DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 7, 2020

Administrator
Samaritan Bethany Home On Eighth
24 - 8th Street Northwest
Rochester, MN 55901

RE: CCN: 245530
Survey Start Date: May 7, 2020

Dear Administrator:

On July 1, 2020 the Minnesota Department(s) of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of June 23, 2020. Per the CMS Memo QSO-20-20-All, enforcement remedies were suspended from March 23, 2020 to May 31, 2020 and will be evaluated at a later date.

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

Feel free to contact me if you have questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Electronically delivered
May 29, 2020

Administrator
Samaritan Bethany Home On Eighth
24 - 8th Street Northwest
Rochester, MN 55901

SUBJECT: SURVEY RESULTS
CCN: 245530
Cycle Start Date: May 7, 2020

Dear Administrator:

SUSPENSION OF SURVEY AND ENFORCEMENT ACTIVITIES

The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with Memorandum QSO-20-20-All, CMS is suspending certain Federal and State Survey Agency surveys, and delaying revisit surveys, for all certified provider and supplier types.

During this time, CMS is prioritizing and conducting only the following surveys: focused infection control surveys, investigations of complaints and facility-reported incidents that are triaged at the Immediate Jeopardy (IJ) level, and revisit surveys for unremoved IJ level deficiencies. With the exception of unremoved IJs, CMS will also be exercising enforcement discretion during the suspension period. For additional information on the prioritization of survey activities please visit https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0.

SURVEY RESULTS

On May 7, 2020, the Minnesota Department of Health completed a COVID-19 Focused Survey at Samaritan Bethany Home On Eighth to determine if your facility was in compliance with Federal requirements related to implementing proper infection prevention and control practices to prevent the development and transmission of COVID-19. The survey revealed that your facility was not in substantial compliance. The findings from this survey are documented on the electronically delivered CMS 2567.

PLAN OF CORRECTION

You must submit an acceptable electronic plan of correction (ePOC) for the enclosed deficiencies that were cited during the May 7, 2020 survey. Samaritan Bethany Home On Eighth may choose to delay submission of an ePOC until after the survey and enforcement suspensions have been lifted. The

provider will have ten days from the date the suspensions are lifted to submit an ePOC. 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. Please note that if an onsite revisit is required, the revisit will be delayed until after survey and enforcement suspensions are lifted. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation.

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; and
- The date that each deficiency will be corrected.

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

Jennifer Kolsrud Brown, Unit Supervisor
Fax: (507) 206-2711
Email: jennifer.kolsrud@state.mn.us

INFORMAL DISPUTE RESOLUTION

You have one opportunity to dispute the deficiencies cited on the May 7, 2020 survey through Informal Dispute Resolution (IDR) in accordance with 42 CFR § 488.331. To receive an IDR, send (1) your written request, (2) the specific deficiencies being disputed, (3) an explanation of why you are disputing those deficiencies, and (4) supporting documentation by fax or email to:

Jennifer Kolsrud Brown, Unit Supervisor
Fax: (507) 206-2711
Email: jennifer.kolsrud@state.mn.us

An IDR may not be used to challenge any aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

An IDR, including any face-to-face meetings, constitutes an informal administrative process that in no way is to be construed as a formal evidentiary hearing. If you wish to be accompanied by counsel for your IDR, then you must indicate that in your written request for informal dispute resolution.

Samaritan Bethany Home On Eighth may choose to delay a request for an IDR until after the survey and enforcement suspensions have been lifted. The provider will have ten days from the date the suspensions are lifted to submit a request for an IDR in accordance with the instructions above.

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES

The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at https://qioprogram.org/. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at https://qioprogram.org/locate-your-qio.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245530	A. BUILDING _____ B. WING _____	C 05/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAMARITAN BETHANY HOME ON EIGHTH	**24 - 8TH STREET NORTHWEST ROCHESTER, MN 55901**

(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 5/6/2020 and 5/7/2020 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 5/6/2020 and 5/7/2020 at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was not in full compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Upon receipt of an acceptable electronic POC, a revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form.	F 000		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an	F 880		6/15/20

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

Electronically Signed | 06/05/2020

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 880	Continued From page 1 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: (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	F 880		

