Electronically Submitted
December 16, 2020

Administrator
Kittson Memorial Healthcare Center
1010 South Birch
Hallock, MN 56728

RE: CCN: 245247
Cycle Start Date: November 24, 2020

Dear Administrator:

On November 24, 2020, survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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 a pattern of deficiencies that constituted immediate jeopardy (Level K), whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On November 24, 2020, the situation of immediate jeopardy to potential health and safety cited at F880 was removed. However, continued non-compliance remains at the lower scope and severity of E.

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 December 31, 2020.

- 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 December 31, 2020 (42 CFR 488.417 (b)), (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 31, 2020, (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 December 31, 2020. 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.

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:

Jen Bahr, RN, Unit Supervisor
Bemidji District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, MN 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104 Mobile: (218) 368-3683

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 May 24, 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,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245247	A. BUILDING _____ B. WING _____	11/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KITTSON MEMORIAL HEALTHCARE CENTER	1010 SOUTH BIRCH HALLOCK, MN 56728

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A COVID-19 Focused Infection Control survey was conducted on 11/19/20, through 11/24/20, at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.73(b)(6). The facility was in full compliance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control survey and abbreviated survey was conducted on 11/19/20, through 11/24/20, at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was determined NOT to be in compliance. The survey resulted in an Immediate Jeopardy (IJ) to resident health and safety at F880. The IJ began on 10/29/20, when the facility identified the first COVID-19 positive resident and failed to ensure residents who were potentially exposed to COVID-19 positive residents were immediately quarantined and staff were aware of when to utilize gowns for quarantined residents. Residents presenting with COVID-19 symptoms were not quarantined and provided a follow up RT-PCR test to ensure the rapid antigen test results were accurate. In addition, the facility did not utilize their empty rooms to cohort residents with potential COVID-19 exposures to one wing to reduce the chances for residents without exposure from contracting COVID-19. Staff	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/24/2020

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F 000	Continued From page 1 presenting with symptoms of COVID-19 were provided a rapid antigen test and allowed to work without being provided a RT-PCR test to confirm the negative COVID-19 test. The administrator, director of nursing (DON) and the infection preventionist (IP) were notified of the IJ on 11/20/20, at 5:10 p.m. The IJ was removed on 11/24/20, at 1:05 p.m. when the facility implemented actions to reduce/ prevent the spread of COVID-19 within the facility. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, a revisit of your facility will be conducted to validate substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 880 SS=K	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:	F 880		1/15/21

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F 880	Continued From page 2 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, 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	F 880		

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F 880	Continued From page 3 identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the Centers for Disease Control (CDC) guidance to prevent/or minimize the transmission of COVID-19 was fully implemented. The facility failed to establish a system to identify which residents were on quarantine to ensure appropriate gown use was used for 3 of 20 residents (R1, R2, R3) identified to be on quarantine precautions; immediately quarantine residents who had symptoms of COVID-19 for 6 of 6 residents (R1, R2, R3, R4, R5, R7) who were displaying signs and symptoms of COVID-19; utilize available rooms to cohort like residents for 1 of 1 residents (R5) who was transferred to a non COVID-19 wing following exposure to COVID-19 residents. In addition, the facility allowed 12 of 15 nursing staff (LPN-A, NA-K, NA-L, RN-B, NA-M, NA-O, LPN-D, LPN-E, NA-P, LPN-F, NA-J, NA-F) who displayed COVID-19 symptoms to work without confirming negative antigen tests with a RT-PCR test. These deficient practices resulted in an immediate jeopardy (IJ) situation which placed 43 out of 50 residents at risk for contracting COVID-19, which had the potential to cause serious illness or death.	F 880	It is the policy of Kittson Healthcare to follow the CDC guidance on Coronavirus Disease 2019 for long term care. On November 22nd, 2020, all COVID positive residents were co-horted at the end of the West wing with a barrier dividing COVID isolated residents from quarantined residents. All remaining residents were put in quarantine with the exception of former positives that have completed their isolation period Residents both in quarantine and isolation are in appropriate transmission based precautions according to Kittson's Novel Virus Policy. Available rooms have been utilized to cohort residents. A majority of residents are in a private rooms. The quarantined residents that are co-horted together, were exposed within the same time frame or both COVID positive. HCP staff were educated on CDC guidance for use of PPE for quarantine and isolation residents. Dedicated equipment was used in all isolation rooms. Policy was reviewed and demonstration of donning and doffing was	

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F 880	Continued From page 4 The IJ began on 10/29/20, when the facility identified the first COVID-19 positive resident and failed to ensure residents who were potentially exposed to COVID-19 positive residents were immediately quarantined and staff were aware of when to utilize gowns for quarantined residents. Residents presenting with COVID-19 symptoms were not quarantined and provided a follow up RT-PCR test to ensure the rapid antigen test results were accurate. In addition, the facility did not utilize their empty rooms to cohort residents with potential COVID-19 exposures to one wing to reduce the chances for residents without exposure from contracting COVID-19. Staff presenting with symptoms of COVID-19 were provided a rapid antigen test and allowed to work without being provided a RT-PCR test to confirm the negative COVID-19 test. The administrator, director of nursing (DON) and the infection preventionist (IP) were notified of the IJ on 11/20/20, at 5:10 p.m. The IJ was removed on 11/24/20, at 1:05 p.m. when the facility implemented actions to reduce/ prevent the spread of COVID-19 within the facility. However, noncompliance remained at the lower scope and severity, pattern, which indicated no actual harm with potential for more than minimal harm that was not IJ (Level E). Findings include: The CDC guidance Coronavirus Disease 2019 (COVID-19) People at Increased Risk dated 9/11/20, identified the risk for severe illness from COVID-19 increased with age, with older adults at the highest risk. Severe illness means a person with COVID-19 may require hospitalization, intensive care, or a ventilator to help them	F 880	provided to staff. Staff are being audited for PPE use daily. Staff will be educated on any change in policy and procedure. Education will be done through email, during report and in the communication book. Just-in-time education will be provided as needed during auditing and observation. All symptomatic residents and staff who received a negative antigen test have been confirmed with a PCR test. Residents and their roommates will be put in TBP until results are confirmed. All staff confirmed positive were sent home and placed on isolation at home and not allowed to work until their isolation of 10 days was completed. Once their isolation was completed and the COVID-19 return-to-work assessment indicated they could return; they were put back on the schedule. All signage that were not CDC approved have now been replaced with CDC approved signs. All rooms now have a PPE supply and trash cans for waste. All negative antigen tests will be confirmed with PCR and staff will not be allowed to work until the PCR results are obtained. All residents and their roommates with negative PCR results will be put in TBP until a confirmatory PCR test is returned. How corrective action will be accomplished for those residents found to have affected by the deficient practice? On November 22nd all residents were put in quarantine or isolation. A Covid-19 wing was assembled on the far end of the	

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F 880	Continued From page 5 breathe, or they may even die. On 11/19/20, at 12:45 p.m. upon entrance to the facility, the administrator stated the facility had five residents and four employees who had tested positive for COVID-19. The administrator stated the county positivity rate was 4.3% and the facility was testing staff and residents two times per week. The administrator identified the facility's first COVID-19 positive case occurred on 10/19/20, when two employees tested positive for COVID-19. On 10/29/20, two residents tested positive for COVID-19. On 11/19/20, at 1:00 p.m. a brief facility tour was conducted with the DON. The west wing of the facility had been turned into a COVID-19 wing and housed COVID-19 positive residents, who were on isolation precautions along with residents with potential exposures to COVID-19 positive residents and were on quarantine. One non-COVID-19 positive resident resided on the west COVID-19 wing, however she stayed in her room and was not on any COVID-19 transmission based precautions. During the tour, room doors of isolated residents who were COVID-19 positive were not closed, as recommended by the CDC. Both the west COVID-19 wing and the east wing of the facility were located on the ground level of the facility and were opposite of each other, separated by a small lobby area and the nurses station. The second floor of the facility was identified as a dementia unit that housed 18 residents, all of whom were non-COVID-19 positive and had not had previous exposures to COVID-19 positive staff or residents. On 11/20/20 at 4:30 p.m. the administrator and DON were interviewed. The administrator stated	F 880	west corridor. A barrier was utilized to separate isolation residents from quarantined residents. Private rooms were utilized as available. Proper PPE was utilized and education given to staff as needed. How the facility will identify other residents having the potential to be affected by the same deficient practice? Ongoing testing of symptomatic residents will be done according to the testing policy; if antigen test is negative, it will be confirmed with a PCR-RT along with the resident and their roommate in TBP until the PCR-RT results are returned. If a resident's test confirms a positive test for COVID-19, the resident will be moved to the covid-19 unit and transmission based precautions will be applied, the roommate will be placed in TBP quarantine and monitored for ongoing symptoms. What measures will be put into place, or systemic changes made to ensure that the deficient practice will not recur? All staff have been educated on the testing policy as well as appropriate cohorting, transmission based precautions, isolation, quarantine, PPE, and hand hygiene. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur? Continued auditing of PPE and hand hygiene will be done weekly until a goal of 95% is met, then monthly. The results will be brought to the Risk Management Committee for review quarterly and corrective actions taken as needed. The DON or her designee is responsible for compliance. Testing	

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F 880	Continued From page 6 14 residents resided on the west COVID-19 wing. Five residents (R9, R10, R11, R18 and R19) were diagnosed with COVID-19 and the remaining nine residents were identified as residents who were exposed to the COVID-19 positive residents. The administrator stated eighteen residents resided on the east wing. Six residents on the east wing were under quarantine due to an exposure to the COVID-19 positive residents, however were not moved to the west COVID-19 wing. The DON stated the facility had seven open beds on the west COVID-19 wing and two open beds on the east wing. RESIDENT QUARANTINE/ GOWN USE /COHORTING: The CDC's Symptoms of Coronavirus, updated 5/13/20, people with COVID-19 have had a wide range of symptoms reported - ranging from mild symptoms to severe illness. Symptoms may appear 2-14 days after exposure to the virus. People with these symptoms may have COVID-19: fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting and diarrhea. This list does not include all possible symptoms. CDC will continue to update this list as we learn more about COVID-19. The CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic dated 11/4/2020, directed facility's to implement mechanisms and policies that promoted situational awareness for facility staff. The guidance indicated to the extent	F 880	compliance will audited twice a week based on the county's positively rate or no new cases for 14 days.	

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possible, patients with suspected or confirmed SARS-CoV-2 infection should be housed in the same room for the duration of their stay in the facility. HCP who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to standard precautions and use an approved N95 or equivalent or higher-level respirator (or facemask if a respirator is not available), gown, gloves, and eye protection. HCP must receive training on and demonstrate an understanding of: when to use PPE, what PPE is necessary, how to properly don, use, and doff PPE in a manner to prevent self-contamination, how to properly dispose of or disinfect and maintain PPE and the limitations of PPE.

R1's quarterly Minimum Data Set (MDS) dated 10/22/20, identified R1 was 94 years of age and had severe cognitive impairment. R1 was unable to ambulate and required extensive assistance with all activities of daily living (ADL's). R1's diagnoses included Alzheimer's disease, dementia, heart disease and diabetes.

R1's mandatory Resident Temperature/Heart Rate and Oxygen Saturation (O2) Tracking Log from 11/1/20 - 11/19/20, identified R1's temperature, pulse and O2 were monitored two times per day. R1's temperature ranged from 97 degrees Fahrenheit (F) to 98.8 degrees (F) on a.m. and p.m. checks 11/1/20 through 11/28/20. On 11/19/20, a.m. R1's temperature was recorded at 99.9 degrees (F).

R1's progress note(s) from 11/1/20 through 11/20/20, identified the following:

-11/7/20, R1 was in her wheelchair and was spending time in the hallways or common areas

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within the unit most of the day.

-11/19/20, R1 was placed in quarantine due to contact exposure to a COVID-19 positive resident.

During observation on 11/19/20, at 2:20 p.m. R1 was seated in her wheelchair in the doorway of her room on the COVID-19 unit. R1 was not wearing a face mask. Licensed practical nurse (LPN)-A was seated on the floor in front of R1 to change a dressing to her right leg. Nursing assistants (NA)-F and NA-G stood in the hallway directly behind LPN-A and were handing LPN-A dressing packages and gloves. All three staff members wore goggles, face masks and gloves, however, the three staff members were not wearing isolation gowns. LPN-A stated R1 was on the unit due to a possible exposure to a COVID-19 positive resident and had been running a fever that morning but stated a rapid antigen test was done that morning and was negative.

During interview on 11/19/20, at 2:31 p.m. LPN-A stated five residents had recently tested positive for COVID-19 and those residents had PPE stations hanging on their doors because gowns were required to be worn for their care. LPN-A stated three residents had displayed elevated temperatures, including R1, that morning but they had done rapid antigen tests on them and all three tests were negative. The other nine residents on the COVID-19 unit, including R1, were under quarantine because of a potential exposure to a COVID-19 positive resident. LPN-A stated the staff did not wear gowns when they provided care for these residents, because they were not positive for COVID-19.

