Electronically Submitted
December 31, 2020

Administrator
Minneota Manor Health Care Center
700 North Monroe Street
Minneota, MN 56264

RE: CCN: 245496
Cycle Start Date: December 10, 2020

Dear Administrator:

On December 10, 2020, survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMOVAL OF IMMEDIATE JEOPARDY

On December 10, 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 F.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective January 15, 2021.

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

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective January 15, 2021, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 15, 2021, (42 CFR 488.417 (b)).

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

NURSE AIDE TRAINING PROHIBITION

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

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective December 10, 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:

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, MN 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 10, 2021 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS DENIAL OF PAYMENT

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

Tamika.Brown@cms.hhs.gov

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

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

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

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

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

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

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

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

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

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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:

ACTIVELY SCREENING RESIDENTS

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

POLICIES/PROCEDURES/SYSTEM CHANGES:

- The facility's Quality Assurance and Performance Improvement Committee must conduct a root cause analysis (RCA) to identify the problem(s) that resulted in this deficiency and develop intervention or corrective action plan to prevent recurrence.

The Infection Preventionist and Director of Nursing shall complete the following:

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

TRAINING/EDUCATION:

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

CDC RESOURCES:

Infection Control Guidance: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html
CDC: Isolation Precautions Guideline:
https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007): https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Personal Protective Equipment: https://www.cdc.gov/niosh/ppe/
Healthcare Infection Prevention and Control FAQs for COVID-19:
https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control-faq.html

MDH RESOURCES:

Personal Protective Equipment (PPE) for Infection Control:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/ppe/index.html
MDH Contingency Standards of Care for COVID-19: Personal Protective Equipment for Congregate Care Settings (PDF): https://www.health.state.mn.us/communities/ep/surge/crisis/ppegrid.pdf
Interim Guidance on Facemasks as a Source Control Measure (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/maskssource.pdf
Interim Guidance on Alternative Facemasks (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/masksalt.pdf
Aerosol-Generating Procedures and Patients with Suspected or Confirmed COVID-19 (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/aerosol.pdf
Droplet Precautions:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html
Airborne Precautions:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html

MONITORING/AUDITING:

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

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

PERSONAL PROTECTIVE EQUIPMENT (PPE)

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

POLICIES/PROCEDURES/SYSTEM CHANGES:

- The facility's Quality Assurance and Performance Improvement Committee must conduct a root cause analysis (RCA) to identify the problem(s) that resulted in this deficiency and develop intervention or corrective action plan to prevent recurrence.

The Infection Preventionist and Director of Nursing, shall complete the following:

- Review policies and procedures for donning/doffing PPE 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 source control masks.
- Review policies regarding standard and transmission based precautions and revise as needed.

TRAINING/EDUCATION:

As a part of corrective action plan, the facility must provide training for the Infection Preventionist, the Director of Nursing, all staff providing direct care to residents, and all staff entering resident's rooms, whether it be for residents' dietary needs or cleaning and maintenance services. The training must cover standard infection control practices, including but not limited to, transmission-based precautions, appropriate PPE use, and donning and doffing of PPE.

- The training may be provided by the Director of Nursing, Infection Preventionist, or Medical Director with an attestation statement of completion.
- The training must include competency testing of staff and this must be documented.
- Residents and their representatives should receive education on the facility's Infection Prevention Control Program as it related to them and to the degree possible/consistent with resident's capacity.
- Online infection prevention training courses may be utilized. The CDC and MDH websites have several infection control training modules and materials.