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F 880	Continued From page 2 (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: Based on observation, interview, and document review the facility failed to follow/implement transmission-based precautions for 5 of 5 residents (R1,R2, R3, R4, R5) admitted/readmitted from a hospital/appointment or became symptomatic. In addition, the facility failed to document infection control (IC) surveillance activities for purposes of analysis in the event of an infectious outbreak. These practices had the potential to effect all 140 residents and staff in the facility. Findings include: Definitions:	F 880	F880 Samaritan Bethany strives to ensure that the facility's infection control program is designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The facility's infection prevention and control program's goal is to prevent, identify, report, investigate, and control infections and communicable diseases for all residents, staff volunteers, visitors, and other individuals providing services under a contractual arrangement	

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F 880	Continued From page 3 Transmission based precautions are the second tier of basic infection control and are to be used in addition to Standard Precautions for patients who may be infected or colonized with certain infectious agents for which additional precautions are needed to prevent infection transmission Standard precautions are used for all patient care. They are based on a risk assessment and make use of common sense practices and personal protective equipment use that protect healthcare providers from infection and prevent the spread of infection from patient to patient R3-Became Symptomatic R3's Admission record, included diagnosis of Parkinson's disease, history of diseases of digestive system, and gastroesophageal reflux disease. R3's Daily Resident Symptom screening indicated on Friday 5/1, documentation indicated R3 had diarrhea" and was "new or worsening". A hand written note dated 5/1/2020, included "Resident has GERD and other diseases of the digestive system, which could cause diarrhea, or something she eat." The record did not have any further mention, assessment, physician notification, or increased monitoring for symptoms. During an observation on 5/6/2020, at 10:45 a.m. R3 sat in her wheelchair next to her bed with a large pink bowel up to her face. During an interview on 5/6/2020, at 10:46 a.m. NA-C stated R3 had vomited about 20-30 minutes ago, the other NA-D had reported to the	F 880	based upon the facility assessment. The facility's standards, policies, and procedures for the program identify when and how isolation should be used for a resident. R1 R1 moved out of the facility on 5/8/2020, prior to receiving 2567. R2 R2 moved out of the facility on 5/8/2020, prior to receiving 2567. R3 On 5/1/2020 documentation indicated R3 had diarrhea that was new or worsening, without further mention, assessment, physician notification or increased monitoring for symptoms. On 5/6/2020 R3 had vomited after eating an apple. The CNP was notified and conducted a telehealth visit at 11:30am with resident. CNP said to observe for any more emesis's or changes in resident and did not feel COVID-19 test was warranted at that time. Temperature was 97.2 at time of telehealth visit. This was an isolated episode and the resident did not have any other symptoms. Due to vomiting not being listed as a symptom on the CDC website at the current time of the symptom, droplet precautions were not initiated at the time of the symptom. Clinical Mentor notified RN-A on 5/6/2020 to immediately implement droplet precautions for R3 upon learning about vomiting episode. Resident had COVID-19 test on 5/6/2020 with negative results on 5/7/2020. R4 On 5/6/2020 it was observed that R4 had	

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F 880	Continued From page 4 licensed practical nurse (LPN)-C. NA-C indicated transmission based precautions had not been implemented. During an interview on 5/6/2020, at 10:48 a.m. NA-D confirmed R3 had vomited about 20-30 minutes ago and R3 did not have a history of nausea and vomiting. NA-D stated the nurse was notified and indicated transmission based precautions had not been implemented. During an interview on 5/6/2020, at 10:50 a.m. LPN-C stated she updated registered nurse (RN) -A, R3 vomited. LPN-C indicated R3 did not normally have nausea and vomiting. LPN-C stated prior to R3 vomiting she ate an apple, and right before R3 vomited LPN-C had taken her vital signs and temperature, which were within normal ranges. LPN-C stated the plan was to notify the physician and continue to monitor. LPN-C stated nausea/vomiting was not a symptom of COVID-19 and since R3 was already isolated, transmission based precautions would not be implemented. During an interview on 5/6/2020, at 10:55 a.m. RN-A stated the physician was made aware of R3's vomiting. RN-A indicated nausea and vomiting were not symptoms of COVID, stated R3 would stay in her room, implement universal precautions. RN-A stated universal precautions consisted of a facemask and gloves upon entering R3's room. During a subsequent observation and interview on 5/6/2020, at 12:45 p.m. R3 sat in her wheelchair in her room with lunch tray in front of her. R3's elbow was on the tray table; she rested the side of her head in her open hand, and was	F 880	a sign on their door indicting they were on 14 day isolation, but no other signage. RN-B stated R4 was on droplet precautions related to leaving the facility for an outside appointment. RN-B stated staff were supposed to enter the room with full PPE; gloves, mask, gown, and eye protection. Resident remained asymptomatic during entire 14 day isolation. R5 On 5/1/2020 it was reported that resident had loose watery stool. Physician notified and ordered COVID-19 test, C-Diff test and isolation precautions. Droplet precautions were implemented on 5/1/2020 as noted in progress note at 5:04pm. A progress note on 5/5/2020 at 10:42am indicated that C-Diff results were negative, indicating contact precautions to be discontinued. On 5/6/2020 it was observed that R5 had a sign on their door indicting they were on 14 day isolation, but no other signage. NA-C stated R5 was on droplet precautions because R5 had been readmitted from the hospital; NA-C stated staff were supposed to wear gown, gloves, mask, and eye protection before entering the room. The PPE cart outside of R5's room did not contain all of the necessary PPE. The cart was restocked with proper PPE. The facility's infection control surveillance log did not identify if and/or when transmission based precautions were implemented when residents demonstrated symptoms of illness for R1, R2 R3, R4, and R5. The logs also did not identify the date the identified symptoms	

