Electronically delivered
September 10, 2021

Administrator
Southview Acres Healthcare Center
2000 Oakdale Avenue
West Saint Paul, MN 55118

RE: CCN: 245189
Cycle Start Date: August 18, 2021

Dear Administrator:

On August 10, 2021, we informed you of imposed enforcement remedies.

On August 18, 2021, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. 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. The most serious deficiencies in your facility were found to be a pattern of deficiencies that constituted immediate jeopardy (Level K), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY

On August 18, 2021, 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.

As a result of the survey findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 25, 2021, will remain in effect.

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

This Department continues to recommend 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 August 25, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 25, 2021.

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.

As we notified you in our letter of August 10, 2021, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), due to the extended survey the new NATCEP loss date is July 23, 2021.

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.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

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:

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 23, 2022 (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

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

Tamika.Brown@cms.hhs.gov

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

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

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

INFORMAL DISPUTE RESOLUTION/ 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

Electronically delivered
September 10, 2021

Administrator
Southview Acres Healthcare Center
2000 Oakdale Avenue
West Saint Paul, MN 55118

Re: State Nursing Home Licensing Orders
Event ID: OYXM11

Dear Administrator:

The above facility was surveyed on August 16, 2021 through August 18, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are

the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Terri Ament, Rapid Response
Licensing and Certification Program
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

DIRECTED PLAN OF CORRECTION -

A Directed Plan of Correction (DPOC) is imposed in accordance with 42 CFR § 488.424. Your facility must include the following in their POC for the deficient practice cited at F880:

In order to assist with identifying appropriate corrective actions and implementing systemic changes, the facility must contract with an independent infection control consultant OR an infection control consultant of the facility's corporation as long as the consultant has not worked with the facility on any infection control practices in the past 2 years period immediately preceding the deficient practice. The IC consultant will 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 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 consultant 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.

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).

- 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:

DIRECTED PLAN OF CORRECTION: 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 with assistance from the Infection Preventionist, with Governing Body oversight 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. 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

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, have an identified donning/doffing area.

- 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

RESOURCES:

Quality Improvement Organization (QIO) Program: https://www.superiorhealthqa.org.
CDC: Isolation Precautions Guideline:
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?C
Responding to Coronavirus (COVID-19) in Nursing Homes:
https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.htm
Strategies for Optimizing the Supply of N95 Respirators:
https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html
Strategies for Optimizing the Supply of Facemasks
https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/face-masks.html

Using Personal Protective Equipment PPE:
https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html
Principles for COVID-19 Cohorting in Long-term Care:
https://www.health.state.mn.us/diseases/coronavirus/hcp/ltcipchohort

MDH TOOL KIT:
COVID-19 Toolkit: Information for Long-term Care Facilities (state.mn.us)
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.htm

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 resident location daily to ensure transmission based precautions (TBP) are appropriately implemented when cohorting residents. The facility will decrease these audits as compliance for TBP are achieved.

- The Director of Nursing, Infection Preventionist or designee will review the results of audits, and monitoring with the Quality Assurance Program Improvement (QAPI) program.

QIO web link here: https://www.superiorhealthqa.org/

DIRECTED PLAN OF CORRECTION - 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 with assistance from

the Infection Preventionist, with Governing Body oversight 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. 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

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

- Review policies and procedures for donning/doffing PPE during COVID-19 with current guidelines to include crisis standard of care, contingency standard of care and standard care..
- Develop and implement a policy and procedure for source cotrol masks.
- Develop and implement a policy and procedure for proper use of gowns.
- 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 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.

RESOURCES:

Superior Health Quality Alliance:
https://www.superiorhealthqa.org/
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
Strategies for Optimizing the Supply of N95 Respirators:
https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html
Strategies for Optimizing the Supply of Facemasks
https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/face-masks.html
Using Personal Protective Equipment PPE:
https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html
Personal Protective Equipment (PPE) for Infection Control:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/ppe/index.html
ShapeMDH 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, and other facility leadership will conduct real time audits on proper use of gowns to ensure PPE is in use.

- The Director of Nursing, Infection Preventionist, or designee will review the results of audits and monitoring with the Quality Assurance Program Improvement (QAPI) program.

In accordance with 42 CFR § 488.402(f), the DPOC remedy is effective 15 calendar days from the date of the enforcement letter.

To successfully complete the DPOC, the facility must provide documentation to support evidence the DPOC was completed.

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

- A revisit will not be completed prior to receipt of documentation confirming the DPOC was completed.

- 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.

EPOC:

The ePOC system is programmed, so the facility cannot upload additional documents after MDH formally accepts the Plan of Correction through the EPOC system.