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On 11/20/20, at 9:07 a.m. NA-K had on a N95 facemask, faceshield, goggles, and an isolation gown. NA-K removed her isolation gown inside R11's room, who was COVID-19 positive, and performed hand hygiene prior to exiting R11's room. NA-K entered R1's room and shut the door to assist R1 with care. NA-K did not put on an isolation gown prior to entering the room. R1's room had a purple flower sign hanging on the outside of her door, however did not have a PPE cart or drape near/on her door, nor CDC signage to direct staff to what type of PPE was needed for R1's care. NA-K began to gather supplies in R1's room and then stated, "Oh, wait a minute." NA-K stated she was unsure if staff were required to wear an isolation gown to provide care to R1 or not. NA-K stated there was no PPE setup in R1's room, but stated she was going to leave the room to obtain an isolation gown to put on, just to be safe. NA-K exited R1's room and went to another resident's PPE cart and obtained a clean isolation gown. NA-K put on the isolation gown and asked LPN-C if she was to wear a gown when providing care to R1. LPN-C stated she was supposed to wear a gown with R1 . NA-K again entered R1's room to provide care, wearing an isolation gown and finished providing care to R1.

During interview on 11/20/20, at 9:15 a.m. NA-K stated R1 was under quarantine but was not positive for COVID-19, therefore it was hard to tell if she needed to wear a gown when providing care to R1. NA-K indicated there was no PPE cart or station setup outside R1's room and there was nothing to identify R1 was under quarantine and what, if any PPE was supposed to be used. NA-K stated she was told who was on quarantine through shift report. NA-K stated she could

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usually tell if a gown was needed if the resident had a PPE drape on their door. NA-K stated there was not a PPE cart or drape on/in R1's room to identify she was on quarantine and a gown was supposed to be worn when providing direct resident care.

R7's quarterly MDS dated 9/3/20, identified R7 was 87 years of age and had minimal cognitive impairment. R7 required extensive assistance with all ADL's. R7's diagnoses included diabetes, heart disease and chronic kidney disease.

R7's progress note dated 11/16/20, indicated R7's COVID-19 test was negative.

During observation on 11/19/20, at 3:37 p.m. NA-H entered R7's room on the west COVID-19 wing, to assist with toileting. NA-H wore a N95 facemask, goggles and a faceshield. NA-H did not put on an isolation gown prior to entering R7's room. NA-H removed the cloth gait belt from around her neck and placed it around R7's waist. NA-H donned (put on) gloves and leaned over R7, while on the toilet to assist R7 with placing her hands on the toilet seat grab bar. NA-H's uniform came into direct contact with R7's shoulder and arm as she assisted her. NA-H physically assisted R7 to a standing position and provided perineal cares along with pulling up her undergarments and clothing. NA-H transferred R7 to her wheelchair. NA-H assisted R7 to use hand sanitizer. NA-H removed the cloth gait belt from around R7's waist and placed the cloth gait belt around her neck. NA-H performed hand hygiene and exited the room.

During observation on 11/19/20, at 4:05 p.m. the DON was hanging purple flower signs on several

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resident doors on the west COVID-19 wing. The DON was overheard, explaining to staff working on the COVID-19 wing, the purple flower signs were to identify residents that were under quarantine and the staff were to wear isolation gowns to care for those residents. Further, if the resident door had a yellow flowered sign, the resident was under isolation and full PPE was needed when caring for the resident. The DON did not hang a purple or yellow flower sign on R7's door, despite R7's potential exposure to COVID-19 positive residents.

During interview on 11/19/20, at 4:30 p.m. registered nurse (RN)-A stated there were five positive residents on the COVID-19 wing and the other residents on the wing were there due to a potential exposure to a positive resident. RN-A stated the purple flower signs indicated the resident had a possible exposure to a COVID-19 positive resident and needed to be quarantined. The yellow flower signs indicated a COVID-19 positive residents that were under isolation. RN-A stated the residents on the COVID-19 wing that did not have a purple or yellow flower sign on their door were not under any type of quarantine and only gloves, masks and eye protection was needed to care for those residents. RN-A indicated R7 had frequently come out of her room to leave the COVID-19 wing to play cards with other residents. RN-A indicated R7's activities would have exposed her to a COVID-19 positive residents because of this. RN-A stated R7's door did not have a purple or yellow flowered sign on her door. Further, R7's door should have a purple flowered sign on the door to indicate to staff she was under quarantine, and to don an isolation gown when providing cares. RN-A indicated the purple and yellow signs could be

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confusing for staff.

During interview on 11/20/20, at 8:50 a.m. LPN-C stated R7 was leaving the west wing to play cards until 11/16/20, and had potential exposure to COVID-19 positive residents during that time. All the residents residing on the COVID-19 wing were there because they all had a potential exposure to the COVID-19 positive residents. Staff were not putting on isolation gowns to care for some of the residents on the COVID-19 wing because they were not a potential risk and then stated, "but I guess they are a potential risk." LPN-C stated she did not know why some of the residents were not considered to have had a potential exposure and things were changing every day.

On 11/20/20, at 8:53 NA-J stated R7's roommate, R6 was moved to another room the previous night after she had tested positive for COVID-19. There was no purple flower sign or precaution sign to indicate to staff that R7 had a high risk exposure to her roommate, a positive COVID-19 resident, and would need to be quarantined to her room and staff would need to use gowns while providing direct resident care.

During interview on 11/19/20, at 3:45 p.m. NA-E stated staff only wore isolation gowns for the COVID-19 positive residents. NA-E stated they did not wear isolation gowns for the quarantined resident as it made the residents nervous and fearful that they were ill with COVID-19.

R5's annual MDS dated 11/3/20, identified R5 was 79 years of age and had intact cognition. R5 required limited assistance with dressing, toileting and grooming. The MDS included a diagnosis of

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weakness.

R5's progress note(s) from 11/1/20 through 11/20/20, identified the following:

-11/19/20, R5 was put into quarantine due to contact exposure from a COVID-19 positive resident with whom she shared a bathroom. Options were discussed with R5 regarding room changes. R5 was offered to remain in her room or to move to a room on the east non-COVID-19 wing. R5 opted to move to the east, non-quarantine wing as she was worried about contracting the virus.

On 11/20/20, at 8:05 a.m. R5 was observed seated in a chair, in her new room on the east wing. R5's door had a purple flower sign hanging on it. There was no PPE station setup near R5's room or door but a red bag garbage can was located just inside the door to her room, which was open. R5 stated she had just moved to the east wing room the previous night.

On 11/20/20, at 8:10 a.m. LPN-B stated R5 had been moved to the room from the west COVID-19 wing. LPN-B stated she thought the purple flower signs were from an activity project the residents had done.

On 11/20/20, at 8:15 a.m. NA-I stated the signs posted on resident doors looked like purple flowers but she did not know why they were hanging on some of the resident doors.

During interview on 11/20/20, at 8:35 a.m. LPN-B stated she had seen a red bag garbage in R5's room but there was not a transmission based precaution sign on R5's door. LPN-B stated she

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asked another nurse if R5 needed use of PPE for care. A resident on quarantine usually had yellow PPE drapes hanging on their doors to indicate they were quarantined. Some of the residents on the east wing were residents who had an exposure to COVID-19 positive residents but had tested negative. Further, LPN-B did not know which of the residents on the east wing had exposure but stated she thought it was the residents who had PPE drapes hanging on their doors. After checking with another nurse, it was clarified the purple flower sign on resident doors was to identify the residents under quarantine. LPN-B was unsure if all the staff knew what the purple flower signs meant. Following the interview, LPN-B went down the hall to instruct the two NAs working on the unit on the purple flower signs.

During interview on 11/20/20, at 8:40 a.m. LPN-C stated the purple flower signs on some of the resident doors on both the east and the west COVID-19 wings were to indicate the resident was under quarantine and the yellow signs on some of the resident doors on the west COVID-19 wing indicated the resident was positive for COVID-19 and under isolation. The facility was not using the standard CDC precaution signs because they were trying to protect the resident's dignity and had chosen to use the purple and yellow signs instead.

On 11/20/20, at 8:47 a.m. the DON stated R5 had been moved to the east wing where there were no COVID-19 positive residents because the room she occupied on the west COVID-19 wing had a shared bathroom. The resident who shared the bathroom with R5 had tested positive for COVID-19 and could not use a commode so they

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moved R5 to a new room on the east wing and did not move R5 to another open room on the west COVID-19 wing even though R5 had potential exposure.

R4's quarterly MDS dated 10/16/20, indicated R4 was 95 years of age and had moderate cognitive impairment. R4 required extensive assistance with all ADL's. R4's diagnoses included heart failure, and chronic bronchitis.

R4's progress note dated 11/16/20, indicated R4's rapid COVID antigen test was negative.

During observation on 11/20/20, at 9:22 a.m. R4 was seated in a chair in her room. R4 demonstrated an active, loose sounding, productive cough. NA-J entered R4's room wearing goggles and a N95 face mask to assist her to the bathroom. NA-J did not don gloves or an isolation gown when entering R4's room. NA-J indicated R4 was very hard of hearing and put her hands on either side of R4's chair and leaned toward R4 to put her mouth close to R4's ear in order for R4 to hear her. R4 was not wearing a source control mask and continued to cough during this encounter. LPN-C entered room wearing a N95 mask and goggles, but did not don gloves or an isolation gown. NA-J and LPN-C assisted R4 into a stand lift and wheeled the lift into the bathroom. R4 continued to cough frequently during the transfer. NA-J stated R4 had a quick COVID-19 antigen test done the previous day that was negative. LPN-C lowered the lift to seat R4 onto the toilet. LPN-C left the bathroom to pull back the linens on the bed in preparation for R4 to lie down. LPN-C's scrub uniform pants came into direct contact with R4's bedding. LPN-C returned to the bathroom and

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using the stand lift, assisted R4 to stand. NA-J put on gloves and assisted R4 with perineal care and pulled up R4's brief and pants , NA-J's uniform brushed against R4 as she was assisting her with cares. R4 was assisted to her bed during which time NA-J and LPN-C's uniforms brushed against R4 and R4's bedding.

R4's progress note dated 11/16/20, indicated R4's rapid COVID antigen test was negative. R4 exhibited COVID-19 symptoms of a loose productive cough, however, R4 was not placed under quarantine until a second, confirmatory RT-PCR test was done.

R3's quarterly MDS dated 10/7/20, identified R3 was 102 years of age and had moderate cognitive impairment. R3 required extensive assistance with all ADL's. R3 diagnoses included Alzheimer's disease and chronic kidney disease.

R3's mandatory Resident Temperature/Heart Rate and Oxygen Saturation (O2) Tracking Log dated 11/1/20 through 11/19/20, identified R3's temperature, pulse and O2 were monitored two times per day 11/1/20 through 11/19/20. R3's temperature ranged 97 degrees (F) to 98.8 degrees (F) on a.m. and p.m. shifts from 11/1/20 through 11/28/20. On 11/19/20, R3's a.m. temperature was recorded at 100.3 degrees (F).

R3's progress note dated 11/20/20, indicated rapid COVID-19 antigen test done due to R3 exhibiting symptoms of runny nose, headache and fever. Test results of the antigen test were negative.

During observation on 11/20/20, at 9:44 a.m. NA-J and NA-K entered R3's room to assist her

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to the bathroom. There was a purple flower sign on R3's door, however no PPE station or PPE drape was located in the room. Both staff members were wearing N95 masks, goggles and faceshield's; however they did not put on isolation gowns or gloves prior to entering R3's room. Using the stand lift, NA-J and NA-K assisted R3 to a standing position and quickly wheeled the lift to the toilet. NA-J lowered R3's pants and NA-K lowered R3 onto the toilet. After toileting, NA-J assisted R3 to a standing position and NA-K donned gloves and assisted R3 with perineal care. R3 was then wheeled to her bed and lowered on to the bed. NA-K removed her gloves and assisted to lift R3's legs into the bed at which time NA-K's uniform came into contact with R3 and her bedding. NA-J covered R3 with her blankets and her uniform was observed to come into contact with R3's blankets. Both NA's entered R3's bathroom to wash their hands at the resident's sink. The front of their uniforms touched the sink while washing their hands.

During interview with NA-J and NA-K, on 11/20/20, at 10:00 a.m. NA-J stated her uniform had the potential to brush against residents and their belongings when not wearing an isolation gown and stated she was sure they did. NA-J stated that was why the staff wore isolation gowns for the COVID-19 positive residents. NA-K indicated R3 was under quarantine but did not have the virus.

R3's Covid-19 test results identified R3 had COVID-19 RT-PCR test on: 10/8/20, 10/12/20, 10/15/20, 10/19/20, 10/22/20, 10/26/20, 10/29/20, 11/2/20 and 11/17/20, all the tests negative. R3 was not tested for Covid-19 on 11/5/20, 11/9/20 and 11/20/20, however, R3 was not placed under

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quarantine until 11/19/20 due to a potential exposure to another COVID-19 positive resident. R3's RT-PCR Covid-19 test on 11/21/20, identified she tested positive for COVID-19.

R2's annual MDS dated 8/26/20, indicated R2 was 85 years of age and had moderate cognitive impairment. R2 required extensive assistance with all ADL's. The MDS identified diagnoses that included Alzheimer's disease, cerebral vascular disease and chronic kidney disease.