CDC RESOURCES:

Infection Control Guidance: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html
CDC: Isolation Precautions Guideline:
https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007): https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Personal Protective Equipment: https://www.cdc.gov/niosh/ppe/
Healthcare Infection Prevention and Control FAQs for COVID-19:
https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control-faq.html

MDH RESOURCES:

Personal Protective Equipment (PPE) for Infection Control:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/ppe/index.html
MDH Contingency Standards of Care for COVID-19: Personal Protective Equipment for Congregate Care Settings (PDF): https://www.health.state.mn.us/communities/ep/surge/crisis/ppegrid.pdf
Interim Guidance on Facemasks as a Source Control Measure (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/maskssource.pdf
Interim Guidance on Alternative Facemasks (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/masksalt.pdf
Aerosol-Generating Procedures and Patients with Suspected or Confirmed COVID-19 (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/aerosol.pdf
Droplet Precautions:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html

Airborne Precautions:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html

MONITORING/AUDITING:

- The Director of Nursing, the Infection Preventionist, and other facility leadership will conduct audits of donning/doffing PPE with Transmission Based Precautions i.e. Droplet precautions.
- The Director of Nursing, Infection Preventionist, and other facility leadership will conduct routine audits on all shifts four times a week for one week, then twice weekly for one week once compliance is met. Audits should continue until 100% compliance is met on source control masking for staff, visitors and residents.
- The Director of Nursing, Infection Preventionist, and other facility leadership will conduct real time audits on all aerosolized generating procedures to ensure PPE is in us.
- The Director of Nursing, Infection Preventionist, or designee will review the results of audits and monitoring with the Quality Assurance Program Improvement (QAPI) program.

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.

ACTIVE SCREENING

- 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:

- Develop and implement procedures, policies, and forms regarding active screening for temperature and signs and symptoms of COVID-19, in accordance with CDC guidelines to be conducted at the point of entry for every person who enters the facility. The procedures and policy must restrict entrance to anyone who does not meet the criteria as outlined by the CDC. This procedure must include actively measuring and recording staff temperature and assessment of shortness of breath, new or changed cough, and sore throat. The results must be documented. The MDH COVID-19 Toolkithttps://www.health.state.mn.us/diseases/coronavirus/hcp/ltctoolkit.pdf has examples of forms to utilize for staff screening.

TRAINING/EDUCATION:
As part of a corrective action plan, the facility must provide training for Infection Preventionist and all other staff who enter the facility, as well as staff responsible for the screening. The training must cover the need for active screening. The CDC has training videos available for COVID-19 which may be utilized, Training for Healthcare Professionals; https://www.cdc.gov/coronavirus/2019-ncov/hcp/training.html and the MDH COVID-19 Toolkit may be utilized.

- Include documentation of the completed training 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.

CDC RESOURCES:
Infection Control Guidance: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html
CDC: Isolation Precautions Guideline:
https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007): https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Personal Protective Equipment: https://www.cdc.gov/niosh/ppe/
Healthcare Infection Prevention and Control FAQs for COVID-19:
https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control-faq.html

MDH RESOURCES:
Personal Protective Equipment (PPE) for Infection Control:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/ppe/index.html
MDH Contingency Standards of Care for COVID-19: Personal Protective Equipment for Congregate Care Settings (PDF): https://www.health.state.mn.us/communities/ep/surge/crisis/ppegrid.pdf
Interim Guidance on Facemasks as a Source Control Measure (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/maskssource.pdf
Interim Guidance on Alternative Facemasks (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/masksalt.pdf
Aerosol-Generating Procedures and Patients with Suspected or Confirmed COVID-19 (PDF):https://www.health.state.mn.us/diseases/coronavirus/hcp/aerosol.pdf
Droplet Precautions:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html
Airborne Precautions:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html

MONITORING/AUDITING:

- The Director of Nursing, the Infection Preventionist, and other facility leadership will conduct audits on all shifts, four times a week for one week, twice weekly for one week and biweekly thereafter, until 100% compliance is achieved to ensure active screening is being completed at the point of entry for all persons who enter the facility.