To resolve this, after the POC is received, and meets all the required POC components. The supervisor will reject the POC for F880 in the system, BUT will identify in the comment section, "POC accepted but waiting additional documents complete DPOC process."

By completing this process the ePOC portal opens for the facility to upload the final DPOC documents for review.

If additional information is required for the POC, the supervisor will identify this in the comment section.

Adding attachments DPOC:

When adding DPOC attachments, the software does not have a limit to the number of attachments, but each attachments cannot be greater than 4MB. If this occurs, the attachment will not upload in the ePOC system.

ASPEN web ePOC guide for providers:
https://qtso.cms.gov/system/files/qtso/ePOC-Fac_PG_11.9.4.2_FINAL.pdf

Training videos for ePOC provider: https://qtso.cms.gov/training-materials/epoc-providers

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

Use this for IJ

Item	Checklist: Documents Required for Successful Completion of the Directed Plan
1	Consultant name and credentials meeting the criteria outlined above and copy of executed contract with consultant.

2 Documentation demonstrating that the RCA was completed as described above
3 Documentation of the RCA and interventions/correction action plan were reviewed with QA committee and/or Governing Body President, with confirmation this was completed.
4 List of facility policies and procedures with any updates/changes.
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, include sign in sheets.
9 Summary of staff training post-test/competency results, to include facility actions in response to any failed post-tests.
10 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00102	A. BUILDING: _____ B. WING _____	C 08/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	2000 OAKDALE AVENUE WEST SAINT PAUL, MN 55118

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 8/16/21, through 8/18/21, a standard abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be OUT of compliance with the MN State Licensure. The following complaint was	2 000		

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	00102	A. BUILDING: _____ B. WING _____	C 08/18/2021

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2 000	Continued From page 1 UNSUBSTANTIATED: H5189199C (MN75541) However, as a result of the investigation a licensing order was issued at S1390. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of	2 000		

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2 000	Continued From page 2 state form	2 000		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow the Centers for Disease Control (CDC) guidelines to prevent	21390	Corrected	9/24/21

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21390	Continued From page 3 and/or minimize the transmission of COVID-19 related to failure to appropriately quarantine residents who had been directly exposed to COVID-19 for 4 of 18 residents (R1, R4, R5, and R6). In addition, failed to implement N95 respirators for 18 of 18 residents (R1, R4, R5, R6, R7, R8, R8, R9, R10, R11, R12, R13, R14, R15, R16, R17, R18, R19, and R20) who were quarantined due to direct exposure to COVID-19. This resulted in an immediate jeopardy (IJ) due to the increased risk for transmission of COVID-19. The IJ began on 8/05/21 when the facility failed to ensure residents who were in quarantine status due to an exposure to COVID-19 were not out of their room involved in activities with other residents, potentailly exposing them to COVID-19. Also, failed to implement transmission-based precautions (TBP) utilizing all necessary personal protective equipment (PPE) including N95 respirators, for R1 who was quarantined on 8/5/21, after being exposed to nursing assistant (NA)-A who had tested positive for COVID on 8/4/21. The facility administrator and director of nursing (DON) were notified of the IJ on 8/17/21, at 4:15 p.m. The IJ was removed on 8/18/21, at 1:42 p.m. but noncompliance remained at the lower scope and severity level of an E, pattern, no actual harm with potential for more than minimal harm that is not IJ. Findings include: Current CDC guidance dated 2/10/21, directed health care workers who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH-approved N95 or equivalent or higher-level respirator, gown, gloves, and eye protection.	21390		

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21390	Continued From page 4 R1's Face Sheet printed 8/18/21, indicated R1's diagnoses included left leg amputation, type 2 diabetes and had moderate cognitive impairment. On 8/3/21, NA-A had COVID-19 symptoms and she was tested for COVID-19 on 8/3/21, at 12:00 p.m. NA-A's lab results confirmed she was COVID-19 positive on 8/4/21, at 8:04 a.m. NA-A's positive test results was reported to the facility on 8/4/21, at 9:58 p.m.. NA-A's schedule indicated NA-A worked shifts from 7:00 a.m. to 3:15 p.m. on 8/2/21, 8/3/21, and 8/4/21. NA-A cared for R1. In addition, NA-A also cared for residents in group five on two skilled south (R4, R5, R6, R7, R8, R8, R9, R10, R11) and group three on two skilled center (R12, R13, R14, R15, R16, R17, R18, R19 and R20). Facility staffing unit records indicated R1 had a high-risk exposure to a positive COVID-19 staff (NA-A) on 8/3/21, and was placed on quarantine. Facility conducted contact tracing which revealed the 17 additional residents with possible exposure from NA-A and were placed on quarantine. On 8/16/21, at 10:27 a.m. R1 was observed in his wheelchair with no mask on across from the nursing station next to the tv room with several other residents in the tv room and in the hallways. Staff did not intervene to encourage R1 back to his room or to don a surgical mask. Registered nurse (RN)-D was interviewed and stated R1 was on quarantine and staff were to bring him to his room when he came out. RN-D stated if R1 did come out of his room, staff were to encourage R1 to wear a mask. On 8/16/21, between 2:32 p.m. to 2:44 p.m.	21390		