R2's mandatory Resident Temperature/Heart Rate and Oxygen Saturation (O2) Tracking Log dated 11/1/20 through 11/19/20, identified R2's temperature, pulse and O2 were monitored two times per day 11/1/20 through 11/19/20. R1's temperature ranged 97 degrees (F) to 98.8 degrees (F) on a.m. and p.m. checks 11/1/20 through 11/28/20. On 11/19/20 a.m. R2's temperature was recorded at 100.5 degrees (F).

R2's progress note(s) from 11/1/20 through 11/20/20, identified the following:

- 11/12/20, R2 received Tylenol (a pain reliever and fever reducer) daily, three times per day for pain.

- 11/19/20, R2 had a slightly elevated temperature in the morning, however was normal by the afternoon.

During observation on 11/20/20, at 9:57 a.m. R2 was lying in her bed, with the door open. There was a purple flower sign hanging on the front of R2's door. No PPE cart or drape was observed in the room and there were no PPE trash and/or laundry baskets in the room. NA-K entered R2's

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room. NA-K was wearing a N95 mask and a face shield. NA-K did not don an isolation gown or gloves. NA-K removed her cloth gait belt from around her waist and placed it around R2's waist. NA-K placed an arm around R2's shoulders and behind her knees to assist her to sit on the edge of the bed. Positioning R2's arms around her neck, NA-K braced her knees against R2's knees and hugged R2 around her waist to assist to stand and pivot transfer to her wheelchair. NA-K wheeled R2 into the bathroom and repeated the same hugging transfer onto the toilet. Toileting care was not observed as R2 requested the bathroom door stay shut. After assisting with toileting, NA-K wheeled R2 back to her bed and using the cloth gait, repeated the same hugging transfer back into bed. NA-K removed the cloth gait belt from around R2's waist and put the gait belt around her own waist. NA-K then placed an arm behind R2's shoulders and behind R2's knees and assisted R2 into a lying position on the bed, covered R2 with a blanket, completed hand hygiene and exited the room.

R2's COVID-19 testing results identified R2 was tested on 11/19/20, with a rapid antigen test with a negative result, following an onset of a fever. R2 was tested on 11/21/20, with a RT-PCR test with a positive COVID-19 test result.

During interview on 11/20/20, at 10:51 a.m. the DON and the facility infection preventionist (IP) were interviewed. The DON stated when they identified the COVID-19 positive residents they moved those residents to the very end of the west wing to create a west COVID-19 wing, with the exception of R11, who remained in the middle of the hall because of her mental and physical needs. The positive COVID-19 residents were

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placed in isolation with dedicated equipment and staff were to use full PPE, including gowns with resident cares. They attempted to identify residents that had high risk exposures with COVID-19 positive residents. They identified R1, R2 and R5 as residents with high risk exposures and placed them under quarantine. R5 was moved from the west COVID-19 wing to the east non- COVID-19 positive wing on 11/19/20, because R5 had been sharing a bathroom with a COVID-19 positive resident, R11, who needed the use of the bathroom. R7 was also placed into quarantine because her roommate, R6, had just tested positive. R6 was moved to the end of the hall with the other COVID-19 positive residents.

Quarantined, non-COVID-19, residents were identified by a purple flower sign on their door so staff would understand the difference between quarantined residents and COVID-19 positive isolated residents. Full PPE was required when caring for the residents in the quarantined rooms, including gowns. Staff were not be able to go between the purple flowered rooms (quarantined) with other purple flowered rooms. Staff would need to disrobe upon exiting the purple flowered room and put on new gowns before entering another purple flowered room. COVID-19 positive residents were in isolation rooms and the staff were able to go between rooms of COVID-19 positive residents utilizing the same PPE, even though the west wing had a mixture of COVID-19 positive and negative residents. The facility had decided to use the colored flowered signs for resident dignity reasons and to keep the residents from worrying about it and what it meant. Some of the staff were not aware of the meaning of the colored flower signs as the facility had just started implementing the flowered sign

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system and had not yet educated all the staff on it. Education was planned to be done during report for the remaining staff. There were residents on the east non COVID wing that they had identified may have come into contact with COVID-19 positive residents, however, those residents had not been moved to the west COVID-19 wing. Those residents remained on the east non-COVID positive wing and had purple flowers (quarantine) on their doors and full PPE was required for their care.

The facility policy Kittson Healthcare Novel Virus Event (COVID-19) revised 11/20, indicated residents would be actively screened and symptomatic residents would be isolated as soon as possible. Signage on residents doors would identify transmission based precautions would be required prior to entering the room. Staff would be required to gown, glove, wear a face mask and eye protection to enter. Cohorting of residents would be done in the nursing home if there were two or more positive COVID-19 cases. Residents who were symptomatic of COVID-19 or refused to be tested would be isolated to their rooms, staff would monitor ill residents three times per day with dedicated medical equipment.

The CDC Strategies for Optimizing the Supply of Isolation Gowns updated 10/9/20, identified the facility could prioritize gown use for those under observation. Gowns should be prioritized for the following activities: "During care activities where splashes and sprays are anticipated, which typically includes aerosol generating procedures; During the following high-contact patient care activities that provide opportunities for transfer of pathogens to other patients and staff via the soiled clothing of healthcare providers, such as:

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Dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, wound care."

QUARANTINING OF SYMPTOMATIC STAFF:

The CDC Interim Guidance for Rapid Antigen Testing for SARS-CoV-2 dated 9/4/20, identified the sensitivity of current FDA-authorized antigen tests varies, and thus negative diagnostic testing results should be handled differently depending on the testing device and its stated performance characteristics. In most cases, negative antigen diagnostic test results are considered presumptive. CDC recommends confirming negative antigen test results with an RT-PCR test when the pretest probability is relatively high, especially if the patient is symptomatic or has a known exposure to a person confirmed to have COVID-19. Ideally, confirmatory RT-PCR testing should take place within two days of the initial antigen testing.

The facility's staff symptom tracking log for October 2020, and November 2020, identified fifteen staff had complaints of COVID-19 signs and symptoms. The staff were given a quick antigen test the day of their complaints and twelve were determined to be negative for COVID-19. The twelve staff, while symptomatic, were allowed to work despite displaying potential signs and symptoms of COVID-19, without being quarantined to home pending a PCR COVID-19 confirmation test of the negative results.

-LPN-A complained of a runny nose. and a rapid antigen test was done on 10/5/20, The antigen

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test was negative. LPN-A worked a shift on 10/5/20, and 10/7/20. On 10/8/20, a PCR COVID-19 test was administered during the facility's routine testing.

-NA-K had a rapid antigen test done on 11/5/20, for complaints of symptoms which were not identified on the staff symptom tracking log. NA-K worked 11/10/20, 11/11/20 and 11/12/20. On 11/12/20, a PCR COVID-19 test was administered during the facility's routine testing.

-NA-L complained of symptoms of a runny nose and a rapid antigen test was done on 11/5/20. NA-L worked 11/5/20, 11/6/20, 11/9/20, 11/10/20 and 11/12/20. On 11/12/20, a PCR COVID-19 test was administered during the facility's routine testing.

-RN-B had a rapid antigen test on 11/5/20, for complaint which were not identified on the staff symptom tracking log. RN-B worked 11/5/20, 11/6/20 and 11/9/20. On 11/9/20, a PCR COVID-19 test was administered during the facility's routine testing.

-NA-M complained of symptoms of a runny nose and a rapid antigen test was done on 11/5/20. NA-M worked 11/5/20, 11/7/20, 11/8/20, 11/9/20, 11/10/20, and 11/11/20. On 11/12/20, a PCR COVID-19 test was administered during the facility's routine testing.

-NA-N complained of symptoms that were not identified on the staff symptom tracking log and a rapid antigen test was done on 11/8/20. NA-N worked on 11/8/20 and 11/9/20. On 11/9/20, a PCR COVID-19 test was administered during the facility's routine testing.

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-NA-O complained of symptoms of diarrhea and a rapid antigen test was done on 11/8/20. NA-O worked on 11/8/20. On 11/9/20, a PCR COVID-19 test was administered.

-LPN-D complained of symptoms of diarrhea and a rapid antigen test was done on 11/8/20. LPN-D worked on 11/8/20, 11/10/20, 11/11/20 and 11/12/20. On 11/12/20, a PCR COVID-19 test was administered during the facility's routine testing.

-LPN-E complained of symptoms of illness. LPN-E's rapid antigen test on 11/13/20, was negative. LPN-E worked on 11/13/20 and 11/16/20. On 11/16/20, a PCR COVID-19 test was administered during the facility's routine testing.

-NA-P complained of symptoms of runny nose and congestion and a rapid antigen test was done on 11/13/20, was negative. NA-P worked on 11/13/20 and 11/16/20. On 11/16/20, a PCR COVID-19 test was administered during the facility's routine testing.

-LPN-F complained of symptoms of runny nose and a rapid antigen test was done on 11/15/20. LPN-F worked on 11/15/20. On 11/16/20, a PCR COVID-19 test was administered during the facility's routine testing.

-NA-J complained of symptoms of sore throat and nasal congestion and a rapid antigen test was done on 11/16/20. NA-J worked on 11/16/20. On 11/19/20, NA-J's PCR COVID-19 test was administered during the facility's routine testing.

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On 11/19/20, at 3:19 p.m. NA-F and NA-G were observed working (with residents) on the east non-COVID-19 wing. NA-F stated she had nasal congestion and chest congestion. A rapid antigen test had been done at the start of her shift and was negative so she was cleared to work. NA-F denied having a fever.

During interview on 11/20/20, at 11:00 a.m. the DON stated if residents exhibited symptoms of illness, a rapid antigen test was done. The facility did not put residents under quarantine unless the test was positive or if they knew the resident had direct exposure to COVID-19. If an employee was ill they would be required to get a rapid antigen test done and be fever free before they could return to work. If the rapid antigen test was negative, the employee would be allowed to work if they felt up to it. The facility did a rapid antigen test on both resident and employees if exhibiting symptoms of illness and a COVID-19 RT- PCR test was done two times per week for the facility testing protocols. The facility did not obtain a second confirmatory PCR test following a rapid antigen test for symptomatic residents or employees. Residents were not quarantined when they exhibited symptoms as long as a rapid antigen test was done with negative results. Symptomatic employees were able to work their scheduled shifts as long as a rapid antigen test was done with negative results and there was no fever. A more accurate COVID-19 RT- PCR test was done two times per week on both staff and residents and she felt that was sufficient.

The IJ that began on 10/29/20, was removed on 11/24/20, at 1:05 p.m. when the facility implemented actions to reduce/prevent the spread of COVID-19 within the facility.

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F 880	Continued From page 26 Observations, interviews and record review identified the facility had updated their policies and procedures regarding, PPE, quarantining of staff and residents and cohorting. Residents were cohorted to wings with like residents, CDC approved signs were placed on all residents doors who were isolated and/ or quarantined. Staff and residents were given RT-PCR COVID-19 tests to identify residents and staff who were positive for COVID-19 and were isolated and or removed from the schedule as indicated by COVID positive RT-PCR test results. All staff received education to the updated polices and procedures. Further, the facility contacted their health care coalition for assistance with PPE supplies.	F 880		
F 886 SS=F	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or	F 886		1/15/21

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suspected exposure to COVID-19;
(iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county;
(v) The response time for test results; and
(vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19.

§483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests;

§483.80 (h)((3) For each instance of testing:
(i) Document that testing was completed and the results of each staff test; and
(ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test.

§483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19.

§483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested.