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):
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Droplet Precautions:
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Airborne Precautions:
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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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245496	A. BUILDING _____ B. WING _____	12/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNEOTA MANOR HEALTH CARE CENTER	700 NORTH MONROE STREET MINNEOTA, MN 56264

(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 12/7/20 through 12/10/20 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 was conducted on 12/7/20 through 12/10/20, 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 COVID Focused Infection Control survey resulted in an Immediate Jeopardy (IJ) at F880 on 11/14/20, when it was identified the facility failed to immediately implement TBP and isolation when symptoms of COVID-19 were identified. The facility further failed to conduct appropriate infection control surveillance to track, trend, and analyze infections throughout the facility. The IJ was removed on 12/10/20. There was no finding of Substandard Quality of Care (SQC), therefore, no extended survey was required. The facility's plan of correction (POC) will serve as your allegation of compliance upon the	F 000		

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

Electronically Signed | 01/08/2021

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

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F 000	Continued From page 1 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=L	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and	F 880		3/12/21

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

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F 880	Continued From page 3 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 follow Centers for Disease Control (CDC) and Centers for Medicare and Medicaid Services (CMS) guidelines to prevent or minimize the transmission of COVID-19 for implementing transmission based precautions (TBP) for 6 of 6 COVID positive residents (R4, R38, R9, R26, R35 and R36) with symptoms of COVID-19 during an outbreak of COVID-19. The facility also failed to have active ongoing surveillance for infection control program with appropriate personal protective equipment (PPE) usage and storage. The facility's failures resulted in an immediate jeopardy (IJ) situation for all 36 residents. The IJ began on 11/14/20, when it was identified the facility failed to immediately implement quarantine and use of TBP when residents were identified with potential symptoms of COVID-19. The facility further failed to conduct appropriate infection control surveillance to track, trend, and analyze infections. The facility's administrator was informed of the immediate jeopardy on 12/8/20 at 4:40 p.m.. The IJ was removed on 12/10/20, but non-compliance remained at the lower scope and severity of F, widespread, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: SCREENING / ISOLATION / TBP Review of the resident progress notes, bowel records and COVID screenings identified: R4's progress note dated 11/22/20 at 3:11 p.m.,	F 880	ID Tag F880: Corrective action for F880 is completed for three distinct issues raised in the 2567: " Implementation of transmission based protocols " Active ongoing surveillance " Personal protective equipment usage and storage Implementation of Transmission Based Protocols: On December 10, 2020, the facility put the policy Updated MMHCC protocol for when a resident is suspected to have NEW respiratory symptoms to include ALL symptoms. Implemented 12-10-20 into place. Staff members including CNAs, TMAs, LPNs, and RNs were trained shift to shift beginning on 12/10/20. An employee roster was kept to verify training was completed. The policy put into place on 12/10/20 is a systemic change that will change our practice as it relates to the affected residents. The protocol includes staff notifying a nurse of any suspected symptoms so an assessment can be conducted immediately and TBP initiated. All residents were assessed for signs and symptoms of Covid-19 and any residents who displayed symptoms were put on TBP immediately. Residents R4, R38, R9, R26, R35 and	

