Electronically delivered
September 1, 2020

Administrator
St Mark's Living
400 - 15th Avenue Southwest
Austin, MN 55912

RE: CCN: 245369
Cycle Start Date: August 19, 2020

Dear Administrator:

On August 19, 2020, a 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.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), 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 October 1, 2020.

- 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 October 1, 2020. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 1, 2020.

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

your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

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 October 1, 2020, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, St Mark's Living will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 1, 2020. 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:

Jennifer Kolsrud Brown, Unit Supervisor
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Phone: 507-206-2727

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 February 19, 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

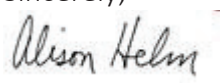
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

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.

Feel free to contact me if you have questions.

Sincerely,



Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	C 08/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARKS LIVING	**400 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A COVID-19 Focused Infection Control survey was conducted 8/18/20 and 8/19/20 at your facility by the Minnesota Department of health to determine compliance with Emergency Preparedness regulations [§] 483.73(b)(6). The facility was in full compliance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 8/18/20 and 8/19/20 an abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities.The facility was not in full complaince. The following complaint was found to be unsubstantiated. H5369091C However, as a result of the investigation a deficiency was identified at F690. In addition, a COVID-19 Focused Infection Control survey was conducted on 8/18/20 and 8/19/20 at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was not in full compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the	F 000		

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

Electronically Signed | 09/10/2020

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F 000	Continued From page 1 Department's acceptance. Upon receipt of an acceptable electronic POC, a revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form	F 000		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore	F 690		9/11/20

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F 690	Continued From page 2 continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure appropriate care of a catheter bag was completed for 1 of 1 resident (R3). Findings Include: During an observation on 8/19/20, at 11:14 a.m. R3 was observed in lying in bed in low position, with a fall mat next to the bed and the soft call light was in reach. R3's catheter bag was uncovered and was placed on the floor mat next to the bed with no barrier. R3's admission Minimum Data Set dated 7/28/20 indicated R3 had a indwelling catheter, short and long term memory problems and severely impaired decision making skills for daily living. R3's care plan included, "The resident has a Catheter Neurogenic bladder, Terminal condition." Interventions: "CATHETER: The resident has Catheter. Position catheter bag and tubing below the level of the bladder and away from room door entrance. Ensure it is hung appropriately." During an interview on 8/19/20, at 11:17 a.m., licensed practical nurse (LPN)-A verified though	F 690	Corrective Action R3's catheter bag was appropriately covered up by a dignity bag and properly hung from the side of bed to ensure the bag doesn't touch the floor. Actions completed on 8/19/20. Correction Action as it applies to all residents In house audit was completed on all residents with catheters. Audit included ensuring each catheter bag had an appropriate dignity bag covering it and that each catheter bag was properly stored off the ground. Audits were completed on 9/1/20 and 9/8/20. All nursing staff were re-educated on the facility's policy regarding Catheter Care and Infection Control. Education was completed on 9/8/20. Date of completion: 9/11/20 Recurrence will be prevented by: DON or designee will complete weekly audits for 3 months. Audit will address ensuring appropriate covers or dignity	

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F 690	Continued From page 3 observation of R3's catheter bag was on the floor mat with no cover or barrier. LPN-A said the catheter bag should have a cover on it and should not be touching the ground. LPN-A stated it was the facility practice to have catheter bags covered with a bag. LPN-A stated the bag must have come off or the aides forgot to put one. LPN-A stated the concern was obviously for infection by not having the bag covered if the opening to the catheter were to touch the ground. LPN-A stated she was going to get a cover on the catheter bag and make sure it was not touching the ground. During an interview on 6/19/20, at 11:33 a.m. nursing assistant (NA)-A stated R3 did not have a catheter bag cover and stated they use the bags for the covers more on the 4/5 wing. NA-A stated she did not know why R3 did not use a catheter bag cover. NA-A stated they (catheter bag covers) were kept in the linen room on this hall. NA-A stated the first day R3 was here they used a bag to cover the catheter but that was it. NA-A stated, "No" a catheter bag should not be on the fall mat or floor and stated it could be an infection issue if dirt were to get into the tubing. During an interview on 6/19/20, at 11:42 a.m. NA-B stated she got R3 ready today and stated she put a dignity bag on his catheter bag that morning. NA-B stated there are some (dignity bags) in the storeroom and normally they (residents) have one in their room. NA-B stated the catheter bag should not be touching the floor because of bacteria, would not want bacteria getting into the catheter because it could make R3 sick. During an observation on 8/19/20, at 11:47 a.m.	F 690	bags are in place on each catheter bag in the facility, while ensuring proper catheter tubing and drainage bag storage is being maintained. Results will be shared and discussed with the QAPI committee. Correction will be monitored by: Don or designee ; QAPI committee.	