§483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing

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F 886	Continued From page 28 efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to test health care personal (HCP) for COVID-19 according to Centers for Disease Control (CDC) direction for 3 of 3 nursing assistants (NA-A, NA-B, NA-C) who were reviewed in the sample. In addition, the facility failed to ensure a second, confirmatory, RT-PCR (real-time reverse transcription polymerase chain reaction (rRT-PCR) test for the qualitative detection of nucleic acid from SARS-CoV-2 in upper and lower respiratory specimens) test was performed within two days, when employees complained of COVID-19 symptoms as recommended by the CDC, for 8 of 13 nursing staff (LPN-A, NA-K, NA-L, RN-B, NA-M, LPN-D,NA-P, NA-J) tested with a rapid antigen test (screening test) after complaints of COVID-19 symptoms. This had the potential to affect all 50 residents who resided in the facility during a COVID-19 focused infection control survey. Findings include: On 11/19/20, at 12:45 p.m. upon entrance to the facility, the administrator stated the facility had a current census of 50 residents. They currently had five residents and four employees who had tested positive for COVID-19. The administrator stated the county positivity rate was 4.3% and the facility was testing staff and residents two times per week. The administrator identified the facility's first COVID-19 positive case occured on 10/19/20, when two employees tested positive for COVID-19. On 10/29/20, two residents tested	F 886	It is the policy of Kittson Healthcare to follow the CDC Guidance of Testing Healthcare Personnel as well as CMS QSO 20-38, and the recommended guidance from CDC for rapid Antigen Testing for SARS-CoV-2 being confirmed with an RT-PCR test if the antigen test is negative. All residents and staff that have been tested via a rapid antigen test due to symptoms of SARS-CoV-2 have been confirmed with a RT-PCR. All HCP reporting symptoms are tested with an antigen test. If an antigen test is negative a confirmatory PCR test is completed.Staff that have reported COVID-19 symptoms will not be allowed to work until they have been tested with a confirmatory RT-PCR as negative. During outbreak testing compliance will be audited twice a week. If staff miss scheduled testing, they will need to be swabbed and COVID-19 test performed through the facility lab Abbott ID NOW NAAT testing analyzer 48 hours prior to their next schedule shift, or be taken off the schedule until this test can be performed. Testing will be based on the county's positivity rating or new cases in the last 14 days. All staff that have missed a testing day will be asked to come in to test with a PCR, or will not be placed on the schedule if out of compliance. Auditing will be completed by the Administrator or her designee. Auditing of the staff testing compliance will be done by the	

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F 886	Continued From page 29 positive for COVID-19. STAFF MANDATORY TESTING: The CDC's Interim Guidance on Testing Healthcare Personnel for SARS-CoV-2 [COVID-19] Testing Healthcare Personnel dated 7/17/20, identified: "In nursing homes, expanded viral testing of all HCP is recommended in response to an outbreak in the facility...An outbreak is defined as a new SARS-CoV-2 infection in any HCP [health care personal] or any nursing home-onset SARSCoV-2 infection in a resident. Expanded viral testing includes initial testing of all HCP followed by repeat testing of all previously negative HCP, generally between every 3 days to 7 days, until the testing identifies no new cases of SARS-CoV-2 infection among residents or HCP for a period of at least 14 days since the most recent positive result. Expanded viral testing of HCP could also be considered in other healthcare settings in some situations (e.g., when multiple instances of SARS-CoV-2 transmission are identified among patients or HCP)." The facility's undated, staff line testing form indicated mandatory testing began on 10/5/20, and the facility was testing two times weekly, on Mondays and Thursdays, 10/5/20, through 11/19/20, The staff line testing form and corresponding working schedules for October 2020, and November 2020, identified the following: NA-A was tested on the following facility mandatory RT-PCR test dates:10/5/20, 10/12/20, 11/9/20, 11/16/20 and 11/19/20. NA-A failed to	F 886	administrator or a designee based on the testing requirements of outbreak testing (once every 3-7 days) or as determined by the county positivity rating (once a month if positivity is less than 5%; once every 3-7 days if the positivity is between 5-10%; twice a week mandatory testing if the positivity is 10% or over.)	

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(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 886	Continued From page 30	F 886		

get tested on the following facility mandatory RT-PCR test dates; 10/8/20, 10/15/20, 10/19/20, 10/22/20, 10/26/20, 10/29/20, 11/2/20, 11/5/20 and 11/12/20.
NA-A continued to work his shifts as scheduled in October and November, despite missing 9 of 14 facility's scheduled mandatory RT-PCR testing.

NA-B was tested on the following facility mandatory RT-PCR test dates: 10/5/20, 10/8/20, 10/15/20, 10/19/20, 10/22/20, 11/2/20, 11/9/20, 11/12/20, 11/16/20 and 11/19/20 NA-B failed to get tested on the following facility mandatory RT-PCR test dates; 10/12/20, 10/26/20, 10/29/20,11/5/20.
NA-B continued to work her shifts as scheduled in October and November, despite missing 4 of 14 facility's scheduled mandatory RT-PCR testing.

NA-C was tested on the following facility mandatory RT-PCR test dates:10/5/20, 10/8/20, 10/12/20, 10/15/20, 10/26/20, 11/2/20, 11/5/20, 11/9/20, 11/16/20 and 11/19/20.
NA-C failed to get tested on the following facility mandatory RT-PCR test dates:10/19/20, 10/22/20, 10/29/20 and 11/12/20. NA-C continued to work her shifts as scheduled in October and November 2020, despite missing 4 of the facility's 14 scheduled mandatory RT-PCR testing.

FOLLOW UP TESTING WITH SYMPTOMS:

The CDC Interim Guidance for Rapid Antigen Testing for SARS-CoV-2 dated 9/4/20, identified the sensitivity of current FDA-authorized antigen tests varies, and thus negative diagnostic testing results should be handled differently depending on the testing device and its stated performance characteristics. In most cases, negative antigen

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	245247	A. BUILDING _____ B. WING _____	11/24/2020

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KITTSON MEMORIAL HEALTHCARE CENTER	1010 SOUTH BIRCH HALLOCK, MN 56728

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F 886	Continued From page 31	F 886		

diagnostic test results are considered presumptive. CDC recommends confirming negative antigen test results with an RT-PCR test when the pretest probability is relatively high, especially if the patient is symptomatic or has a known exposure to a person confirmed to have COVID-19. Ideally, confirmatory RT-PCR testing should take place within two days of the initial antigen testing.

The CDC Symptoms of Coronavirus, updated 5/13/20, identified people with COVID-19 had a wide range of symptoms reported - ranging from mild symptoms to severe illness. Symptoms may appear 2-14 days after exposure to the virus. People with these symptoms may have COVID-19: fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting and diarrhea. This list does not include all possible symptoms. CDC will continue to update this list as we learn more about COVID-19.

The facility's Staff Symptom Tracking Log for October and November 2020, along with the undated, staff line testing form indicated eight staff had complaints of COVID-19 signs and symptoms and were given a quick antigen test the day they presented with symptoms and did not receive a follow up RT-PCR test in the required time frame. The cooresponding schedules identified the staff continued to work despite symptoms. The logs and schedules identified the following:

-Licensed practical nurse (LPN)-A complained of symptoms of runny nose and a rapid antigen test

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F 886	Continued From page 32	F 886		

was done on 10/5/20. LPN-A worked a shift on 10/5/20, and 10/7/20. LPN-A's confirmatory RT-PCR test was done on 10/8/20, three days after her rapid antigen test was completed and not within two days as recommended by the CDC.

-NA-K had a rapid antigen test done on 11/5/20, however, her symptoms were not identified on the staff infection log. NA-K worked 11/10/20, 11/11/20 and 11/12/20. NA-K did not receive a confirmatory RT-PCR test until 11/12/20, seven days after her initial rapid antigen test was completed.

-NA-L complained of symptoms of runny nose and a rapid antigen test was done on 11/5/20. NA-L worked 11/5/20, 11/6/20, 11/9/20, 11/10/20 and 11/12/20. NA-L did not receive a confirmatory RT-PCR test until 11/12/20, seven days after her initial rapid antigen test was completed.

-Registered nurse (RN)-B received a rapid antigen test on 11/5/20, however, her symptoms were not identified on the staff infection log. RN-B worked 11/5/20, 11/6/20 and 11/9/20 RN- B did not receive a confirmatory RT-PCR test until four days after her initial rapid antigen test was completed.

-NA-M complained of symptoms of runny nose and a rapid antigen test was done on 11/5/20. NA-M worked 11/5/20, 11/7/20, 11/8/20, 11/9/20, 11/10/20, and 11/11/20. NA-M did not receive a confirmatory RT-PCR test until 11/12/20, seven days after his initial rapid antigen test was completed.

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-LPN-D complained of symptoms of diarrhea and a rapid antigen test was done on 11/8/20. LPN-D worked on 11/8/20, 11/10/20, 11/11/20 and 11/12/20. LPN-D did not receive a confirmatory RT-PCR test until 11/12/20, four days after her initial rapid antigen test was completed.

-NA-P complained of symptoms of runny nose and congestion and a rapid antigen test was done on 11/13/20. NA-P worked on 11/13/20 and 11/16/20. NA-P did not receive a confirmatory RT-PCR test until 11/16/20, three days after her initial rapid antigen test was completed.

-NA-J complained of symptoms of sore throat and stuffy nose and a rapid antigen test was done on 11/16/20. NA-J worked on 11/16/20. NA-J did not receive a confirmatory RT-PCR test until 11/19/20, three days after her initial rapid antigen test was completed.

During interview on 11/24/20, at 10:20 a.m. the administrator stated she did most of the staff COVID-19 testing. She noticed NA-A was missing many of the required testing and so on 11/1/20, she had started to come in on Sundays to test the weekend staff that had difficulty coming in during the week for testing. The administrator identified it was the facility's expectation for all staff to be tested every three to seven days or not be allowed to work.

During interview on 11/24/20, at 11:10 a.m. the director of nursing (DON) stated if staff were to call in sick, they were told to get an antigen test and if they had no fever in the last 24 hours they would be able to come to work. If the staff did not have a fever and were complaining of other symptoms such as nasal congestion or a cough,

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F 886	Continued From page 34 she would have them do a quick antigen test and if negative, the facility would leave it up to them if they felt well enough to work. The DON confirmed the facility was not following the quick antigen test with a confirmatory PCR test when staff developed symptoms of illness. The DON stated they were all being tested with the PCR test twice weekly and indicated she felt that was adequate, despite being in a facility outbreak. The facility policy Kittson Healthcare Novel Virus Event (COVID-19) revised 11/20, indicated staff would be monitored for signs and symptoms of respiratory illness prior to coming into work. Staff with fever are requested to remain at home. Staff with symptoms consistent with COVID-19 other than fever were instructed to notify their manager immediately to arrange for testing. Further, no employees would be allowed to work while ill. If staff refused or missed testing, the facility would encourage them to test at the next opportunity. During an outbreak, all staff who refused testing would not be allowed into the facility until outbreak testing was completed.	F 886		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 25, 2021

Administrator
Kittson Memorial Healthcare Center
1010 South Birch
Hallock, MN 56728

RE: CCN: 245247
Cycle Start Date: November 24, 2020

Dear Administrator:

On December 16, 2020, we notified you a remedy was 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 19, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective December 31, 2020 be discontinued as of January 19, 2021. (42 CFR 488.417 (b))

However, as we notified you in our letter of December 16, 2020, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from December 31, 2020. This does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

Electronically Submitted
December 16, 2020

Administrator
Kittson Memorial Healthcare Center
1010 South Birch
Hallock, MN 56728

RE: CCN: 245247
Cycle Start Date: November 24, 2020

Dear Administrator:

On November 24, 2020, survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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 a pattern of deficiencies that constituted immediate jeopardy (Level K), whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On November 24, 2020, the situation of immediate jeopardy to potential health and safety cited at F880 was removed. However, continued non-compliance remains at the lower scope and severity of E.

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 December 31, 2020.

- 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 December 31, 2020 (42 CFR 488.417 (b)), (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 31, 2020, (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 December 31, 2020. 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.

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:

Jen Bahr, RN, Unit Supervisor
Bemidji District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, MN 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104 Mobile: (218) 368-3683

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 May 24, 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,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 000	Initial Comments A COVID-19 Focused Infection Control survey was conducted on 11/19/20, through 11/24/20, at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.73(b)(6). The facility was in full compliance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control survey and abbreviated survey was conducted on 11/19/20, through 11/24/20, at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was determined NOT to be in compliance. The survey resulted in an Immediate Jeopardy (IJ) to resident health and safety at F880. The IJ began on 10/29/20, when the facility identified the first COVID-19 positive resident and failed to ensure residents who were potentially exposed to COVID-19 positive residents were immediately quarantined and staff were aware of when to utilize gowns for quarantined residents. Residents presenting with COVID-19 symptoms were not quarantined and provided a follow up RT-PCR test to ensure the rapid antigen test results were accurate. In addition, the facility did not utilize their empty rooms to cohort residents with potential COVID-19 exposures to one wing to reduce the chances for residents without exposure from contracting COVID-19. Staff	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/24/2020

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F 000	Continued From page 1 presenting with symptoms of COVID-19 were provided a rapid antigen test and allowed to work without being provided a RT-PCR test to confirm the negative COVID-19 test. The administrator, director of nursing (DON) and the infection preventionist (IP) were notified of the IJ on 11/20/20, at 5:10 p.m. The IJ was removed on 11/24/20, at 1:05 p.m. when the facility implemented actions to reduce/ prevent the spread of COVID-19 within the facility. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, a revisit of your facility will be conducted to validate substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 880 SS=K	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:	F 880		1/15/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 2 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, 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	F 880		

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F 880	Continued From page 3 identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the Centers for Disease Control (CDC) guidance to prevent/or minimize the transmission of COVID-19 was fully implemented. The facility failed to establish a system to identify which residents were on quarantine to ensure appropriate gown use was used for 3 of 20 residents (R1, R2, R3) identified to be on quarantine precautions; immediately quarantine residents who had symptoms of COVID-19 for 6 of 6 residents (R1, R2, R3, R4, R5, R7) who were displaying signs and symptoms of COVID-19; utilize available rooms to cohort like residents for 1 of 1 residents (R5) who was transferred to a non COVID-19 wing following exposure to COVID-19 residents. In addition, the facility allowed 12 of 15 nursing staff (LPN-A, NA-K, NA-L, RN-B, NA-M, NA-O, LPN-D, LPN-E, NA-P, LPN-F, NA-J, NA-F) who displayed COVID-19 symptoms to work without confirming negative antigen tests with a RT-PCR test. These deficient practices resulted in an immediate jeopardy (IJ) situation which placed 43 out of 50 residents at risk for contracting COVID-19, which had the potential to cause serious illness or death.	F 880	It is the policy of Kittson Healthcare to follow the CDC guidance on Coronavirus Disease 2019 for long term care. On November 22nd, 2020, all COVID positive residents were co-horted at the end of the West wing with a barrier dividing COVID isolated residents from quarantined residents. All remaining residents were put in quarantine with the exception of former positives that have completed their isolation period Residents both in quarantine and isolation are in appropriate transmission based precautions according to Kittson's Novel Virus Policy. Available rooms have been utilized to cohort residents. A majority of residents are in a private rooms. The quarantined residents that are co-horted together, were exposed within the same time frame or both COVID positive. HCP staff were educated on CDC guidance for use of PPE for quarantine and isolation residents. Dedicated equipment was used in all isolation rooms. Policy was reviewed and demonstration of donning and doffing was	