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21390	Continued From page 5	21390		

observations made of two north unit revealing all the transmission-based precaution bins did not have N95 respirators.

On 8/16/21, at 11:09 a.m. RN-B was observed less than six feet from R4 and R5 in the resident hallway tending to R4's bleeding boil. R4 and R5 had been exposed to COVID-19 from NA-A, and should have been on quarantine. RN-B was not wearing eye protection. In a subsequent interview, RN-B confirmed she did not have her eye protection on when she was within 6 feet of R4 and R5.

On 8/16/21, at 12:51 p.m. R1 was observed holding the hand of R6 in front of the nurse's station next to the tv room with a surgical mask under his chin. R6 did not have a mask on, and R1 and R6 were less than six feet apart from each other. Staff then encouraged R1 to pull up his surgical mask over his nose but did not encourage him to go back to his room. Both R1 and R6 had been exposed to COVID-19 from NA-A, and should have been on quarantine.

On 8/16/21, at 2:21 p.m. NA-B was observed coming down the TCU resident hallway (two residents in quarantine on this unit) towards the main entrance check-in site with no eye protection. In a subsequent interview, NA-B confirmed she did not have her eye protection on.

On 8/16/21, at 2:32 p.m. NA-C was observed within the resident hallways of the TCU with no eye protection on, and NA-C confirmed she did not have eye protection.

During interview on 8/16/21, at 3:17 p.m. the DON confirmed not all staff had been fit tested for N95 respirators. The DON stated staff were not

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21390	Continued From page 6 wearing N95 respirators unless they were doing aerosol generating procedures. The DON stated she was unsure if staff were to wear N95 respirators when providing close cares for residents on quarantine. The DON stated the facility did have N95 respirators available, and some staff had been fit tested. On 8/17/21, at 2:28 p.m. RN-E stated N95 respirators should be worn when providing direct cares for a resident on quarantine. On 8/17/21, at 3:00 p.m. the DON stated staff were not consistently wearing N95 respirators when doing cares for residents on quarantine. The facility policy Personal Protective Equipment - Using Face Masks last revised on 8/17/21, directed staff on when to don eye protection and N95 respirators as follows: Equipment and Supplies 1. High-efficiency disposable masks (surgical/medical grade); 2. Eyewear (e.g., goggles) (Note: When the use of a mask is indicated, appropriate eyewear must also be worn.). When to Use a Mask 4. N95 mask or higher must be worn when caring for COVID positive residents, during aerosol treatments, while residents are in quarantine and during facility outbreaks. The IJ was removed on 8/19/21, at 1:42 p.m. when it was verified through observation, staff interviews and document review the facility educated staff on quarantine and the use of N95 respirators and began fit-testing direct care staff who would be wearing N95 respirators, and the facility supplied N95 respirators for staff to use.	21390		

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21390	Continued From page 7 SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could review/revise facility policies to ensure they contain all components of an infection control program, including daily cumulative tracking and trending of all illnesses in the facility, immediate implementation of droplet precautions to mitigate COVID-19 transmission, ensure the appropriate use of PPE, and prevent staff from working with symptoms of COVID-19. The DON or designee could educate all staff on existing or revised policies and perform audits to ensure the policies are being followed. The results of those audits should be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. Time Period for Correction: Twenty-one (21) days.	21390		

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E 000	Initial Comments On 8/16/21, through 8/18/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a focused infection control survey. The facility was NOT in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 8/16/21, through 8/18/21, a standard abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH). The facility was found NOT to be in compliance with the requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. The survey resulted in an immediate jeopardy (IJ) to resident health and safety (F880). The IJ began on 8/4/21, when the failed to ensure staff were wearing N95s when caring for residents with COVID-19 or those under quarantine. The director of nursing (DON) and administrator were notified of the IJ on 8/17/21, 4:15 p.m. The IJ was removed on 8/18/21, at 1:42 p.m. The following complaint was UNSUBSTANTIATED: H5189199C (MN75541) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are	F 000		