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F 880	Continued From page 4 identified that R4 had been lethargic all shift and had a temperature of 99.0 Fahrenheit (F). That same day, R4 had refused breakfast and needed assistance eating lunch. R4 had needed total assistance with toileting and was noted as "weak". There was no mention that TBP had been implemented or the provider had been updated on R4's new symptoms. R4 resided on the unit in the facility that had the COVID outbreak beginning on 11/19/20. On 11/23/20, notes identified R4 had been tested on 11/20/20 with the results returning on 11/23/20 that R4 was positive for COVID. Only after testing positive was R4 placed on TBP and moved to the COVID unit. R38's progress note dated 11/25/20, identified that R38 had "incontinent bowel during night and had been hollering out". R38 was admitted to the facility on 11/12/20. She was on TBP upon admission. Review of R38's bowel records identified R38 had diarrhea documented on 11/14/20, 11/15/20, 11/17/20, and 11/24/20. On 11/26/20, R38 had been taken off TBP. R38 had been tested for COVID on 11/24/20 during routine testing, with those positive results from the lab reported to the facility 11/27/20, 1 day after TBP were removed. There was no documentation that the facility had updated the provider on the diarrhea as a potential symptom of COVID or placed R38 in TBP upon onset of symptoms. R38's plan of care identified on 11/27/20, R38 was found to be COVID-19 positive, placed on TBP again and moved to the designated COVID area of the facility. R9's bowel records identified diarrhea on 11/11/20, 11/14/20, and again on 11/24/20. On 11/20/20, R9 was noted as "running a low grade temperature". There was no mention R9 had	F 880	R36 remained on TBP per CDC guidance. The facilitys policy on Discontinuation of Transmission Based Precautions was reviewed and or revised in April, June, July, September and December of 2020 to be in line with the most recent CDC guidance. The protocol for residents with suspected COVID-19 has been updated to include starting TBP immediately if a resident is experiencing any symptom of fever of >100.0 (or subjective fever). The TBP for residents with symptoms remain in place until further assessment by the IP or DON. The Discontinuation of Transmission Based Precautions policy was revised 2/2021. The facility will identify residents with the potential to be impacted by utilizing the forms described in the Active Ongoing Surveillance section below. The practice implemented was a systemic change in that it now directs staff who identify any symptom of COVID to notify the nurse, who will conduct an assessment and initiate TBP if indicated. The Director of Nursing, the Infection Preventionist, or designee will conduct weekly audits to ensure compliance with the MMHCC COVID protocol policy for the next 12 weeks, and after that time will conduct audits as directed by the Quality Assurance committee at the facility. The portion of the deficiency was corrected as of 12/10/20. Active Ongoing Surveillance: The facility implemented new tracking and monitoring forms including:	

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F 880	Continued From page 5 been placed on TBP with onset of potential COVID symptoms. R9's plan of care identified on 11/27/20, R9 was found to be COVID-19 positive and isolated to designated area of the facility. R26's progress notes identified on 11/28/20, R26 was experiencing vomiting, diarrhea, refused meals and was very sleepy. The progress note lacked documentation that R26 was on TBP or that the provider had been updated with new symptoms at that time. On 12/2/20, R26 was positive for COVID. R26's plan of care identified on 12/2/20, R26 had been placed on TBP and moved to the COVID designated area of the facility only after receiving the positive result. R35's bowel records identified diarrhea on 11/17/20 and 11/19/20. On 11/19/20, R35 had a fever of 102.3 F with Tylenol was administered. On 11/20/20, R35 continued to have a fever and reported he did not feel well . On 11/22/20, R35 had temperature of 101.5 F at 5:00 a.m., remained lethargic and refused meals. R35 had diarrhea and complained of nausea. There was no documentation to support R35 was placed on TBP at the onset of symptoms on 11/17/20. R35's 11/20/20 COVID test, received from the lab on 11/23/20, identified R35 was positive for COVID-19. R35 was then moved to the COVID unit and placed on TBP at that time. R36's bowel records identified loose stools on 11/16/20 and 11/23/20. On 11/20/20, R36 was also identified as having had a low grade fever and was to have routine scheduled COVID testing that day. On 11/22/20, R36 was lethargic and had a temperature of 99.4 F. On 11/23/20, identified R36's test results returned as positive for COVID. Only after receiving the positive	F 880	MDH Long Term Tool Kit: 1. Appendix E: Active Resident Monitoring for COVID-19 Symptoms **Update to symptom key from original information received 12-10-20. 2. Appendix F: Template Line List for Residents with signs & Symptoms of COVID 19: Date implemented (12-9-20) **updated symptom key and form to the correct IJ allegations and reflect MDHs most current recommendations Every resident who did not have a positive COVID test was assessed using these forms on 12/9/20. Corrective action was accomplished for all residents, both those impacted and those with the potential to be impacted, by assessing immediately and then implementing the use of these forms going forward. Training staff began on 12/9/20 as assessments were completed, and policy changes were communicated on 12/10/20. Training to front line staff was completed shift to shift starting 12/10/20. An employee roster was kept to verify training was completed with date and signature included on the roster. Going forward, the Director of Nursing, the Infection Preventionist, or designee will audit the following forms weekly for 12 weeks. Additionally, the IP will summarize the active screening and line listing findings monthly and this will be reviewed by the Quality Assurance committee: " Active Resident Monitoring Forms " Template Line List for Residents w/	