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F 880	Continued From page 5 not eating. NA-E stated she had just started her shift, was aware that R3 had vomited earlier, and was not informed or directed to use any transmission-based precautions. NA-E stated R3 did not have a history of nausea/vomiting and that was not her baseline. Rehab Unit- During an observation and interview on 5/6/2020, at 8:43 a.m., licensed practical nurse (LPN)-A said new admissions were quarantined for 14 days; signs were placed on the resident's door that indicated to "see a nurse" and identified the date the "stay at home" ended. Surveyor observed 2 rooms that had signs on door for R1 and R2. LPN-A stated the new admissions were allowed to come out for therapy sessions wearing a mask. LPN-A stated no personal protective equipment required to enter the new admit rooms. LPN-A wore a cloth mask and stated staff were provided a clean cloth mask at the beginning of your shift; the same masks was worn into all the quarantined resident rooms. LPN-A stated new admissions and other residents are screened daily and if residents display symptoms, she would report to the registered nurse and residents would be put on precautions and tested. LPN-A stated no residents on this unit currently displayed symptoms. During an observation and interview on the rehab unit on 5/6/2020, at 9:16 a.m., nursing assistant (NA)-A was wearing cloth mask. NA-A stated no personal protective equipment other than cloth mask was required to enter new admission rooms. NA-A stated that only residents with symptoms or positive COVID are required to wear	F 880	resolved. Lists were created for PPE carts indicating the proper PPE needed for 14 day isolation and transmission based precautions. Staff will wear proper PPE as indicated above including surgical masks, eye protection, gloves and a gown for residents on 14 day isolation. New signs have been created for residents on transmission-based precautions indicating the PPE needed to enter the room. Donning and doffing signs have been created for residents on transmission-based precautions. Facility policies have been updated to require a progress note stating when transmission-based precautions were implemented, what type of precautions, when symptoms resolve, and when precautions are discontinued. The facility's infection control surveillance log will identify the date symptoms resolved. Daily resident symptom screening will be updated 6/8/2020 to include all symptoms of COVID-19 now listed on the CDC website and MDH toolkit. Education will be provided to all nursing staff on symptom notification, PPE usage and signage. Licensed nurses will also receive education on the implementation and documentation of transmission based precautions. Education sessions will occur on 6/9/2020, 6/10/2020 and 6/12/2020. All staff meetings will occur on 6/9/2020 to review F880 and the associated plan of correction. RN reviews resident symptoms screening daily for fever and any new or worsening symptoms. Clinical Mentor or Assistant	

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F 880	Continued From page 6 personal protective equipment. R1 R1's Move in Record, identified R1 was admitted from a hospital to the facilities rehab unit on 4/23/2020, and included diagnoses of Parkinson's disease, dysphagia, atrial fibrillation, osteoporosis, hypertension, malignant melanoma of skin, obstructive sleep apnea, and malignant neoplasm of axilla and upper limb lymph nodes. R1's Daily Resident Symptom Screening, included screening for temperature, oxygen saturation, cough, shortness of breath, and diarrhea. The symptom screeners were reviewed in conjunction with medication administration records and progress notes. R1's record lacked an evaluation and increased symptom monitoring after the development of loose stools. -Symptom Screen for 4/29/2020, indicated a hand written notation at the bottom of the form included, "loose stool charted x 1." -Symptom Screen for 4/30/2020, indicated a hand written notation at the bottom of the form included, "Diarrhea charted 2x-over the night and during the day." -Symptom Screen for 5/1/2020, indicated "yes" R1 had diarrhea that was a new symptom. According to progress note dated 5/1/2020 at 3:58 p.m., R1 had "some diarrhea". -R1's progress note dated 5/2/2020 at 2:50 p.m. indicated R1 is forgetful about current restrictions regarding COVID-19 and keeps coming out of room with diarrhea symptoms. -A hand written note dated 5/4, included, "...resident reported formed BM yesterday [5/3/2020]."	F 880	Clinical Mentor reviews weekly to ensure policies were followed. Audits will be completed for three months by Community Leader, Clinical Mentor, and Assistant Clinical Mentor to ensure proper PPE usage, signage, and documentation of implementation and discontinuation for transmission based precautions, along with resolution date of symptoms. Community Leader and Clinical Mentor will monitor for compliance. Findings will be reported at Quality Assurance Committee meetings. Date of completion: 6/15/2020	