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F 880	Continued From page 4 The IJ began on 10/29/20, when the facility identified the first COVID-19 positive resident and failed to ensure residents who were potentially exposed to COVID-19 positive residents were immediately quarantined and staff were aware of when to utilize gowns for quarantined residents. Residents presenting with COVID-19 symptoms were not quarantined and provided a follow up RT-PCR test to ensure the rapid antigen test results were accurate. In addition, the facility did not utilize their empty rooms to cohort residents with potential COVID-19 exposures to one wing to reduce the chances for residents without exposure from contracting COVID-19. Staff presenting with symptoms of COVID-19 were provided a rapid antigen test and allowed to work without being provided a RT-PCR test to confirm the negative COVID-19 test. The administrator, director of nursing (DON) and the infection preventionist (IP) were notified of the IJ on 11/20/20, at 5:10 p.m. The IJ was removed on 11/24/20, at 1:05 p.m. when the facility implemented actions to reduce/ prevent the spread of COVID-19 within the facility. However, noncompliance remained at the lower scope and severity, pattern, which indicated no actual harm with potential for more than minimal harm that was not IJ (Level E). Findings include: The CDC guidance Coronavirus Disease 2019 (COVID-19) People at Increased Risk dated 9/11/20, identified the risk for severe illness from COVID-19 increased with age, with older adults at the highest risk. Severe illness means a person with COVID-19 may require hospitalization, intensive care, or a ventilator to help them	F 880	provided to staff. Staff are being audited for PPE use daily. Staff will be educated on any change in policy and procedure. Education will be done through email, during report and in the communication book. Just-in-time education will be provided as needed during auditing and observation. All symptomatic residents and staff who received a negative antigen test have been confirmed with a PCR test. Residents and their roommates will be put in TBP until results are confirmed. All staff confirmed positive were sent home and placed on isolation at home and not allowed to work until their isolation of 10 days was completed. Once their isolation was completed and the COVID-19 return-to-work assessment indicated they could return; they were put back on the schedule. All signage that were not CDC approved have now been replaced with CDC approved signs. All rooms now have a PPE supply and trash cans for waste. All negative antigen tests will be confirmed with PCR and staff will not be allowed to work until the PCR results are obtained. All residents and their roommates with negative PCR results will be put in TBP until a confirmatory PCR test is returned. How corrective action will be accomplished for those residents found to have affected by the deficient practice? On November 22nd all residents were put in quarantine or isolation. A Covid-19 wing was assembled on the far end of the	

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F 880	Continued From page 5 breathe, or they may even die. On 11/19/20, at 12:45 p.m. upon entrance to the facility, the administrator stated the facility had five residents and four employees who had tested positive for COVID-19. The administrator stated the county positivity rate was 4.3% and the facility was testing staff and residents two times per week. The administrator identified the facility's first COVID-19 positive case occurred on 10/19/20, when two employees tested positive for COVID-19. On 10/29/20, two residents tested positive for COVID-19. On 11/19/20, at 1:00 p.m. a brief facility tour was conducted with the DON. The west wing of the facility had been turned into a COVID-19 wing and housed COVID-19 positive residents, who were on isolation precautions along with residents with potential exposures to COVID-19 positive residents and were on quarantine. One non-COVID-19 positive resident resided on the west COVID-19 wing, however she stayed in her room and was not on any COVID-19 transmission based precautions. During the tour, room doors of isolated residents who were COVID-19 positive were not closed, as recommended by the CDC. Both the west COVID-19 wing and the east wing of the facility were located on the ground level of the facility and were opposite of each other, separated by a small lobby area and the nurses station. The second floor of the facility was identified as a dementia unit that housed 18 residents, all of whom were non-COVID-19 positive and had not had previous exposures to COVID-19 positive staff or residents. On 11/20/20 at 4:30 p.m. the administrator and DON were interviewed. The administrator stated	F 880	west corridor. A barrier was utilized to separate isolation residents from quarantined residents. Private rooms were utilized as available. Proper PPE was utilized and education given to staff as needed. How the facility will identify other residents having the potential to be affected by the same deficient practice? Ongoing testing of symptomatic residents will be done according to the testing policy; if antigen test is negative, it will be confirmed with a PCR-RT along with the resident and their roommate in TBP until the PCR-RT results are returned. If a resident's test confirms a positive test for COVID-19, the resident will be moved to the covid-19 unit and transmission based precautions will be applied, the roommate will be placed in TBP quarantine and monitored for ongoing symptoms. What measures will be put into place, or systemic changes made to ensure that the deficient practice will not recur? All staff have been educated on the testing policy as well as appropriate cohorting, transmission based precautions, isolation, quarantine, PPE, and hand hygiene. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur? Continued auditing of PPE and hand hygiene will be done weekly until a goal of 95% is met, then monthly. The results will be brought to the Risk Management Committee for review quarterly and corrective actions taken as needed. The DON or her designee is responsible for compliance. Testing	

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F 880	Continued From page 6 14 residents resided on the west COVID-19 wing. Five residents (R9, R10, R11, R18 and R19) were diagnosed with COVID-19 and the remaining nine residents were identified as residents who were exposed to the COVID-19 positive residents. The administrator stated eighteen residents resided on the east wing. Six residents on the east wing were under quarantine due to an exposure to the COVID-19 positive residents, however were not moved to the west COVID-19 wing. The DON stated the facility had seven open beds on the west COVID-19 wing and two open beds on the east wing. RESIDENT QUARANTINE/ GOWN USE /COHORTING: The CDC's Symptoms of Coronavirus, updated 5/13/20, people with COVID-19 have had a wide range of symptoms reported - ranging from mild symptoms to severe illness. Symptoms may appear 2-14 days after exposure to the virus. People with these symptoms may have COVID-19: fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting and diarrhea. This list does not include all possible symptoms. CDC will continue to update this list as we learn more about COVID-19. The CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic dated 11/4/2020, directed facility's to implement mechanisms and policies that promoted situational awareness for facility staff. The guidance indicated to the extent	F 880	compliance will audited twice a week based on the county's positively rate or no new cases for 14 days.	

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possible, patients with suspected or confirmed SARS-CoV-2 infection should be housed in the same room for the duration of their stay in the facility. HCP who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to standard precautions and use an approved N95 or equivalent or higher-level respirator (or facemask if a respirator is not available), gown, gloves, and eye protection. HCP must receive training on and demonstrate an understanding of: when to use PPE, what PPE is necessary, how to properly don, use, and doff PPE in a manner to prevent self-contamination, how to properly dispose of or disinfect and maintain PPE and the limitations of PPE.

R1's quarterly Minimum Data Set (MDS) dated 10/22/20, identified R1 was 94 years of age and had severe cognitive impairment. R1 was unable to ambulate and required extensive assistance with all activities of daily living (ADL's). R1's diagnoses included Alzheimer's disease, dementia, heart disease and diabetes.

R1's mandatory Resident Temperature/Heart Rate and Oxygen Saturation (O2) Tracking Log from 11/1/20 - 11/19/20, identified R1's temperature, pulse and O2 were monitored two times per day. R1's temperature ranged from 97 degrees Fahrenheit (F) to 98.8 degrees (F) on a.m. and p.m. checks 11/1/20 through 11/28/20. On 11/19/20, a.m. R1's temperature was recorded at 99.9 degrees (F).

R1's progress note(s) from 11/1/20 through 11/20/20, identified the following:

-11/7/20, R1 was in her wheelchair and was spending time in the hallways or common areas

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within the unit most of the day.

-11/19/20, R1 was placed in quarantine due to contact exposure to a COVID-19 positive resident.

During observation on 11/19/20, at 2:20 p.m. R1 was seated in her wheelchair in the doorway of her room on the COVID-19 unit. R1 was not wearing a face mask. Licensed practical nurse (LPN)-A was seated on the floor in front of R1 to change a dressing to her right leg. Nursing assistants (NA)-F and NA-G stood in the hallway directly behind LPN-A and were handing LPN-A dressing packages and gloves. All three staff members wore goggles, face masks and gloves, however, the three staff members were not wearing isolation gowns. LPN-A stated R1 was on the unit due to a possible exposure to a COVID-19 positive resident and had been running a fever that morning but stated a rapid antigen test was done that morning and was negative.

During interview on 11/19/20, at 2:31 p.m. LPN-A stated five residents had recently tested positive for COVID-19 and those residents had PPE stations hanging on their doors because gowns were required to be worn for their care. LPN-A stated three residents had displayed elevated temperatures, including R1, that morning but they had done rapid antigen tests on them and all three tests were negative. The other nine residents on the COVID-19 unit, including R1, were under quarantine because of a potential exposure to a COVID-19 positive resident. LPN-A stated the staff did not wear gowns when they provided care for these residents, because they were not positive for COVID-19.

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On 11/20/20, at 9:07 a.m. NA-K had on a N95 facemask, faceshield, goggles, and an isolation gown. NA-K removed her isolation gown inside R11's room, who was COVID-19 positive, and performed hand hygiene prior to exiting R11's room. NA-K entered R1's room and shut the door to assist R1 with care. NA-K did not put on an isolation gown prior to entering the room. R1's room had a purple flower sign hanging on the outside of her door, however did not have a PPE cart or drape near/on her door, nor CDC signage to direct staff to what type of PPE was needed for R1's care. NA-K began to gather supplies in R1's room and then stated, "Oh, wait a minute." NA-K stated she was unsure if staff were required to wear an isolation gown to provide care to R1 or not. NA-K stated there was no PPE setup in R1's room, but stated she was going to leave the room to obtain an isolation gown to put on, just to be safe. NA-K exited R1's room and went to another resident's PPE cart and obtained a clean isolation gown. NA-K put on the isolation gown and asked LPN-C if she was to wear a gown when providing care to R1. LPN-C stated she was supposed to wear a gown with R1 . NA-K again entered R1's room to provide care, wearing an isolation gown and finished providing care to R1.

During interview on 11/20/20, at 9:15 a.m. NA-K stated R1 was under quarantine but was not positive for COVID-19, therefore it was hard to tell if she needed to wear a gown when providing care to R1. NA-K indicated there was no PPE cart or station setup outside R1's room and there was nothing to identify R1 was under quarantine and what, if any PPE was supposed to be used. NA-K stated she was told who was on quarantine through shift report. NA-K stated she could

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usually tell if a gown was needed if the resident had a PPE drape on their door. NA-K stated there was not a PPE cart or drape on/in R1's room to identify she was on quarantine and a gown was supposed to be worn when providing direct resident care.

R7's quarterly MDS dated 9/3/20, identified R7 was 87 years of age and had minimal cognitive impairment. R7 required extensive assistance with all ADL's. R7's diagnoses included diabetes, heart disease and chronic kidney disease.

R7's progress note dated 11/16/20, indicated R7's COVID-19 test was negative.

During observation on 11/19/20, at 3:37 p.m. NA-H entered R7's room on the west COVID-19 wing, to assist with toileting. NA-H wore a N95 facemask, goggles and a faceshield. NA-H did not put on an isolation gown prior to entering R7's room. NA-H removed the cloth gait belt from around her neck and placed it around R7's waist. NA-H donned (put on) gloves and leaned over R7, while on the toilet to assist R7 with placing her hands on the toilet seat grab bar. NA-H's uniform came into direct contact with R7's shoulder and arm as she assisted her. NA-H physically assisted R7 to a standing position and provided perineal cares along with pulling up her undergarments and clothing. NA-H transferred R7 to her wheelchair. NA-H assisted R7 to use hand sanitizer. NA-H removed the cloth gait belt from around R7's waist and placed the cloth gait belt around her neck. NA-H performed hand hygiene and exited the room.

During observation on 11/19/20, at 4:05 p.m. the DON was hanging purple flower signs on several

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resident doors on the west COVID-19 wing. The DON was overheard, explaining to staff working on the COVID-19 wing, the purple flower signs were to identify residents that were under quarantine and the staff were to wear isolation gowns to care for those residents. Further, if the resident door had a yellow flowered sign, the resident was under isolation and full PPE was needed when caring for the resident. The DON did not hang a purple or yellow flower sign on R7's door, despite R7's potential exposure to COVID-19 positive residents.

During interview on 11/19/20, at 4:30 p.m. registered nurse (RN)-A stated there were five positive residents on the COVID-19 wing and the other residents on the wing were there due to a potential exposure to a positive resident. RN-A stated the purple flower signs indicated the resident had a possible exposure to a COVID-19 positive resident and needed to be quarantined. The yellow flower signs indicated a COVID-19 positive residents that were under isolation. RN-A stated the residents on the COVID-19 wing that did not have a purple or yellow flower sign on their door were not under any type of quarantine and only gloves, masks and eye protection was needed to care for those residents. RN-A indicated R7 had frequently come out of her room to leave the COVID-19 wing to play cards with other residents. RN-A indicated R7's activities would have exposed her to a COVID-19 positive residents because of this. RN-A stated R7's door did not have a purple or yellow flowered sign on her door. Further, R7's door should have a purple flowered sign on the door to indicate to staff she was under quarantine, and to don an isolation gown when providing cares. RN-A indicated the purple and yellow signs could be

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confusing for staff.