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F 880	Continued From page 6 COVID results was R36 placed on TBP and moved to the COVID unit. There was no mention R36 was on TBP at anytime while symptomatic prior to testing positive while symptomatic. Interview on 12/7/20 at 10:11 a.m., with licensed practical nurse (LPN)-A identified the resident screening process included having the nurse aides (NA) check the resident's temperature and oxygen saturations twice a day. The nurse then reviewed that limited information and signed off, vital signs were within normal limits. The nurse did not review a list of symptoms with each resident. She was not aware of any form or report the nurse fills out for identified infection symptoms except for residents who have been started on an antibiotic. The outbreak was on the the unit identified as "Park" which began on 11/19/20. All residents who had tested positive at that time were located on that unit. LPN-A confirmed if a resident was placed on TBP or if they notified the provider of potential symptoms, staff would have documented that information in the progress notes or on a fax to the provider. Interview on 12/7/20 at 10:38 a.m., with NA-E identified if a resident had diarrhea, NA staff were to report that information to the nurse. If a resident reported a cough or headache, the nurse would be notified. NA-E confirmed NA's do not place any precautionary TBP for a resident until a nurse was available to assess, and would not care for the resident differently by putting on droplet precautions PPE unless the nurse advised them to do so. Interview on 12/8/20 at 9:26 a.m., with TMA-A identified the only symptoms she identified as reportable to the nurse were if a resident was	F 880	SS of COVID " Weekly Resident COVID Symptoms The portion of the deficiency was corrected as of 12/10/20. Personal Protective Equipment Usage and Storage: Our policy titled Donning and Doffing Personal protective Equipment (PPE)-COVID 19 was reviewed for clarity regarding correct PPE to be worn in the COVID area. The staff person was re-trained on wearing goggles into the unit and performing hand hygiene when exiting unit. The Donning and Doffing policy for the Covid unit was additionally revised on 2/11/21 and staff will be re-educated on this policy by 3/12/21. Corrective action for those residents affected will be accomplished through training and re-education in policy going forward as the policy puts measures into place to ensure this will not occur in the future. The Director of Nursing, Infection Preventionist, or designee will audit compliance with the new policy on a weekly basis if there are residents in the Covid unit for 12 weeks and then on a schedule to be determined by the Quality Assurance committee. The facility contracted with an infection control consultant to provide consultation and oversight for infection prevention and control within the facility. With the assistance of the ICP Consultant, the facility is assessing, analyzing and reviewing processes, procedures and training as specified below: 1. Consultant was identified and name	