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

Electronically Signed | 09/20/2021

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F 000	Continued From page 1 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, an on-site revisit of your facility may be conducted to validate that 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: §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:	F 880		9/24/21

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F 880	Continued From page 2 (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 IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 880		

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F 880	Continued From page 3 Based on observation, interview, and document review, the facility failed to follow the Centers for Disease Control (CDC) guidelines to prevent and/or minimize the transmission of COVID-19 related to failure to appropriately quarantine residents who had been directly exposed to COVID-19 for 4 of 18 residents (R1, R4, R5, and R6). In addition, failed to implement N95 respirators for 18 of 18 residents (R1, R4, R5, R6, R7, R8, R8, R9, R10, R11, R12, R13, R14, R15, R16, R17, R18, R19, and R20) who were quarantined due to direct exposure to COVID-19. This resulted in an immediate jeopardy (IJ) due to the increased risk for transmission of COVID-19. The IJ began on 8/4/21 when the facility failed to ensure residents who were in quarantine status due to an exposure to COVID-19 were not out of their room involved in activities with other residents, potentailly exposing them to COVID-19. Also, failed to implement transmission-based precautions (TBP) utilizing all necessary personal protective equipment (PPE) including N95 respirators, for R1 who was quarantined on 8/5/21, after being exposed to nursing assistant (NA)-A who had tested positive for COVID on 8/4/21. The facility administrator and director of nursing (DON) were notified of the IJ on 8/17/21, at 4:15 p.m. The IJ was removed on 8/18/21, at 1:42 p.m. but noncompliance remained at the lower scope and severity level of an E, pattern, no actual harm with potential for more than minimal harm that is not IJ. Findings include: Current CDC guidance dated 2/10/21, directed health care workers who enter the room of a patient with suspected or confirmed SARS-CoV-2	F 880	F 880 R 1, R 4, R 5, and R 6 were placed in quarantine and were assessed for COVID-19 symptoms. No ill effects were experienced for this deficient practice. For R 1, R 4, R 5, and R 6, their respiratory COVID care plans were reviewed and updated as needed. Resident refusals of mask wearing will be documented. The MD was made aware of this deficient practice. R 1, R 4, R 5, R 6, R 7, R 8, R 9, R 10, R 11, R 12, R 13, R 14, R 15, R 16, R 17, R 18, R 19 and R20 remained in quarantine and were assessed for COVID-19 symptoms and no ill effects were experienced for this deficient practice. R 1, R 4, R 5, R 6, R 7, R 8, R 9, R 10, R 11, R 12, R 13, R 14, R 15, R 16, R 17, R 18, R 19 and R20 their respiratory COVID care plans were reviewed and updated as needed. Resident refusals of wearing a mask will be documented. The MD was made aware of this deficient practice. All residents in quarantine were educated to remain in their rooms while in quarantine and to wear a mask when in the common areas of the facility. Future residents will be educated upon admission on the mask wearing procedure, a respiratory care plan will be initiated and masks will be provided for wear. Future residents will also be placed in the appropriate transmission based precautions with room door/signage indicating status along with PPE bin. Facility staff were in-serviced on the PPE Using Face Mask Policy and Procedure with emphasis on item #9 that N95 or	