During interview on 11/20/20, at 8:50 a.m. LPN-C stated R7 was leaving the west wing to play cards until 11/16/20, and had potential exposure to COVID-19 positive residents during that time. All the residents residing on the COVID-19 wing were there because they all had a potential exposure to the COVID-19 positive residents. Staff were not putting on isolation gowns to care for some of the residents on the COVID-19 wing because they were not a potential risk and then stated, "but I guess they are a potential risk." LPN-C stated she did not know why some of the residents were not considered to have had a potential exposure and things were changing every day.

On 11/20/20, at 8:53 NA-J stated R7's roommate, R6 was moved to another room the previous night after she had tested positive for COVID-19. There was no purple flower sign or precaution sign to indicate to staff that R7 had a high risk exposure to her roommate, a positive COVID-19 resident, and would need to be quarantined to her room and staff would need to use gowns while providing direct resident care.

During interview on 11/19/20, at 3:45 p.m. NA-E stated staff only wore isolation gowns for the COVID-19 positive residents. NA-E stated they did not wear isolation gowns for the quarantined resident as it made the residents nervous and fearful that they were ill with COVID-19.

R5's annual MDS dated 11/3/20, identified R5 was 79 years of age and had intact cognition. R5 required limited assistance with dressing, toileting and grooming. The MDS included a diagnosis of

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weakness.

R5's progress note(s) from 11/1/20 through 11/20/20, identified the following:

-11/19/20, R5 was put into quarantine due to contact exposure from a COVID-19 positive resident with whom she shared a bathroom. Options were discussed with R5 regarding room changes. R5 was offered to remain in her room or to move to a room on the east non-COVID-19 wing. R5 opted to move to the east, non-quarantine wing as she was worried about contracting the virus.

On 11/20/20, at 8:05 a.m. R5 was observed seated in a chair, in her new room on the east wing. R5's door had a purple flower sign hanging on it. There was no PPE station setup near R5's room or door but a red bag garbage can was located just inside the door to her room, which was open. R5 stated she had just moved to the east wing room the previous night.

On 11/20/20, at 8:10 a.m. LPN-B stated R5 had been moved to the room from the west COVID-19 wing. LPN-B stated she thought the purple flower signs were from an activity project the residents had done.

On 11/20/20, at 8:15 a.m. NA-I stated the signs posted on resident doors looked like purple flowers but she did not know why they were hanging on some of the resident doors.

During interview on 11/20/20, at 8:35 a.m. LPN-B stated she had seen a red bag garbage in R5's room but there was not a transmission based precaution sign on R5's door. LPN-B stated she

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asked another nurse if R5 needed use of PPE for care. A resident on quarantine usually had yellow PPE drapes hanging on their doors to indicate they were quarantined. Some of the residents on the east wing were residents who had an exposure to COVID-19 positive residents but had tested negative. Further, LPN-B did not know which of the residents on the east wing had exposure but stated she thought it was the residents who had PPE drapes hanging on their doors. After checking with another nurse, it was clarified the purple flower sign on resident doors was to identify the residents under quarantine. LPN-B was unsure if all the staff knew what the purple flower signs meant. Following the interview, LPN-B went down the hall to instruct the two NAs working on the unit on the purple flower signs.

During interview on 11/20/20, at 8:40 a.m. LPN-C stated the purple flower signs on some of the resident doors on both the east and the west COVID-19 wings were to indicate the resident was under quarantine and the yellow signs on some of the resident doors on the west COVID-19 wing indicated the resident was positive for COVID-19 and under isolation. The facility was not using the standard CDC precaution signs because they were trying to protect the resident's dignity and had chosen to use the purple and yellow signs instead.

On 11/20/20, at 8:47 a.m. the DON stated R5 had been moved to the east wing where there were no COVID-19 positive residents because the room she occupied on the west COVID-19 wing had a shared bathroom. The resident who shared the bathroom with R5 had tested positive for COVID-19 and could not use a commode so they

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moved R5 to a new room on the east wing and did not move R5 to another open room on the west COVID-19 wing even though R5 had potential exposure.

R4's quarterly MDS dated 10/16/20, indicated R4 was 95 years of age and had moderate cognitive impairment. R4 required extensive assistance with all ADL's. R4's diagnoses included heart failure, and chronic bronchitis.

R4's progress note dated 11/16/20, indicated R4's rapid COVID antigen test was negative.

During observation on 11/20/20, at 9:22 a.m. R4 was seated in a chair in her room. R4 demonstrated an active, loose sounding, productive cough. NA-J entered R4's room wearing goggles and a N95 face mask to assist her to the bathroom. NA-J did not don gloves or an isolation gown when entering R4's room. NA-J indicated R4 was very hard of hearing and put her hands on either side of R4's chair and leaned toward R4 to put her mouth close to R4's ear in order for R4 to hear her. R4 was not wearing a source control mask and continued to cough during this encounter. LPN-C entered room wearing a N95 mask and goggles, but did not don gloves or an isolation gown. NA-J and LPN-C assisted R4 into a stand lift and wheeled the lift into the bathroom. R4 continued to cough frequently during the transfer. NA-J stated R4 had a quick COVID-19 antigen test done the previous day that was negative. LPN-C lowered the lift to seat R4 onto the toilet. LPN-C left the bathroom to pull back the linens on the bed in preparation for R4 to lie down. LPN-C's scrub uniform pants came into direct contact with R4's bedding. LPN-C returned to the bathroom and

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using the stand lift, assisted R4 to stand. NA-J put on gloves and assisted R4 with perineal care and pulled up R4's brief and pants , NA-J's uniform brushed against R4 as she was assisting her with cares. R4 was assisted to her bed during which time NA-J and LPN-C's uniforms brushed against R4 and R4's bedding.

R4's progress note dated 11/16/20, indicated R4's rapid COVID antigen test was negative. R4 exhibited COVID-19 symptoms of a loose productive cough, however, R4 was not placed under quarantine until a second, confirmatory RT-PCR test was done.

R3's quarterly MDS dated 10/7/20, identified R3 was 102 years of age and had moderate cognitive impairment. R3 required extensive assistance with all ADL's. R3 diagnoses included Alzheimer's disease and chronic kidney disease.

R3's mandatory Resident Temperature/Heart Rate and Oxygen Saturation (O2) Tracking Log dated 11/1/20 through 11/19/20, identified R3's temperature, pulse and O2 were monitored two times per day 11/1/20 through 11/19/20. R3's temperature ranged 97 degrees (F) to 98.8 degrees (F) on a.m. and p.m. shifts from 11/1/20 through 11/28/20. On 11/19/20, R3's a.m. temperature was recorded at 100.3 degrees (F).

R3's progress note dated 11/20/20, indicated rapid COVID-19 antigen test done due to R3 exhibiting symptoms of runny nose, headache and fever. Test results of the antigen test were negative.

During observation on 11/20/20, at 9:44 a.m. NA-J and NA-K entered R3's room to assist her

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to the bathroom. There was a purple flower sign on R3's door, however no PPE station or PPE drape was located in the room. Both staff members were wearing N95 masks, goggles and faceshield's; however they did not put on isolation gowns or gloves prior to entering R3's room. Using the stand lift, NA-J and NA-K assisted R3 to a standing position and quickly wheeled the lift to the toilet. NA-J lowered R3's pants and NA-K lowered R3 onto the toilet. After toileting, NA-J assisted R3 to a standing position and NA-K donned gloves and assisted R3 with perineal care. R3 was then wheeled to her bed and lowered on to the bed. NA-K removed her gloves and assisted to lift R3's legs into the bed at which time NA-K's uniform came into contact with R3 and her bedding. NA-J covered R3 with her blankets and her uniform was observed to come into contact with R3's blankets. Both NA's entered R3's bathroom to wash their hands at the resident's sink. The front of their uniforms touched the sink while washing their hands.

During interview with NA-J and NA-K, on 11/20/20, at 10:00 a.m. NA-J stated her uniform had the potential to brush against residents and their belongings when not wearing an isolation gown and stated she was sure they did. NA-J stated that was why the staff wore isolation gowns for the COVID-19 positive residents. NA-K indicated R3 was under quarantine but did not have the virus.

R3's Covid-19 test results identified R3 had COVID-19 RT-PCR test on: 10/8/20, 10/12/20, 10/15/20, 10/19/20, 10/22/20, 10/26/20, 10/29/20, 11/2/20 and 11/17/20, all the tests negative. R3 was not tested for Covid-19 on 11/5/20, 11/9/20 and 11/20/20, however, R3 was not placed under

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quarantine until 11/19/20 due to a potential exposure to another COVID-19 positive resident. R3's RT-PCR Covid-19 test on 11/21/20, identified she tested positive for COVID-19.

R2's annual MDS dated 8/26/20, indicated R2 was 85 years of age and had moderate cognitive impairment. R2 required extensive assistance with all ADL's. The MDS identified diagnoses that included Alzheimer's disease, cerebral vascular disease and chronic kidney disease.

R2's mandatory Resident Temperature/Heart Rate and Oxygen Saturation (O2) Tracking Log dated 11/1/20 through 11/19/20, identified R2's temperature, pulse and O2 were monitored two times per day 11/1/20 through 11/19/20. R1's temperature ranged 97 degrees (F) to 98.8 degrees (F) on a.m. and p.m. checks 11/1/20 through 11/28/20. On 11/19/20 a.m. R2's temperature was recorded at 100.5 degrees (F).

R2's progress note(s) from 11/1/20 through 11/20/20, identified the following:

- 11/12/20, R2 received Tylenol (a pain reliever and fever reducer) daily, three times per day for pain.

- 11/19/20, R2 had a slightly elevated temperature in the morning, however was normal by the afternoon.

During observation on 11/20/20, at 9:57 a.m. R2 was lying in her bed, with the door open. There was a purple flower sign hanging on the front of R2's door. No PPE cart or drape was observed in the room and there were no PPE trash and/or laundry baskets in the room. NA-K entered R2's

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room. NA-K was wearing a N95 mask and a face shield. NA-K did not don an isolation gown or gloves. NA-K removed her cloth gait belt from around her waist and placed it around R2's waist. NA-K placed an arm around R2's shoulders and behind her knees to assist her to sit on the edge of the bed. Positioning R2's arms around her neck, NA-K braced her knees against R2's knees and hugged R2 around her waist to assist to stand and pivot transfer to her wheelchair. NA-K wheeled R2 into the bathroom and repeated the same hugging transfer onto the toilet. Toileting care was not observed as R2 requested the bathroom door stay shut. After assisting with toileting, NA-K wheeled R2 back to her bed and using the cloth gait, repeated the same hugging transfer back into bed. NA-K removed the cloth gait belt from around R2's waist and put the gait belt around her own waist. NA-K then placed an arm behind R2's shoulders and behind R2's knees and assisted R2 into a lying position on the bed, covered R2 with a blanket, completed hand hygiene and exited the room.

R2's COVID-19 testing results identified R2 was tested on 11/19/20, with a rapid antigen test with a negative result, following an onset of a fever. R2 was tested on 11/21/20, with a RT-PCR test with a positive COVID-19 test result.

During interview on 11/20/20, at 10:51 a.m. the DON and the facility infection preventionist (IP) were interviewed. The DON stated when they identified the COVID-19 positive residents they moved those residents to the very end of the west wing to create a west COVID-19 wing, with the exception of R11, who remained in the middle of the hall because of her mental and physical needs. The positive COVID-19 residents were

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placed in isolation with dedicated equipment and staff were to use full PPE, including gowns with resident cares. They attempted to identify residents that had high risk exposures with COVID-19 positive residents. They identified R1, R2 and R5 as residents with high risk exposures and placed them under quarantine. R5 was moved from the west COVID-19 wing to the east non- COVID-19 positive wing on 11/19/20, because R5 had been sharing a bathroom with a COVID-19 positive resident, R11, who needed the use of the bathroom. R7 was also placed into quarantine because her roommate, R6, had just tested positive. R6 was moved to the end of the hall with the other COVID-19 positive residents.

Quarantined, non-COVID-19, residents were identified by a purple flower sign on their door so staff would understand the difference between quarantined residents and COVID-19 positive isolated residents. Full PPE was required when caring for the residents in the quarantined rooms, including gowns. Staff were not be able to go between the purple flowered rooms (quarantined) with other purple flowered rooms. Staff would need to disrobe upon exiting the purple flowered room and put on new gowns before entering another purple flowered room. COVID-19 positive residents were in isolation rooms and the staff were able to go between rooms of COVID-19 positive residents utilizing the same PPE, even though the west wing had a mixture of COVID-19 positive and negative residents. The facility had decided to use the colored flowered signs for resident dignity reasons and to keep the residents from worrying about it and what it meant. Some of the staff were not aware of the meaning of the colored flower signs as the facility had just started implementing the flowered sign

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system and had not yet educated all the staff on it. Education was planned to be done during report for the remaining staff. There were residents on the east non COVID wing that they had identified may have come into contact with COVID-19 positive residents, however, those residents had not been moved to the west COVID-19 wing. Those residents remained on the east non-COVID positive wing and had purple flowers (quarantine) on their doors and full PPE was required for their care.