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F 880	Continued From page 7 "acting different" or was "warm to the touch". Interview on 12/8/20 at 9:57 a.m., with LPN-A identified residents were tested for COVID twice a week. If a resident was "doing horrible" she would contact the provider. If resident had other potential COVID symptoms like diarrhea, she would not notify the provider unless a resident would have a decline. When COVID first started, residents had to have 2 negative test results before coming off TBP, but she was unsure if that policy was in effect at the current time. Interview on 12/8/20 at 11:23 a.m., with registered nurse (RN)-B identified the facility process for determining if a resident can be taken off TBP as once a resident had tested positive, they would be on TBP for 14 days. If a resident tested negative they would need to be symptom free for 24 hours. At that time, staff would be able to remove TBP without physician oversight. RN-B confirmed when a resident had a negative test result, TBP were appropriate to remove after they had no symptoms for 24 hours. Review of the 4/30/20, CDC, Discontinuation of TBP for patients with COVID-19, in effect at the time of the survey, identified in order for TBP to be removed, for: 1. Symptom based strategy, at least 3 days must have passed since recovery and at least 10 days have passed since symptoms first appeared. 2. Test based strategy, resolution of a fever without the use of fever reducing medications and improvement in respiratory symptoms and negative results from at least 2 consecutive respiratory PCR specimens collected equal to or greater than 24 hours apart must occur.	F 880	and credentials were reviewed and provided, meeting the requirement of the DPOC by 1/15/2021. 2. Executed contract with ICP consultant by 1/15/2021. 3. The facility completed an infection control self-assessment with the ICP Consultant, LNHA, DON, and ICP by 1/21/21. 4. A root cause analysis of the survey findings was completed on 1/28/21 by ICP Consultant, LNHA, DON, ICP, Medical Director, a governing board member and management. 5. The ICP Consultant will review policies and procedures related to COVID and provide any recommended changes to the ICP, DON and LHNA. Completed by 3/12/21. 6. The DON, ICP and Administrator are meeting weekly with the contracted ICP beginning on 1/18/21 for two months. 7. The DON, ICP and LNHA with consultation from the ICP Consultant will prepare trainings for staff on any changes made to policies and procedures as a result of the work above and will maintain records of the content of the trainings, names and positions of staff to be trained, sign in sheets, and summary of post-test results. This will be completed 3/12/21. 8. The facility will provide training for the Infection Preventionist, the Director of Nursing, nursing leadership/management, and facility administration. The training will cover standard infection control practices, active surveillance, tracking and trending for a comprehensive infection control program. Training will be completed	

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F 880	Continued From page 8 Interview on 12/8/20 at 3:09 p.m., with administrator identified the facility has scheduled COVID testing twice a week on Tuesday and Fridays. COVID tests were sent to a contracted lab and the results were returned much faster than when they have had to send to a local hospital lab. The administrator identified the facility was unable to send specimens to the contracted lab for days not scheduled for testing. The administrator revealed she was unsure why the facility should test "every little symptom" as "just about anything could be a potential symptom of COVID". The administrator confirmed staff may be "missing some charting" but were doing the best they can with the staff they had. Interview on 12/8/20 at 3:44 p.m., with the director of nursing (DON) identified if a resident had potential symptoms of COVID the nurse would recheck the reported symptom, assess the resident, and monitor the resident for that shift. If there was still a concern staff would "run it by one of the staff at the daily stand up meeting" and implement TBP. She confirmed staff were to be charting in the progress notes to identify when and if TBP were implemented. The DON identified staff routinely didn't document as they practiced charting by exception. The DON indicated the facility had a report sheet from the daily stand-up meetings that should identify residents being monitored for symptoms. However, the facility staff was unable to locate any of those reports in her absence as she unable to be onsite at the time. The IP stepped into the role after the last staff IP resigned. The current IP was trained by the previous staff. The DON was aware the IP had not taken the infection preventionist course. The IP did work full time at the facility but had other responsibilities.	F 880	3/5/21. 9. An audit schedule has been developed to include the ICP, DON or designee to audit all IC processes weekly x 12 weeks, then monthly x 3 months then as directed by the Quality Assurance committee at the facility to assure ongoing to ensure the infection control program and components are being performed appropriately.	

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The DON indicated she "had been through thousands of meeting and either the IP or myself would be the one to decide if a resident can come off TBP". She agreed any implementation of TBP documentation was lacking.

Review of the Center for Clinical Standards and Quality/Survey and Certification Group memo, QSO-20-38-NH identified facilities must test residents and facility staff identified with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19, to prevent the transmission of COVID-19. Residents with signs and symptoms must be tested. While the test results are pending, residents with signs or symptoms should be placed on TBP in accordance with CDC guidance.

Review of the policy dated 8/28/19, Notification of Change in Condition Policy identified staff were to notify the provider for new onset illness or when a significant change occurred with a resident.

Review of the policy dated 3/27/19, Standard and Transmission Based Precautions policy identified the goal was to prevent spread of infection from resident to resident or to employees. The decision to place a resident on TBP would be done by the IP, the charge nurse, DON or designated nurse. The IDT (Inter-Departmental Team) would communicate initiation, duration, and termination of TBP during the daily meeting with department managers communicating with appropriate staff and affected departments.

