ cup of hash browns, ½ baked beans and ½ cup fresh fruit or ½ cup applesauce.

An email dated 12/1/20, at 3:06 p.m. from registered nurse (RN)-A to RN-B stated, "On Thursday, 11/26/20, at supper time. Staff verified ticket placed on tray and began to feed resident. Staff noted resident as swallowing food without chewing. During the feeding, staff noted resident was not responding to staff's question as to "are you ready for another bite", then observed resident with tears in her eyes. Staff called for help as it was noted that resident was exhibiting signs of choking. Head of bed was elevated to 90 degrees, two staff came in and assisted with change in position with residents's leg swung to the side of the bed while another staff provided

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back thrust to resident and noted a piece of food item expectorate from resident's mouth. Staff assessed resident's cognition and resident responded to her name and that she was ok."

An email dated 12/1/20, at 3:20 p.m. from LPN-A to RN-B stated, "On Thursday 11/26 around dinner time, RN-A called for help. I rushed to the room, when I noticed the resident was choking. I came out and called LPN-B for help. The three of us helped the resident into a sitting position with the legs on the front of the floor and started performing chest thrust. I left the two nurses, went to call 911. When I went back to the room the patient had expelled out the food particle that was chocking her. After the patient was stable, we realized she was given the wrong tray meal. It was a regular meal that was served but the patient required pureed. On-call provided was notified of the incident and voicemail left for the sister."

An email dated 12/1/20, at 11:02 p.m. from LPN-B to RN-B stated, "So I was passing medication. RN-A called me for help while feeding the resident. I went to pass medication and LPN-A also called me. I ran into the room and resident was choking. We got her up into a seated position and hit her back to dislodge the food. Something was expectorated. Next LPN-A called 911 and I stayed with the resident in a seated position. We put resident back to bed then EMS arrived, evaluated resident, and resident was deemed to be "ok"."

During an interview on 12/7/20, at 2:57 p.m. RN-B (manager for the unit where the incident occurred) stated she had not been sure of the exact reason for the incident. RN-B stated it could

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have been because R1 received the room tray of the previous resident who resided in the room and the nurse did not verify if it was the appropriate meal ticket for R1. After the choking incident the staff who worked on the unit where the incident happened had been educated and audits started.

The facility Inservice and Meeting Record on Diet Verification dated 11/27/20, indicated 14 staff were educated. These 14 staff members worked on the unit where the incident occurred. Although education was provided for staff on R1's unit, additional training was not provided for all facility staff that assist or feed residents with dining service. According to the facility's Consistency Census Report, printed 12/8/20, there are 21 residents in the facility that received food with altered textures; these residents reside on several units within the facility.

The facility Diet Policy and Procedure dated 9/16/20, indicated pureed texture should be presented in a pureed form.

The facility Feeding of Residents by Staff Policy dated 12/9/19, indicated that staff should check that the correct meal is provided for a resident by comparing their wristband or other means of identification with a meal ticket.

Although the facility had done education for dietary staff and staff on the unit where the incident occurred, they had not implemented housewide education to ensure residents were being fed the correct diet for all 21 residents with altered texture diets that resided in other units within in the facility.

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| F 805 | Continued From page 9<br>The immediate jeopardy that began on 11/26/20, was removed on 12/8/20, when the facility identified root cause of the incident. The facility immediately took action to educate all facility staff prior to the start of their shift. Education included root cause analysis, proper diet verification of tray cards, proper diet consistencies, and ramification of improper procedures. The facility conducted audits to ensure compliance and resident safety Altered Diet Reference boards were created and posted in the kitchenettes to reference to ensure proper compliance with diets. Policies were reviewed with no changes. | F 805 | | |
| F 880 SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>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.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§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; | F 880 | | 1/12/21 |

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| F 880 | Continued From page 10<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(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<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. | F 880 | | |