The facility policy Kittson Healthcare Novel Virus Event (COVID-19) revised 11/20, indicated residents would be actively screened and symptomatic residents would be isolated as soon as possible. Signage on residents doors would identify transmission based precautions would be required prior to entering the room. Staff would be required to gown, glove, wear a face mask and eye protection to enter. Cohorting of residents would be done in the nursing home if there were two or more positive COVID-19 cases. Residents who were symptomatic of COVID-19 or refused to be tested would be isolated to their rooms, staff would monitor ill residents three times per day with dedicated medical equipment.

The CDC Strategies for Optimizing the Supply of Isolation Gowns updated 10/9/20, identified the facility could prioritize gown use for those under observation. Gowns should be prioritized for the following activities: "During care activities where splashes and sprays are anticipated, which typically includes aerosol generating procedures; During the following high-contact patient care activities that provide opportunities for transfer of pathogens to other patients and staff via the soiled clothing of healthcare providers, such as:

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Dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, wound care."

QUARANTINING OF SYMPTOMATIC STAFF:

The CDC Interim Guidance for Rapid Antigen Testing for SARS-CoV-2 dated 9/4/20, identified the sensitivity of current FDA-authorized antigen tests varies, and thus negative diagnostic testing results should be handled differently depending on the testing device and its stated performance characteristics. In most cases, negative antigen diagnostic test results are considered presumptive. CDC recommends confirming negative antigen test results with an RT-PCR test when the pretest probability is relatively high, especially if the patient is symptomatic or has a known exposure to a person confirmed to have COVID-19. Ideally, confirmatory RT-PCR testing should take place within two days of the initial antigen testing.

The facility's staff symptom tracking log for October 2020, and November 2020, identified fifteen staff had complaints of COVID-19 signs and symptoms. The staff were given a quick antigen test the day of their complaints and twelve were determined to be negative for COVID-19. The twelve staff, while symptomatic, were allowed to work despite displaying potential signs and symptoms of COVID-19, without being quarantined to home pending a PCR COVID-19 confirmation test of the negative results.

-LPN-A complained of a runny nose. and a rapid antigen test was done on 10/5/20, The antigen

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test was negative. LPN-A worked a shift on 10/5/20, and 10/7/20. On 10/8/20, a PCR COVID-19 test was administered during the facility's routine testing.

-NA-K had a rapid antigen test done on 11/5/20, for complaints of symptoms which were not identified on the staff symptom tracking log. NA-K worked 11/10/20, 11/11/20 and 11/12/20. On 11/12/20, a PCR COVID-19 test was administered during the facility's routine testing.

-NA-L complained of symptoms of a runny nose and a rapid antigen test was done on 11/5/20. NA-L worked 11/5/20, 11/6/20, 11/9/20, 11/10/20 and 11/12/20. On 11/12/20, a PCR COVID-19 test was administered during the facility's routine testing.

-RN-B had a rapid antigen test on 11/5/20, for complaint which were not identified on the staff symptom tracking log. RN-B worked 11/5/20, 11/6/20 and 11/9/20. On 11/9/20, a PCR COVID-19 test was administered during the facility's routine testing.

-NA-M complained of symptoms of a runny nose and a rapid antigen test was done on 11/5/20. NA-M worked 11/5/20, 11/7/20, 11/8/20, 11/9/20, 11/10/20, and 11/11/20. On 11/12/20, a PCR COVID-19 test was administered during the facility's routine testing.

-NA-N complained of symptoms that were not identified on the staff symptom tracking log and a rapid antigen test was done on 11/8/20. NA-N worked on 11/8/20 and 11/9/20. On 11/9/20, a PCR COVID-19 test was administered during the facility's routine testing.

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-NA-O complained of symptoms of diarrhea and a rapid antigen test was done on 11/8/20. NA-O worked on 11/8/20. On 11/9/20, a PCR COVID-19 test was administered.

-LPN-D complained of symptoms of diarrhea and a rapid antigen test was done on 11/8/20. LPN-D worked on 11/8/20, 11/10/20, 11/11/20 and 11/12/20. On 11/12/20, a PCR COVID-19 test was administered during the facility's routine testing.

-LPN-E complained of symptoms of illness. LPN-E's rapid antigen test on 11/13/20, was negative. LPN-E worked on 11/13/20 and 11/16/20. On 11/16/20, a PCR COVID-19 test was administered during the facility's routine testing.

-NA-P complained of symptoms of runny nose and congestion and a rapid antigen test was done on 11/13/20, was negative. NA-P worked on 11/13/20 and 11/16/20. On 11/16/20, a PCR COVID-19 test was administered during the facility's routine testing.

-LPN-F complained of symptoms of runny nose and a rapid antigen test was done on 11/15/20. LPN-F worked on 11/15/20. On 11/16/20, a PCR COVID-19 test was administered during the facility's routine testing.

-NA-J complained of symptoms of sore throat and nasal congestion and a rapid antigen test was done on 11/16/20. NA-J worked on 11/16/20. On 11/19/20, NA-J's PCR COVID-19 test was administered during the facility's routine testing.

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On 11/19/20, at 3:19 p.m. NA-F and NA-G were observed working (with residents) on the east non-COVID-19 wing. NA-F stated she had nasal congestion and chest congestion. A rapid antigen test had been done at the start of her shift and was negative so she was cleared to work. NA-F denied having a fever.

During interview on 11/20/20, at 11:00 a.m. the DON stated if residents exhibited symptoms of illness, a rapid antigen test was done. The facility did not put residents under quarantine unless the test was positive or if they knew the resident had direct exposure to COVID-19. If an employee was ill they would be required to get a rapid antigen test done and be fever free before they could return to work. If the rapid antigen test was negative, the employee would be allowed to work if they felt up to it. The facility did a rapid antigen test on both resident and employees if exhibiting symptoms of illness and a COVID-19 RT- PCR test was done two times per week for the facility testing protocols. The facility did not obtain a second confirmatory PCR test following a rapid antigen test for symptomatic residents or employees. Residents were not quarantined when they exhibited symptoms as long as a rapid antigen test was done with negative results. Symptomatic employees were able to work their scheduled shifts as long as a rapid antigen test was done with negative results and there was no fever. A more accurate COVID-19 RT- PCR test was done two times per week on both staff and residents and she felt that was sufficient.

The IJ that began on 10/29/20, was removed on 11/24/20, at 1:05 p.m. when the facility implemented actions to reduce/prevent the spread of COVID-19 within the facility.

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F 880	Continued From page 26 Observations, interviews and record review identified the facility had updated their policies and procedures regarding, PPE, quarantining of staff and residents and cohorting. Residents were cohorted to wings with like residents, CDC approved signs were placed on all residents doors who were isolated and/ or quarantined. Staff and residents were given RT-PCR COVID-19 tests to identify residents and staff who were positive for COVID-19 and were isolated and or removed from the schedule as indicated by COVID positive RT-PCR test results. All staff received education to the updated polices and procedures. Further, the facility contacted their health care coalition for assistance with PPE supplies.	F 880		
F 886 SS=F	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or	F 886		1/15/21

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suspected exposure to COVID-19;
(iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county;
(v) The response time for test results; and
(vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19.

§483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests;

§483.80 (h)((3) For each instance of testing:
(i) Document that testing was completed and the results of each staff test; and
(ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test.

§483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19.

§483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested.

§483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing

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F 886	Continued From page 28 efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to test health care personal (HCP) for COVID-19 according to Centers for Disease Control (CDC) direction for 3 of 3 nursing assistants (NA-A, NA-B, NA-C) who were reviewed in the sample. In addition, the facility failed to ensure a second, confirmatory, RT-PCR (real-time reverse transcription polymerase chain reaction (rRT-PCR) test for the qualitative detection of nucleic acid from SARS-CoV-2 in upper and lower respiratory specimens) test was performed within two days, when employees complained of COVID-19 symptoms as recommended by the CDC, for 8 of 13 nursing staff (LPN-A, NA-K, NA-L, RN-B, NA-M, LPN-D,NA-P, NA-J) tested with a rapid antigen test (screening test) after complaints of COVID-19 symptoms. This had the potential to affect all 50 residents who resided in the facility during a COVID-19 focused infection control survey. Findings include: On 11/19/20, at 12:45 p.m. upon entrance to the facility, the administrator stated the facility had a current census of 50 residents. They currently had five residents and four employees who had tested positive for COVID-19. The administrator stated the county positivity rate was 4.3% and the facility was testing staff and residents two times per week. The administrator identified the facility's first COVID-19 positive case occured on 10/19/20, when two employees tested positive for COVID-19. On 10/29/20, two residents tested	F 886	It is the policy of Kittson Healthcare to follow the CDC Guidance of Testing Healthcare Personnel as well as CMS QSO 20-38, and the recommended guidance from CDC for rapid Antigen Testing for SARS-CoV-2 being confirmed with an RT-PCR test if the antigen test is negative. All residents and staff that have been tested via a rapid antigen test due to symptoms of SARS-CoV-2 have been confirmed with a RT-PCR. All HCP reporting symptoms are tested with an antigen test. If an antigen test is negative a confirmatory PCR test is completed.Staff that have reported COVID-19 symptoms will not be allowed to work until they have been tested with a confirmatory RT-PCR as negative. During outbreak testing compliance will be audited twice a week. If staff miss scheduled testing, they will need to be swabbed and COVID-19 test performed through the facility lab Abbott ID NOW NAAT testing analyzer 48 hours prior to their next schedule shift, or be taken off the schedule until this test can be performed. Testing will be based on the county's positivity rating or new cases in the last 14 days. All staff that have missed a testing day will be asked to come in to test with a PCR, or will not be placed on the schedule if out of compliance. Auditing will be completed by the Administrator or her designee. Auditing of the staff testing compliance will be done by the	

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F 886	Continued From page 29 positive for COVID-19. STAFF MANDATORY TESTING: The CDC's Interim Guidance on Testing Healthcare Personnel for SARS-CoV-2 [COVID-19] Testing Healthcare Personnel dated 7/17/20, identified: "In nursing homes, expanded viral testing of all HCP is recommended in response to an outbreak in the facility...An outbreak is defined as a new SARS-CoV-2 infection in any HCP [health care personal] or any nursing home-onset SARSCoV-2 infection in a resident. Expanded viral testing includes initial testing of all HCP followed by repeat testing of all previously negative HCP, generally between every 3 days to 7 days, until the testing identifies no new cases of SARS-CoV-2 infection among residents or HCP for a period of at least 14 days since the most recent positive result. Expanded viral testing of HCP could also be considered in other healthcare settings in some situations (e.g., when multiple instances of SARS-CoV-2 transmission are identified among patients or HCP)." The facility's undated, staff line testing form indicated mandatory testing began on 10/5/20, and the facility was testing two times weekly, on Mondays and Thursdays, 10/5/20, through 11/19/20, The staff line testing form and corresponding working schedules for October 2020, and November 2020, identified the following: NA-A was tested on the following facility mandatory RT-PCR test dates:10/5/20, 10/12/20, 11/9/20, 11/16/20 and 11/19/20. NA-A failed to	F 886	administrator or a designee based on the testing requirements of outbreak testing (once every 3-7 days) or as determined by the county positivity rating (once a month if positivity is less than 5%; once every 3-7 days if the positivity is between 5-10%; twice a week mandatory testing if the positivity is 10% or over.)	

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get tested on the following facility mandatory RT-PCR test dates; 10/8/20, 10/15/20, 10/19/20, 10/22/20, 10/26/20, 10/29/20, 11/2/20, 11/5/20 and 11/12/20.
NA-A continued to work his shifts as scheduled in October and November, despite missing 9 of 14 facility's scheduled mandatory RT-PCR testing.

NA-B was tested on the following facility mandatory RT-PCR test dates: 10/5/20, 10/8/20, 10/15/20, 10/19/20, 10/22/20, 11/2/20, 11/9/20, 11/12/20, 11/16/20 and 11/19/20 NA-B failed to get tested on the following facility mandatory RT-PCR test dates; 10/12/20, 10/26/20, 10/29/20,11/5/20.
NA-B continued to work her shifts as scheduled in October and November, despite missing 4 of 14 facility's scheduled mandatory RT-PCR testing.

NA-C was tested on the following facility mandatory RT-PCR test dates:10/5/20, 10/8/20, 10/12/20, 10/15/20, 10/26/20, 11/2/20, 11/5/20, 11/9/20, 11/16/20 and 11/19/20.
NA-C failed to get tested on the following facility mandatory RT-PCR test dates:10/19/20, 10/22/20, 10/29/20 and 11/12/20. NA-C continued to work her shifts as scheduled in October and November 2020, despite missing 4 of the facility's 14 scheduled mandatory RT-PCR testing.

FOLLOW UP TESTING WITH SYMPTOMS:

The CDC Interim Guidance for Rapid Antigen Testing for SARS-CoV-2 dated 9/4/20, identified the sensitivity of current FDA-authorized antigen tests varies, and thus negative diagnostic testing results should be handled differently depending on the testing device and its stated performance characteristics. In most cases, negative antigen

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diagnostic test results are considered presumptive. CDC recommends confirming negative antigen test results with an RT-PCR test when the pretest probability is relatively high, especially if the patient is symptomatic or has a known exposure to a person confirmed to have COVID-19. Ideally, confirmatory RT-PCR testing should take place within two days of the initial antigen testing.