PPE

Observation and interview on 12/7/20 at 11:05 a.m., in and outside the COVID unit with NA-F

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and licensed practical nurse (LPN)-A identified at the entrance to the COVID unit was a table before the closed doors with hand sanitizer. Signage on the door identified: "Stop do not enter, designated staff only, COVID unit". NA-F identified staff enter the unit at the beginning of their shift and stay on unit for the entire shift. NA-F stated a nurse would enter the unit to complete rounds on the residents and give medication such as insulin. At 11:14 a.m., LPN-A was observed to enter the unit without all appropriate PPE, she was not wearing eye protection. LPN-A walked to the desk area, placed her hand on the railing next to the desk, spoke to TMA-A briefly and exited the unit without performing hand hygiene.

SURVEILLANCE

Interview and document review on 12/7/20 at 12:24 p.m. with infection preventionist (IP) identified the COVID outbreak started 11/19/20, with a resident on the Park unit. Those residents were the first to test positive for COVID. The IP reported R19 was the only resident she was aware of, not on that wing who had potential symptoms, however R19's test results were negative. The IP confirmed residents who displayed any symptoms of COVID were not tested unless it was a scheduled test day in the facility. The only time they would test a resident outside of scheduled test days, would be if a provider ordered a test. The provider however, was not notified of potential symptom of COVID, such as diarrhea. Residents with any symptom should be placed on TBP and monitored. If symptoms were a 1 day occurrence with no further symptoms for 24 hours, staff were allowed to remove that resident from any TBP that may

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F 880	Continued From page 11 have been placed without contacting the provider for assessment of potential symptoms. The IP was unable to provide documentation of any residents with symptoms having been immediately placed on TBP. Review of the above 6 residents' progress notes with the IP reviewed identified she agreed none of the above mentioned residents had documentation of been placed on TBP with onset of symptoms. IP stated, "I guess we dropped the ball." The IP proceeded to identify only residents treated with antibiotics were documented by the charge nurse to the surveillance in the electronic charting system (Matrix). From the Matrix documentation, the IP transferred that information onto the IP line list. Review of the IC electronic surveillance line list with the IP identified October and November 2020 were blank. Review of the facility's Infection Control (IC) Program Surveillance documentation included an electronic line list for residents by month. The Infection Log columns identified only residents treated with antibiotics were tracked and monitored. The surveillance lacked documentation for any other symptoms of infection including any potential COVID symptoms. None of the residents above who were identified as positive for COVID were included. The surveillance lacked ongoing daily surveillance to track all types of infections, symptoms, and actions taken from tracking and trending illness. Continued interview and document review on 12/7/20 at 12:45 p.m. with the IP identified the resident COVID screening was done by the nursing assistants with the nurse reviewing that data. The NA documents the temperature and oxygen saturation on a paper log, the nurse then verifies it is within normal limits, and signs off on	F 880		

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the form. The nurse was only to document the presence of signs and symptoms of COVID in the resident progress notes, and was not expected to document the absence of symptoms. IP confirmed she had not completed infection preventionist training. She had been assigned the course, but not completed any of the modules. Review of the facility's Infection Control (IC) Program Surveillance documentation included an electronic line list for residents by month.

Further interview on 12/8/20 at 11:48 a.m., with the IP identified R35 was monitored on 11/19/20, with no TBP placed, and then tested the next day during routine testing. R35 had positive results for COVID on 11/23/20. If a resident had a fever, staff would give Tylenol and monitor to see if their fever resolved. Staff should contact the provider if the fever had not resolved and chart in the progress notes. The IP confirmed there was no documentation in R35's progress notes to identify TBP had been implemented at symptom onset. The IP identified R38 had been in TBP as a new admission but taken off after the 14 days. R38 had diarrhea identified by staff on 11/24/20, the same day as routine testing. No TBP were implemented . Staff had not identified R38's diarrhea as potential symptom of COVID-19. Review of other above mentioned residents with the IP identified she agreed there was no documentation to support TBP had been implemented when residents showed signs and symptoms of potential COVID. The IP indicated the facility "should have a spread sheet of some type to document symptoms and TBP". IP confirmed she relied on staff verbally keeping her updated, with discussion at the stand up meetings, and a review of progress notes. The IP identified she had "little training" when she took