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F 880	Continued From page 4 infection should adhere to Standard Precautions and use a NIOSH-approved N95 or equivalent or higher-level respirator, gown, gloves, and eye protection. R1's Face Sheet printed 8/18/21, indicated R1's diagnoses included left leg amputation, type 2 diabetes and had moderate cognitive impairment. On 8/3/21, NA-A had COVID-19 symptoms and she was tested for COVID-19 on 8/3/21, at 12:00 p.m. NA-A's lab results confirmed she was COVID-19 positive on 8/4/21, at 8:04 a.m. NA-A's positive test results was reported to the facility on 8/4/21, at 9:58 p.m.. NA-A's schedule indicated NA-A worked shifts from 7:00 a.m. to 3:15 p.m. on 8/2/21, 8/3/21, and 8/4/21. NA-A cared for R1. In addition, NA-A also cared for residents in group five on two skilled south (R4, R5, R6, R7, R8, R8, R9, R10, R11) and group three on two skilled center (R12, R13, R14, R15, R16, R17, R18, R19 and R20). Facility staffing unit records indicated R1 had a high-risk exposure to a positive COVID-19 staff (NA-A) on 8/3/21, and was placed on quarantine. Facility conducted contact tracing which revealed the 17 additional residents with possible exposure from NA-A and were placed on quarantine. On 8/16/21, at 10:27 a.m. R1 was observed in his wheelchair with no mask on across from the nursing station next to the tv room with several other residents in the tv room and in the hallways. Staff did not intervene to encourage R1 back to his room or to don a surgical mask. Registered nurse (RN)-D was interviewed and stated R1 was on quarantine and staff were to bring him to his	F 880	higher must be used during, quarantine, aerosol treatments and for COVID positive residents. Nursing staff was also in-serviced on the COVID 19 facility guidelines item# 26 and on the MDH COVID-19 PPE Grid for congregate facilities. N-95 Fit testing began for facility staff on 8/18/2021 and will be ongoing. A directed plan of correction will be developed utilizing an outside consultant to review and identify a root cause for this deficiency. Once identified, a plan will be readily implemented and executed per the consultant direction. The infection preventionist along with the director of nursing will review cohorting of residents with a focus on identifying a unit or location for residents who may be exposed or have symptoms of COVID, education to residents on remaining in their rooms while in quarantine and if they leave the room, they must wear a mask and provide dedicated equipment for use. The Director of Nursing and Infection Preventionist is responsible for facility compliance. Audits on Donning and Doffing of PPE, aerosolized generating procedures in real time, N-95 mask wearing during quarantine and resident mask compliance while in the facility common areas will begin on all shifts 4x a week for one week, then twice weekly for one week until 100% compliance is met. All audits will be reviewed by the Administration and the Administrator will	

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	245189	A. BUILDING _____ B. WING _____	C 08/18/2021

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F 880	Continued From page 5 room when he came out. RN-D stated if R1 did come out of his room, staff were to encourage R1 to wear a mask. On 8/16/21, between 2:32 p.m. to 2:44 p.m. observations made of two north unit revealing all the transmission-based precaution bins did not have N95 respirators. On 8/16/21, at 11:09 a.m. RN-B was observed less than six feet from R4 and R5 in the resident hallway tending to R4's bleeding boil. R4 and R5 had been exposed to COVID-19 from NA-A, and should have been on quarantine. RN-B was not wearing eye protection. In a subsequent interview, RN-B confirmed she did not have her eye protection on when she was within 6 feet of R4 and R5. On 8/16/21, at 12:51 p.m. R1 was observed holding the hand of R6 in front of the nurse's station next to the tv room with a surgical mask under his chin. R6 did not have a mask on, and R1 and R6 were less than six feet apart from each other. Staff then encouraged R1 to pull up his surgical mask over his nose but did not encourage him to go back to his room. Both R1 and R6 had been exposed to COVID-19 from NA-A, and should have been on quarantine. On 8/16/21, at 2:21 p.m. NA-B was observed coming down the TCU resident hallway (two residents in quarantine on this unit) towards the main entrance check-in site with no eye protection. In a subsequent interview, NA-B confirmed she did not have her eye protection on. On 8/16/21, at 2:32 p.m. NA-C was observed within the resident hallways of the TCU with no	F 880	present audit results to QAPI and the Governing Board for review and recommendation. Compliance: 9/24/2021	

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F 880	Continued From page 6	F 880		

eye protection on, and NA-C confirmed she did not have eye protection.

During interview on 8/16/21, at 3:17 p.m. the DON confirmed not all staff had been fit tested for N95 respirators. The DON stated staff were not wearing N95 respirators unless they were doing aerosol generating procedures. The DON stated she was unsure if staff were to wear N95 respirators when providing close cares for residents on quarantine. The DON stated the facility did have N95 respirators available, and some staff had been fit tested.

On 8/17/21, at 2:28 p.m. RN-E stated N95 respirators should be worn when providing direct cares for a resident on quarantine.

On 8/17/21, at 3:00 p.m. the DON stated staff were not consistently wearing N95 respirators when doing cares for residents on quarantine.

The facility policy Personal Protective Equipment - Using Face Masks last revised on 8/17/21, directed staff on when to don eye protection and N95 respirators as follows:
Equipment and Supplies
1. High-efficiency disposable masks (surgical/medical grade);
2. Eyewear (e.g., goggles) (Note: When the use of a mask is indicated, appropriate eyewear must also be worn.).
When to Use a Mask
4. N95 mask or higher must be worn when caring for COVID positive residents, during aerosol treatments, while residents are in quarantine and during facility outbreaks.

The IJ was removed on 8/19/21, at 1:42 p.m.

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F 880	Continued From page 7 when it was verified through observation, staff interviews and document review the facility educated staff on quarantine and the use of N95 respirators and began fit-testing direct care staff who would be wearing N95 respirators, and the facility supplied N95 respirators for staff to use.	F 880		