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| F 880 | Continued From page 11<br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to ensure staff wore appropriate PPE (mask and eye protection) to prevent the spread of COVID-19 according to Centers for Disease Control (CDC) guidelines for 3 of 10 residents (R8, R9, and R10) reviewed for infection control practices.<br><br>Findings include:<br><br>R8's quarterly Minimum Data Set (MDS) dated 9/15/20, had diagnoses of chronic lung disease, high blood pressure, and high cholesterol.<br><br>R9's quarterly MDS dated 9/22/20, indicated R9 had diagnoses of heart failure, high blood pressure, and diabetes.<br><br>R10's quarterly MDS dated 10/20/20, indicated R10 had diagnoses of high blood pressure and high cholesterol.<br><br>During an observation on 12/8/29, at 10:06 a.m., licensed practical nurse (LPN)-C was talking with an unidentified resident in a wheelchair at the nursing desk. The resident was wearing a mask under his nose and LPN-C was wearing a mask but no eye protection.<br><br>During an observation on 12/8/20, at 10:08 a.m., registered nurse (RN)-C was at the medication cart wearing a mask but no eye protection; a face shield was laying on top of the medication cart. There were no residents within six feet of RN-C. | F 880 | Designated by MDH as a COVID Support Site, Redeemer has followed the strictest guidelines in providing 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.<br>To ensure continued compliance, the following plan has been instituted.<br>PPE: -Regarding cited residents: No residents were immediately affected by deficient practice; any resident specifically those with transitional protective precautions has the potential to be affected.<br><br>Policies/Procedures: A RCA was conducted and results are attached. (A1). Policies and Procedures for PPE, including source control masks, donning/doffing, guidelines for crisis standard of care, hand-washing, contingency standard of care and standard care along with transmission based precautions have been reviewed with no changes.<br><br>Training/Ed: Training was conducted through individual and group education sessions provided by DON and Infection Preventionist/Designee for all staff that would be entering a resident room. Topics included: standard infection control | |

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| F 880 | Continued From page 12<br><br>During an observation on 12/8/20, from 10:19 a.m. through 10:25 a.m., RN-C, while passing medications for R9, picked up a face shield from the top of the medication cart and placed it on her head. When RN-C left R9's room, she performed hand hygiene, removed the face shield and placed the face shield on top of the medication cart. RN-C did not clean the face shield or perform hand hygiene after removing the face shield and placing it on top of the medication cart.<br><br>During an interview on 12/8/20, at 10:25 a.m., RN-C stated the expectation for staff in resident areas was to wear mask and face shield at all times. RN-C had received education on this. When asked about RN-C having removed the face shield, RN-C stated the face shield was needed for patient care, but also stated staff were supposed to keep on "24/7."<br><br>During an observation on 12/8/20, at 10:14 a.m., housekeeper (HK)-A entered R10's room and placed linens in the room. HK-A wore a mask but no eye protection. R10 was in the room in her bed, about ten feet away from HK-A.<br><br>During an observation on 12/8/20, at 10:17 a.m., R8, in a wheelchair and wearing a mask, was in the hallway interacting with RN-D who wore a mask by no eye protection. RN-D wore a face shield but the face shield was pushed back to the shield was on top of RN-D's head and his eyes exposed.<br><br>During an observation on 12/8/20, at 10:51 a.m., NA-B was in the dining area with R1 and two other unidentified residents. NA-B was moving around the dining area, sometimes coming within | F 880 | practices, transmission-based precautions, appropriate PPE use including donning/doffing. Residents and or their representatives will receive education on the facility□s Infection Prevention Control Program through a basic informational letter/email.<br><br>Monitoring/Auditing: The DON, Infection Preventionist and other facility leadership will conduct audits of PPE donning/doffing, with Transmission Based Precautions i.e. droplet precautions four times per week for one week, two times per week for a week, then bi weekly thereafter until 100% compliance complete. Audits will continue until 100% compliance is met on source control masking for staff, visitors and residents. Real-time audits on all aerosolized generating procedures will be conducted to ensure PPE is in use. Appropriate signage is in place on doors to ensure proper PPE is used regarding transitional precautions prior to entering a resident room.<br><br>HAND HYGIENE<br>Regarding cited residents: No residents were immediately affected by deficient practice; any resident specifically those with transitional protective precautions has the potential to be affected.<br><br>Policies/Procedures: A RCA was conducted and results are attached. (A1). Policies and procedures were reviewed with no changes.<br>Training/Education: training was provided | |