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F 880	Continued From page 7 R1's record did not address transmission-based precautions after R1 had loose stools/diarrhea for 3 days. R2 R2's AVS dated, 5/1/2020 indicated R2 was discharged from the hospital on 5/1/2020. According to the AVS, R2 was tested for SARS Coronavirus on 4/28/2020 and results were undetected. R2's Move in Record, identified R2's was admitted to the rehab unit with diagnoses that included diabetes, atrial fibrillation, and hypertension. R2's Daily Resident Symptom Screening indicated R2 had a temperature of 99.5 degrees Fahrenheit on 5/2/2020. R2's record lacked evidence of further evaluation of the increase in body temperature, and no increase in symptom monitoring was evident. R2's record did not address transmission-based precautions even after elevation in temperature. R5-no signage or isolation cart -different unit During an observation and interview on 5/6/2020, at 10:50 a.m., R5's room had a sign posted on the door that included, "I am staying home until 5/12/2020", and no other signage was posted. NA-C stated R5 was on droplet precautions because R5 had been readmitted from the hospital; NA-C stated staff were supposed to wear gown, gloves, mask, and eye protection before entering R5's room but confirmed the	F 880		

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F 880	Continued From page 8	F 880		

identification of the necessary droplet precautions was not posted outside R5's room. The cart that was parked outside of the room did not contain all of the necessary PPE to enter the room. NA-C stated staff had been using hospital gowns prior.

According to Hospital after Visit Summary (AVS), R5 was hospitalized on 4/13/2020 and discharged back to the facility on 4/28/2020. The AVS indicated R5 was free from communicable diseases and COVID testing was negative on 4/14/2020.

R5's Move in Record dated, indicated R5 was readmitted to the facility on 4/28/2020, and included diagnoses of acute respiratory failure. The record also included diagnoses of dysphagia (difficulty swallowing), heart failure, history of stroke, and dementia.

Progress note dated 5/1/2020 at 3:39 p.m. included, "it was reported to me this afternoon that resident had loose watery stool that was foul smelling like "starch" per caregiver. Reported to CC [sic]" A subsequent progress note at 3:49 p.m. indicated that R5 had loose watery stool twice with a reported decline in intake "today". The note indicated physician orders were obtained for Covid test, Clostridium Difficile (C-Diff) test, and isolation precautions. A note at 4:58 p.m. directed staff to take vital signs three times a day with parameters on when to contact physician. A note at 5:04 p.m. indicated R5 was only on droplet precautions until the test came back.

Progress note dated 5/2/2020, at 12:20 p.m. included "...resident is negative for Covid-19 at this time. Will discontinue the droplet precautions.

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	245530	A. BUILDING _____ B. WING _____	C 05/07/2020

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SAMARITAN BETHANY HOME ON EIGHTH	24 - 8TH STREET NORTHWEST ROCHESTER, MN 55901

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Still waiting for C-Diff results to come back." At 2:33 p.m. progress note indicated R5 was on contact precautions because the C-Diff test was still pending. Progress notes on 5/4 indicated a second stool sample had been sent out that morning; a subsequent note at 10:42 a.m. indicated R5's C-Diff results were negative. The record did not identify when contact precautions were discontinued and current droplet precautions were implemented as stated per staff interview on 5/6.

R4-no signage- different unit

During an observation and interview on 5/6/2020, at 11:50 a.m. R4's room had a sign posted on the door that included "I am staying home until 5/8/2020," no other signage was posted. RN-B stated R4 was on droplet precautions related to leaving the facility for an outside appointment. RN-B stated staff were supposed to enter the room with full PPE; gloves, mask, gown, and eye protection. RN-B indicated all residents who leave the facility for appointments or hospital returns were put on quarantine for 14 days and monitored for the onset of COVID symptoms.