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F 880	Continued From page 13 over the position approximately in March 2020, and had not completed the infection preventionist course. She revealed she only worked one day a week on the infection control program stating she felt that was "not enough time". Interview on 12/8/20 at 12:44 p.m., with medical director (MD) identified she had discussed the importance of documention previously with the facility. She required the facility to use the SBAR format for written communication. The facility would call her and fax her information at times, with her expectation being that information would be documented in the medical record. She was not aware of any residents with potential symptoms that were not being tested upon identification of symptom or placed on TBP. Her expectation would be if a resident developed symptoms the resident would be placed on TBP, the provider be notified, and the resident be immediately tested regardless if it was not a scheduled day for routine testing. A resident could have a negative test result one day and develop symptoms the next day and also test positive. Her expectation would be the facility followed current Centers for Disease Control (CDC) guidance. Review of the policy dated 3/27/19, Tracking Infections Amongst Staff/Residents Policy identified the goal was to track infections within the facility to help prevent the spread of infections. The IP, DON, or designated person was to track infections on an on-going basis, and look for trends between residents and staff illness. The IP was to review event reports weekly and if a trend was identified, the IP was review staff call-ins for similar symptoms. The policy made no mention how staff were to analyze data to mitigate outbreaks or ensure all potential IC	F 880		

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F 880	Continued From page 14 illness was included. The IJ was removed on 12/10/20 at 5:47 p.m., when it could be verified by observation, interview, and document review the facility had implemented education for staff to identify any and all COVID-19 symptoms, policy changes, and to initiate isolation and TBP for residents immediately at onset of symptoms of COVID-19. In addition, the facility updated its resident screening forms and surveillance tracking forms to document active surveillance on an ongoing cumulative daily basis.	F 880		
F 882 SS=F	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4)(c) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. §483.80 (c) IP participation on quality assessment and assurance committee. The individual designated as the IP, or at least	F 882		1/18/21

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F 882	Continued From page 15 one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the infection preventionist (IP) had completed specialized training in infection prevention and control. This had the potential to affect all 36 residents residing in the facility. Findings include: Interview on 12/7/20 at 12:24 p.m., with infection preventionist (IP)-A identified she started the IP position around March of 2020, and the position of IP as the person who was responsible for the surveillance. The IP identified she had minimal training and had not yet started formal infection preventionist training, but had opened the on-line course. Additional interview on 12/8/20 at 11:48 a.m., identified she stepped into the IP role when the last person resigned. She had little training when she took over the position in March 2020. She revealed she only worked one day a week on the infection control program identifying "there was not enough time". Interview on 12/8/20 at 3:44 p.m., with director of nursing (DON) identified the IP stepped into the infection control role when the last person resigned. The IP trained with that person. The DON confirmed the IP had not taken the infection preventionist course as "COVID hit around that time". The IP does work 40 hours a week at the	F 882	ID Tag F882: Employee IP-A submitted her resignation on 1-18-2021 IP position replaced with M.M., RN IP 1-18-2021 IPOC certification attached Due to nature of the deficiency, this practice had the potential to impact all residents and additional analysis of residents who could be impacted was not completed. The facility will add the completion of specialized training to the job description for the Infection Preventionist, ensuring that all future staff members hired into the role already have the necessary training or are provided it prior to beginning the role. The facility will monitor its corrective actions by auditing the education completed by the Infection Preventionist annually. The deficient practice was corrected 1-18-2021	

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F 882	Continued From page 16 facility but has other responsibilities. Review of IP training transcript Nursing Home Infection Preventionist Training Course MN.TRAIN (national learning management system for health care professionals) the IP had registered for identified no training modules had been started. A policy was requested, but not provided by the facility.	F 882		