The CDC Symptoms of Coronavirus, updated 5/13/20, identified people with COVID-19 had a wide range of symptoms reported - ranging from mild symptoms to severe illness. Symptoms may appear 2-14 days after exposure to the virus. People with these symptoms may have COVID-19: fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting and diarrhea. This list does not include all possible symptoms. CDC will continue to update this list as we learn more about COVID-19.

The facility's Staff Symptom Tracking Log for October and November 2020, along with the undated, staff line testing form indicated eight staff had complaints of COVID-19 signs and symptoms and were given a quick antigen test the day they presented with symptoms and did not receive a follow up RT-PCR test in the required time frame. The cooresponding schedules identified the staff continued to work despite symptoms. The logs and schedules identified the following:

-Licensed practical nurse (LPN)-A complained of symptoms of runny nose and a rapid antigen test

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was done on 10/5/20. LPN-A worked a shift on 10/5/20, and 10/7/20. LPN-A's confirmatory RT-PCR test was done on 10/8/20, three days after her rapid antigen test was completed and not within two days as recommended by the CDC.

-NA-K had a rapid antigen test done on 11/5/20, however, her symptoms were not identified on the staff infection log. NA-K worked 11/10/20, 11/11/20 and 11/12/20. NA-K did not receive a confirmatory RT-PCR test until 11/12/20, seven days after her initial rapid antigen test was completed.

-NA-L complained of symptoms of runny nose and a rapid antigen test was done on 11/5/20. NA-L worked 11/5/20, 11/6/20, 11/9/20, 11/10/20 and 11/12/20. NA-L did not receive a confirmatory RT-PCR test until 11/12/20, seven days after her initial rapid antigen test was completed.

-Registered nurse (RN)-B received a rapid antigen test on 11/5/20, however, her symptoms were not identified on the staff infection log. RN-B worked 11/5/20, 11/6/20 and 11/9/20 RN- B did not receive a confirmatory RT-PCR test until four days after her initial rapid antigen test was completed.

-NA-M complained of symptoms of runny nose and a rapid antigen test was done on 11/5/20. NA-M worked 11/5/20, 11/7/20, 11/8/20, 11/9/20, 11/10/20, and 11/11/20. NA-M did not receive a confirmatory RT-PCR test until 11/12/20, seven days after his initial rapid antigen test was completed.

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-LPN-D complained of symptoms of diarrhea and a rapid antigen test was done on 11/8/20. LPN-D worked on 11/8/20, 11/10/20, 11/11/20 and 11/12/20. LPN-D did not receive a confirmatory RT-PCR test until 11/12/20, four days after her initial rapid antigen test was completed.

-NA-P complained of symptoms of runny nose and congestion and a rapid antigen test was done on 11/13/20. NA-P worked on 11/13/20 and 11/16/20. NA-P did not receive a confirmatory RT-PCR test until 11/16/20, three days after her initial rapid antigen test was completed.

-NA-J complained of symptoms of sore throat and stuffy nose and a rapid antigen test was done on 11/16/20. NA-J worked on 11/16/20. NA-J did not receive a confirmatory RT-PCR test until 11/19/20, three days after her initial rapid antigen test was completed.

During interview on 11/24/20, at 10:20 a.m. the administrator stated she did most of the staff COVID-19 testing. She noticed NA-A was missing many of the required testing and so on 11/1/20, she had started to come in on Sundays to test the weekend staff that had difficulty coming in during the week for testing. The administrator identified it was the facility's expectation for all staff to be tested every three to seven days or not be allowed to work.

During interview on 11/24/20, at 11:10 a.m. the director of nursing (DON) stated if staff were to call in sick, they were told to get an antigen test and if they had no fever in the last 24 hours they would be able to come to work. If the staff did not have a fever and were complaining of other symptoms such as nasal congestion or a cough,

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F 886	Continued From page 34 she would have them do a quick antigen test and if negative, the facility would leave it up to them if they felt well enough to work. The DON confirmed the facility was not following the quick antigen test with a confirmatory PCR test when staff developed symptoms of illness. The DON stated they were all being tested with the PCR test twice weekly and indicated she felt that was adequate, despite being in a facility outbreak. The facility policy Kittson Healthcare Novel Virus Event (COVID-19) revised 11/20, indicated staff would be monitored for signs and symptoms of respiratory illness prior to coming into work. Staff with fever are requested to remain at home. Staff with symptoms consistent with COVID-19 other than fever were instructed to notify their manager immediately to arrange for testing. Further, no employees would be allowed to work while ill. If staff refused or missed testing, the facility would encourage them to test at the next opportunity. During an outbreak, all staff who refused testing would not be allowed into the facility until outbreak testing was completed.	F 886		

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:

- In order to assist with identifying appropriate corrective actions and implementing systemic changes, the facility must contract with an infection control consultant to provide consultation and oversight for infection prevention and control within the facility.

- The consultant shall exercise independent judgement in the performance of all duties under the consultant contract. The consultant shall meet the independent judgement requirement if the consultant is not presently and has not within a five (5) year period immediately preceding June 1, 2020 directly or indirectly affiliated with the facility, facility's owner(s), agent(s), or employee(s).

- The consultant shall have completed infection prevention and control training from a recognized source, such as the Centers for Disease Control and Prevention or American Health Care Association.

- The consultant will be contracted to work with the facility for a minimum of two (2) months.

- The consult will assist the facility in completing the CMS infection control self-assessment. If this assessment was completed prior to the June 4, 2020 survey, the assessment should be reviewed to determine if it is an accurate reflection of the facility's infection control program. The self-assessment can be found in the CMS publication QSO-20-20-All: Prioritization of Survey Activity: https://www.cms.gov/files/document/qso-20-20-all.pdf,

Infection control consultant responsibilities must include, but are not limited to, the following:

- Work with the facility to conduct a Root Cause Analysis (RCA) to identify and address the reasons for noncompliance identified in the CMS-2567.
- The facility's Infection Preventionist, Quality Assurance and Performance Improvement (QAPI) committee, must participate in the completion of the RCA. Information regarding RCAs can be found in the CMS publication 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.

- Take immediate action to implement an infection prevention plan consistent with the requirements at 42 CFR § 483.80 for the affected residents impacted by the noncompliance identified in the CMS-2567 to include identification of other residents that may have been impacted by the noncompliant practices. This plan must include but is not limited to implementation of procedures to ensure:

CHOOSE THE DIRECTION HERE BASED UPON SPECIFICS OF DEFICIENT PRACTICE

PERSONAL PROTECTIVE EQUIPMENT (PPE) Specifically Gown use

- 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 for TBD and 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 gown use using the current CDC guidence and optimization plans.
- 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.

TRACKING AND TRENDING INFECTION CONTROL PROGRAM

- 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 and revise policies for infection surveillance as needed.
- Develop and implement an infection control program sign and symptom tracking tool to monitor all residents and staff for communicable, respiratory infection, according to the CDC guidelines.
- Ensure that the charge nurse for each shift documents all resident and employee infections on the facility's shared infection tracking log. Compliance and review of the infection control log will be completed by the Infection Preventionist daily. The data will be analyzed for possible trends/outbreaks. The Infection Preventionist will investigate any potential outbreaks and follow up as appropriate.
- Conduct rounds throughout the facility to ensure staff is exercising appropriate use of personal protective equipment and to ensure infection control procedures are followed on each unit. Ad hoc education will be provided to persons who are not correctly utilizing equipment and/or infection prevention/control practices. Such monitoring will continue until the facility has been infection free for at least four weeks.
- Review infection prevention tracking and trending. Any unexpected increases in infection must be reported to the Medical Director, Public Health Department, and the state survey agency in order to obtain further assistance to control infection.

TRAINING/EDUCATION:

- As a part of corrective action plan, the facility must provide training for the Infection Preventionist, the Director of Nursing, nursing leadership/management, and facility administration. The training must cover standard infection control practices, active surveillance, tracking and trending for a comprehensive infection control program. The facility may use training resources made available by the Centers for Disease Control and Prevention or a program developed by well-established centers of geriatric health services education, such as schools of medicine or nursing, centers for aging, and area health education centers with established programs in geriatrics.
- Include documentation of the training completed with a timeline for completion.
- The training may be provided by the Director of Nursing, Infection Preventionist, or Medical Director with an attestation statement of completion.
- Tier three or four concerns (harm or IJ) training must be provided by a contracted outside infection prevention consultant.
- Online infection prevention training courses may be utilized. The CDC and MDH websites have several infection control training modules and materials.

CDC RESOURCES:

- Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic. https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html
- Infection Control Guidance for Healthcare Professionals about Coronavirus (COVID-19) https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html

CMS RESOURCES:

- CMS & CDC Offer a specialized, online Infection Prevention and Control Training For Nursing Home Staff in the Long-Term Care Setting

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

MDH RESOURCES:

- Infection Prevention and Control Guidelines https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/guidelines.html
- Infection Control Precautions https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/index.html
- National Healthcare Safety Network (NHSN) https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/nhsn.html
- COVID-19 Toolkit: Information for Long-term Care Facilities (PDF) https://www.health.state.mn.us/diseases/coronavirus/hcp/ltctoolkit.pdf
- Responding to and Monitoring COVID-19 Exposures in Health Care Settings (PDF) https://www.health.state.mn.us/diseases/coronavirus/hcp/response.pdf
- COVID-19 Infection Prevention and Control and Cohorting in Long-term Care (PDF) https://www.health.state.mn.us/diseases/coronavirus/hcp/ltcipchohort.pdf

MONITORING/AUDITING:

Monitoring of approaches to ensure infections are controlled will include:

- The Infection Preventionist and Director of Nursing, each day and more often as necessary, will review infection prevention tracking and trending logs and data analysis. Any unexpected increases in infection will result in communication with the Medical Director, Public Health Department and the state survey agency in order to obtain further assistance to control infection.
- The Director of Nursing, Infection Preventionist, or designee will review the results of audits and monitoring with the Quality Assurance Program Improvement (QAPI) program.

COHORTING RESIDENTS/TRANSMISSION BASED PRECAUTION "ISOLATION"

- 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:

- Grouping of 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.
- Dedicate a unit or part of a unit as the care location for residents with disease, including those with or without current symptoms of illness. Anticipate ways to close off units to prevent spread of illness from ill residents to non-ill residents (e.g., for symptomatic COVID-19, recovered COVID-19 residents, non-COVID-19 suspected residents).
- Confine symptomatic residents and exposed roommates to their rooms. If they must leave their room, ensure the resident is wearing a mask.
- Provide dedicated equipment for areas, as able.

When a resident is placed on transmission-based precautions, the staff should implement the following:

- Clearly identify the type of precautions and the appropriate PPE to be used.
- Place signage in a conspicuous place outside the resident's room (e.g., the door or on the wall next to the door) identifying the CDC category of transmission-based precautions (e.g., contact, droplet, or airborne), instructions for use of PPE, and/or instructions to see the nurse before entering. Ensure that signage also complies with residents' rights to confidentiality and privacy.
- Make PPE readily available near the entrance to the resident's room.
- Don appropriate PPE upon entry into the environment (e.g., room or cubicle) of resident on transmission-based precautions (e.g., contact precautions).
- Use disposable or dedicated noncritical resident-care equipment (e.g., blood pressure cuff, bedside commode). If noncritical equipment is shared between residents, it will be cleaned and disinfected following manufacturer's instructions with an EPA-registered disinfectant after use.
- Clean and disinfect objects and environmental surfaces that are touched frequently (e.g., bed rails, over-bed table, bedside commode, lavatory surfaces in resident bathrooms).

TRAINING/EDUCATION:

- Provide education to residents (to the degree possible/consistent with the resident's capacity) and their representatives or visitors on the use of transmission-based precautions.
- Refer to CDC Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings. https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
- Refer to MDH COVID-19 Infection Prevention and Control and Cohorting in Long-term Care. https://www.health.state.mn.us/diseases/coronavirus/hcp/ltcipchohort.pdf
- MDH: Interim Guidance for Hospital Discharge to Home or Admission to Congregate Living Settings and Discontinuing Transmission-Based Precautions. https://www.health.state.mn.us/diseases/coronavirus/hcp/hospdischarge.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 verify the placement of each new admission and location and audit for transmission based precautions are being appropriately implemented.
- Conduct a Root Cause Analysis (RCA) 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 can be found in the document: 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), 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	Consultant name and credentials meeting the criteria outlined above
2	Executed contract with the consultant
3	Documentation demonstrating that the RCA was completed as described above
4	List of facility policies and procedures reviewed by the consultant.
5	Infection control self-assessment
6	Summary of all changes as a result of the RCA and consultant review – to include a summary of how staff were notified and trained on the changes
7	Content of the trainings provided to staff to include a Syllabus, outline, or agenda as well as any training materials used and provided to staff during the training
8	Names and positions of all staff to be trained
9	Staff training sign-in sheets
10	Summary of staff training post-test results, to include facility actions in response to any failed post-tests
11	Summary of follow-up employee supervision and work performance appraisal to include when employees were observed, what actions were observed, and an evaluation of the effectiveness of any new policies and procedures.

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