During an interview on 5/6/2020, at 12:30 p.m., LPN-B stated residents screened daily for symptoms and vital signs. LPN-B stated if resident reports yes or symptoms are seen, those residents are put on isolation precautions and a nurse and nurse practitioner is notified. LPN-B stated staff take in consideration of those with pre-existing conditions that have similar symptoms. LPN-B stated a personal protective equipment cart is placed outside a resident room and a sign on the door is placed to notify staff. LPN-B stated gown supplies has been down and

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staff had to wear garbage bags in the past.

During an interview on 5/6/2020, at 12:50 p.m. director of nursing (DON) said R3 would continue to monitor and evaluate for nausea/vomiting causes and did not require implementation of transmission based precautions because nausea/vomiting was not a symptom of COVID-19 and that [name] Clinic also did not recognize nausea/vomiting as a symptom. However, appropriate precautions would be implemented. DON also indicated the facility expected staff to only wear a cloth face mask when they entered into resident rooms or assisting residents who were on quarantine related to admission. DON indicated the facility was following the guidance that was outlined on a CDC bulletin for admissions to congregate living.

During review of the facility's infection control surveillance log included names of residents, location of residents, illness symptoms, date of symptom onset, and testing procedure completed. The log did not identify if and/or when transmission based precautions were implemented when residents demonstrated symptoms of illness for R1, R2, R3, R4, R5. The logs also did not identify the date the identified illness symptoms resolved.

During an interview on 5/7/2020, at 11:33 a.m. DON indicated she was responsible for the infection control program. DON confirmed the surveillance logs did not identify if transmission based precautions were implemented, and has not historically documented when precautions were initiated, what type of precautions used, or when precautions were discontinued. DON also verified the type of precautions if any used was

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not documented in the resident's record. DON stated staff would implement precautions based on the symptom screen; for failed screen (fever over 100.0 degrees, new shortness of breath, or cough) they would implement droplet precautions and notify the provider.

Minnesota Department of Health (MDH) Interim Guidance for Hospital Discharge to Home or Admission to Congregate Living Settings and Discontinuing Transmission-Based Precautions dated 5/2/2020, included the following,
-Patients investigated for possible COVID-19 with a negative test: Patients investigated for possible COVID-19 due to onset of concerning signs or symptoms or change in health status who have a negative COVID-19 test can be discharged from a hospital to a congregate setting. All recommended PPE (facemask, eye protection, gloves, and gown) should be worn during care of residents under observation, when PPE supplies allow. At minimum, staff should wear facemask and eye protection during care. Cloth face coverings are not considered PPE.
-At this time, patients with no clinical concern (e.g., no presence of symptoms consistent with COVID-19), can be discharged from a hospital to a congregate living setting following normal procedures. However, they should be quarantined and observed for the development of symptoms. All recommended PPE (facemask, eye protection, gloves, and gown) should be worn during care of residents under observation, when PPE supplies allow. At minimum, staff should wear facemask and eye protection during care. Cloth face coverings are not considered PPE.

According to CMS's Frequently Asked Questions (FAQs) dated 4/24/2020, if the resident has to

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leave the facility for an outside appointment, "the facility should monitor the resident upon return, monitor for fever and signs and symptoms of respiratory infection for 14 days after the outside appointment.

According to the CDC website (https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html) that indicated a last review date of 5/7/2020. People with COVID-19 have wide range of symptoms reported; the literature advised that the common symptom list was not all-inclusive. Other less common symptoms have been reported, including gastrointestinal symptoms like nausea, vomiting, or diarrhea.

Undated facility COVID-19 manual did not direct staff to monitor for the COVID-19 symptoms that were less common, the manual directed staff to monitor for signs of fever and/or respiratory symptoms, if signs/symptoms presented then resident would be placed on isolation precautions per provider direction.
The manual included, "Visual alerts (e.g., signs posters) will be posted at the entrance and in strategic places to provide residents and staff with instructions about respiratory hygiene, hand washing, and donning for PPE.
New Admission/readmissions: The new admission/readmission must agree to be placed in isolation for 14 days where possible. Staff will utilize a surgical facemask, eye protection, and gloves when caring for these residents. If symptoms develop, droplet precautions will be implemented.
Droplet Precautions: Droplet precautions will be implemented for residents with suspected or confirmed COVID-19, should notify the health

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