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F 690	Continued From page 4 R3's catheter bag was now covered with a bag, hanging from the side of the bed and was not touching the floor. During an interview on 8/19/20, at 1:21 p.m. the director of nursing (DON) stated no it (the catheter bag) should not be resting on the fall mat and stated the bags should be covered. Stated it would be an infection control concerns, as it would increase the risk of infections to have it on the floor. The Catheter Care, urinary policy dated September 2014 included, "Infection Control: B. Be sure the catheter tubing and drainage bag are kept off the floor."	F 690		
F 880 SS=D	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	F 880		9/11/20

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F 880	Continued From page 5 arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and	F 880		

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F 880	Continued From page 6 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 interview and document review the facility failed to implement COVID-19 symptom screening for 1 of 3 residents (R3) whose record was reviewed for the focused COVID-19 infection control survey. Findings include: R3's admission record indicated R3 was admitted to the facility on 7/22/20 with diagnoses of encounter for palliative care and chronic heart failure. R3's physician orders were reviewed and revealed no order for COVID-19 symptoms screening had been implemented. R3's treatment administration records for July and August 2020 were reviewed and revealed no documentation of COVID-19 symptoms screening. During an interview on 8/19/2020, at 1:21 p.m. the director of nursing (DON) stated the twice-daily COVID-19 screening was not in place as it should have been since R3's admission to the facility. The DON Stated she created an order today for COVID-19 screening for R3. The DON stated she was not aware it (COVID-19) screening was not in place until the surveyor found it. The DON stated that with the HUC	F 880	Corrective Action R3's chart was updated to include a doctor's order for daily COVID monitoring. Actions completed on 8/19/20. Correction Action as it applies to all residents In-house audit was completed on all residents to ensure each resident had daily COVID monitoring orders in each chart. Audit was completed on 8/25/20 and 9/1/20. All appropriate nursing staff were re-educated on the facility's policy regarding Infection Prevention and Control Policy for suspected or confirmed Coronavirus. Education was completed on 9/8/20. Date of completion: 9/11/20 Recurrence will be prevented by: DON or designee will complete weekly audits for 3 months on each new admission, ensuring each new admission has active daily COVID monitoring orders in their chart. Results will be shared and discussed with the QAPI committee. Correction will be monitored by: Don or	

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F 880	Continued From page 7 (Health Unit Coordinator) having retired the facility did not have anyone in the position that assisted with order entry. The DON stated there was still a nurse manager in place and she was not aware the nurse manger did not place the order for the COVID-19 symptom screening for R3. The DON stated normally we have a HUC and a nurse manager that ensure all proper orders are in place upon admission and R3 admitted during the timeframe when those positions were not filled. The DON stated the nurses having been doing these assessments every day for six months and they did not identify the order was not populating for this resident. The undated Infection Prevention and Control Manual Interim Policy for suspected or confirmed Coronavirus included, "Actively screen all residents daily for fever >100.4F and symptoms of covid-19."	F 880	designee ; QAPI committee.	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 1, 2020

Administrator
St Mark's Living
400 - 15th Avenue Southwest
Austin, MN 55912

Re: Event ID: FDRE11

Dear Administrator:

The above facility survey was completed on August 19, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARKS LIVING	400 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 8/18/20 and 8/19/20 an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be IN compliance with the MN State Licensure. The following complaints were found to be UNSUBSTANTIATED: H5369091C	2 000		

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

Electronically Signed | 09/10/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00394	A. BUILDING: _____ B. WING _____	C 08/19/2020

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2 000	Continued From page 1 The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		

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:

DIRECTED PLAN OF CORRECTION - Actively Screening Residents

- 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:

- Conduct active health screening and surveillance of residents upon admission and twice daily for fever (>100.0F or subjective) and symptoms of COVID-19 (shortness of breath, new or change in cough, chills, sore throat, muscle aches).
- Develop and implement a checking system for order verifications and transciption errors for admits/readmits of residents .
- Group residents, or "cohorting," should be done when possible to separate residents with an infectious disease (positive residents) from residents who are not affected. Plans to cohort should be carefully established in advance and should be centered on implementation of infection control practices.
- Isolate and restrict incoming residents discharged from hospitals, or other facilities, to their room for 14 days.
- Assess newly admitted residents with respiratory symptoms that include cough, fever or shortness of breath for known exposure to a person with COVID-19 in the 14 days prior to illness onset, or recent admission to facilities with COVID-19 cases. Ask discharging facility whether diagnostic testing has been conducted for COVID-19.

TRAINING/EDUCATION:

- Guidance on the use of pulse oximetry is available from MDH: Pulse Oximetry and COVID-19: https://www.health.state.mn.us/diseases/coronavirus/hcp/pulseoximetry.pdf
- Remind residents to practice social distancing and perform frequent hand hygiene.
- Educate and assist the resident to utilize an appropriate mask to reduce droplet spread.

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:

- Chart all clinical measurements and symptoms daily for each resident.
- Use cumulative data to conduct active surveillance. Record daily the number of residents that have been transferred to acute care, even for non-respiratory disease, by using a sheet like that in Appendix E. In some LTC facilities, an increasing number of transferred residents has preceded confirmation of COVID-19 in the facility.
- All residents positive for fever or symptoms should be isolated, placed under transmission-based precautions, and tested for COVID-19. Clinicians are encouraged to test for other causes of respiratory illness in addition to COVID-19.
- Conduct a RCA (root cause analysis) which will be done with assistance from the Infection Preventionist, Quality Assurance and Performance Improvement (QAPI) committee and Governing Body. The RCA should be incorporated into the intervention plan. Information regarding RCAs is available in the Guidance for Performing Root Cause Analysis (RCA) with Performance Improvement Projects (PIPs).

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

In accordance with 42 CFR § 488.402(f), this remedy is effective 15 calendar days from the date of the enforcement letter. The DPOC may be completed before or after that date. The effective date is not deadline for completion of the DPOC. However, 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 should be uploaded as attachments through ePOC.

Imposition of this DPOC does not replace the requirement that the facility must submit a complete POC for

all cited deficiencies (including F880) within 10 days after receipt of the Form CMS 2567.

Item	Checklist: Documents Required for Successful Completion of the Directed Plan
1	Documentation of the RCA and intervention or corrective action plan based on the results with signatures of the QAA Committee members and members of the Governing Body
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.