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| **REDEEMER RESIDENCE INC** | **625 WEST 31ST STREET MINNEAPOLIS, MN 55408** |

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| F 880 | Continued From page 13<br>less than six feet of residents. NA-B was wearing a mask, but her face shield was pushed back on top of her head and her eyes unprotected.<br><br>During an interview on 12/8/20, at 12:35 p.m., the infection preventionist (IP) staff stated all staff should be wearing masks and eye protection when they are on the unit or when in contact with a resident. If staff are at the nursing station and no one was around, they do not need eye protection. They should be wearing eye protection in resident rooms, hallways, dining rooms, and other general care areas. The IP stated residents admitted from a hospital would be on "Transitional Protective Precautions" and provided a sign, dated October 2020, which indicated staff did not need to wear a gown entering the room and should be wearing gloves.<br><br>During an interview on 12/8/20, at 4:05 p.m., the director of nursing (DON) verified all staff should be wearing masks and eye protection when they are in resident care areas. The DON also verified staff did not need to wear eye protection at nursing stations if no residents were around. The DON verified residents admitted from a hospital would be on contact and droplet precautions, which included wearing a gown before entering the room, and doffing the gown upon before exiting the room. The DON verified hand hygiene should be performed after removal of PPE and before exiting the room.<br><br>The facility's Hand Hygiene policy, last revised 10/9/2020, indicated hand hygiene should be performed after removing gloves, after each resident contact, after touching surfaces or equipment near residents, after contact with one's own face or mask, and after removing PPE. | F 880 | by DON and Infection Preventionist/Designee for all staff that would be entering a resident room. Topics included: proper hand hygiene, standard infection control practices, transmission-based precautions, caring for and disinfecting shared medical equipment and finding from the RCA.<br><br>Monitoring/Auditing: Audits will be conducted on all shifts, every day for one week. Results will be reported to the QAPI Committee who will determine the duration for auditing to ensure compliance.<br>The DON or designee will audit 5 percent of charts/episodes monthly for three months to ensure compliance to F880. Results of these audits will be reviewed by the facility QAPI committee who will determine duration and percentages of monitoring/audits to maintain compliance.<br>Those responsible to maintain compliance will be: DON and/or designee. | |

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| F 880 | Continued From page 14<br><br>The facility's COVID-19 Protocol, last revised 11/19/2020, indicated "all employees will wear surgical masks at all times". The protocol also indicated "all employees will wear eye protection at all times when they are in a shared space with residents and/or other employees." The protocol also noted residents who returned from the hospital would be place on "transitional protective precautions", which indicated staff would wear mask and eye protection at all times, gloves if touching surfaces in the room, and gowns to provide direct care.<br><br>The CDC's Preparing for COVID-19 in Nursing Homes' section "Plan for Managing New admissions," dated 11/20/20, indicated residents who were readmitted to the facility should be placed in a single person room, and healthcare workers should wear N95 or facemask, eye protection gloves, and gown when caring for these residents. The guide indicated the observation period was 14 days. | F 880 | | |
| F 883 SS=D | Influenza and Pneumococcal Immunizations<br>CFR(s): 483.80(d)(1)(2)<br><br>§483.80(d) Influenza and pneumococcal immunizations<br>§483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that-<br>(i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;<br>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been | F 883 | | 1/12/21 |

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| F 883 | Continued From page 15 | F 883 | | |

immunized during this time period;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-
(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive

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| F 883 | Continued From page 16<br>the pneumococcal immunization due to medical contraindication or refusal.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure 2 of 5 residents (R6, R7) reviewed for immunizations were offered and/or provided the pneumococcal vaccination series as recommended by the Centers for Disease Control (CDC) to help reduce the risk of associated infection(s).<br><br>Findings include:<br><br>R6's face sheet, printed 12/8/20, indicated R6 was admitted to the facility on 6/10/19, and was 69 years old. The face sheet further indicated R6 had diagnoses of chronic heart disease, chronic liver disease, high blood pressure, high cholesterol, and alcohol dependence.<br><br>R6's immunization record, printed 12/8/20, indicated R6 received the pneumococcal conjugate (PCV13) vaccine on 6/19/19; there was no evidence the pneumococcal polysaccharide vaccine (PPSV23) was offered or refused.<br><br>R7's face sheet, printed 12/8/20, indicated R7 was admitted to the facility on 7/5/19, and was 56 years old. The face sheet further indicated R7 had diagnoses of multiple sclerosis, congestive heart failure, high blood pressure, high cholesterol, chronic kidney failure, and chronic lung disease.<br><br>R7's medical record, including his immunization record printed 12/8/20, was reviewed and lacked evidence R7 was offered and/or provided the full | F 883 | It is the policy of Redeemer Health and Rehab to comply with (F883). The facility practice in to maintain and ensure all residents have the opportunity to obtain influenza and pneumococcal vaccinations.<br>To correct the deficiency and ensure compliance, the facility has developed and implemented a plan including the following:<br>Upon admission all resident records related to immunization history will be obtained. All residents in facility have been audited for immunization compliance. All residents will be offered and documented their vaccination options to maintain compliance. Residents without up to date immunizations will be offered and given vaccines as needed and as resident allows.<br>Documentation will be entered into the Preventative Health section in Matrix if resident refuses vaccinations. Resident will be educated on benefits of immunizations by Nurse Manager or desginee.<br>The DON, Infection Preventionist and other facility leadership will audit all new admits for 3 months to ensure influenza and pneumococcal are completed. Results will be entered in preventive health record and reported to the QAPI Committee. QAPI Committee will determine duration of auditing based on compliance outcomes. Those responsible to maintain compliance will be: The DON | |

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| F 883 | Continued From page 17 | F 883 | | |

series of pneumococcal vaccinations (PPSV3 and PCV13) despite having resided in the facility for over a year.

During an interview on 12/7/20, at 3:30 p.m., registered nurse (RN)-B, who used to be the Infection Preventionist (IP), stated she had a system for tracking but there had been a few interim IP until this IP and she wasn't sure what the current process was for tracking vaccinations. RN-B verified she could not find documentation of vaccination or refusal of PPSV23 for R6 or either penumococcal vaccines for R7.

During an interview on 12/7/20, at 3:45 p.m., the infection preventionist (IP) stated she had not been there long enough to review the vaccination protocols or assure residents were being tracked; "they were completed before I came."

During an interview on 12/7/20, at 4:05 p.m., the director of nursing (DON) stated she did not track anything related to vaccinations and referred to the IP.

A pneumococcal vaccine policy, dated 10/9/20, indicated for adults over age 65, the PCV13 would be given first and then the PPSV23 at least one year later. The policy indicated the facility should use the CDC or state-specific guidelines for residents under age 65 or for residents of any age who are immunocompromised.

They facility's CDC guidance, dated 7/13/15, indicated a different pneumococcal vaccine schedule than for current CDC guidelines.

The CDC guideline, Pneumococcal Vaccine

or designee.

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| F 883 | Continued From page 18<br>Timing for Adults, dated 6/25/20, indicated persons ages 19-64 years old with certain medical conditions, including chronic renal failure, should receive a dose of pneumococcal polysaccharide vaccine (PPSV23) followed by a dose of pneumococcal conjugate (PCV13) at least one year later with a final dose of PSV23 at 65 years or older. The CDC guideline indicated persons 65 or older should receive a dose of PCV13 if not previously received, followed by a dose of PSV23 at least one year later. | F 883 | | |