Electronically delivered
April 28, 2020

Administrator
Johnson Memorial Hosp & Home
1290 Locust Street
Dawson, MN 56232

SUBJECT: SURVEY RESULTS
CCN: 245485
Cycle Start Date: Cycle Start Date: April 17, 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 April 17, 2020, a survey was completed at your facility by the Minnesota Department of Health completed a COVID-19 Focused Survey at Johnson Memorial Hosp & Home 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 plan of correction (POC) for the enclosed deficiencies that were cited during the April 17, 2020 survey. Johnson Memorial Hosp & Home may choose to delay submission of a POC 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 POC. An acceptable POC will serve as your allegation of compliance. Upon receipt of an acceptable POC, 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 POC can lead to termination of your Medicare and Medicaid participation.

To be acceptable, a provider's POC 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.

The POC must be signed and dated by an official facility representative. Please send your POC by fax or email to:

Nicole Osterloh, Unit Supervisor
Health Regulation Division
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230 Cell: 218-340-3083

INFORMAL DISPUTE RESOLUTION

You have one opportunity to dispute the deficiencies cited on the April 17, 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:

Nicole Osterloh, Unit Supervisor
Health Regulation Division
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230 Cell: 218-340-3083

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.

Johnson Memorial Hosp & Home 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,

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245485	A. BUILDING _____ B. WING _____	04/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MEMORIAL HOSP & HOME	1290 LOCUST STREET DAWSON, MN 56232

(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 4/15/20 through 4/17/20, at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.73(b)(6). The facility was IN full compliance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facilty acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control survey was conducted 4/15/20 through 4/17/20, at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was determined to NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an revisit of your facility will be conducted to validate substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		5/8/20

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

Electronically Signed | 05/08/2020

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 §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: (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:	F 880		

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F 880	Continued From page 2 (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: Based on observation, interview, and document review, the faciltiy failed to ensure staff implemented appropriate personal protective equipment when handling soiled linens for 1 of 1 observation during a COVID-19 Focused Infection Control Survey. This had the potential to affect all 55 residents residing at the facility. Findings include: Observation on 4/15/20 at 10:00 a.m., identified	F 880	How corrective action will be accomplished for those residents found to have been affected by the deficient practice: No residents were found to have been affected by the deficient practice during survey time; however, there was potential for residents to be affected due to contamination of high-touch areas. Our corrective actions can be found below.	

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F 880	Continued From page 3 laundry aid (L)-A entered the River Road Wing through the double door entrance wearing gloves. L-A pushed the covered soiled linen cart to the soiled utility room and opened the door. Upon entry, L-A lifted the lid off the gray soiled linen container with her gloved hands and leaned over and into the container to retrieve the soiled linen. L-A's clothing on her torso, arms, and armpits contacted the walls and rim of the container She was not wearing a gown, and the linen was not bagged. L-A exited the soiled utility room and placed the soiled linen into collection cart in the hallway. Without removing her gloves and performing hand hygiene, had opened the door of the soiled utility room replaced the lid onto the soiled linen bin and left the room. Without removing the gloves and performing hand hygiene, she touched the handle of the linen collection cart and pushed it to next soiled utility room on the River Road wing soiled linen room to collect soiled linen. Interview on 4/15/20 at 10:10 a.m., with L-A identified she donned her gloves in the laundry room before coming to the floor to collect soiled linen. L-A collected linen from four soiled utility rooms located in the River Road and Prairie Lane units at the facility. L-A would wear the same contaminated gloves to collect all soiled linen from all the utility rooms in the facility. She agreed she had not worn a gown to collect the linen. L-A and her body and clothing was in contact with the container which held unbagged, soiled linen. L-A had to lean into the soiled linen container to reach the linen at the bottom. She used the same gloves to collect all soiled linen before returning to the laundry room. There were no gloves, gown, or hand sanitizer on the linen cart. L-A was unsure if there were gloves in the	F 880	How the facility will identify other residents having the potential to be affected by the same deficient practice: No residents were found to have been affected by the deficient practice; however, there was potential for residents to be affected due to contamination of high-touch areas. Our corrective actions can be found below. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: CNAs will place all soiled linens in plastic bags before leaving resident rooms and will then place bagged linens in soiled utility brute. Laundry and nursing staff will review Policy Infection Control-Linen 12.0 which indicates linen will be handled in a way to prevent contamination of employee□s uniform. Laundry and nursing staff will review Hand Hygiene policy which indicates hand hygiene is to be performed after gloves are removed. Staff will also receive education on performing hand hygiene before touching high-touch objects such as door handles to prevent cross contamination and transmission of infections. Laundry staff received education on the Infection Control-Linen 12.0 and Hand Hygiene policies on 5/5/20 and nursing staff received education at the beginning of their first scheduled shift starting 4/17/20 an concluded 5/7/20. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not	

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F 880	Continued From page 4 soiled utility rooms or if she was supposed to wear a gown when collecting soiled linen in the units. Laundry staff were expected to wear a gown while handling, sorting and washing soiled linen in the laundry room. Hand hygiene was performed before and after donning and doffing gloves. Gloves were to be removed and hand hygiene performed after handling soiled linen. After L-A had retrieved the soiled linens, she would launder those items, folding, hanging and redistributing the laundered linen throughout the facility. Interview on 4/15/20 at 12:00 p.m., with the infection control preventionist (ICP) identified laundry staff were expected to remove gloves and perform hand hygiene after handling soiled linen and before touching high-touch objects such as door handles to prevent cross contamination and transmission of infections. If there was potential for staff to contaminate clothing while handling soiled linen, staff were to don a gown to handling soiled linen. The 9/20/18, Infection Control-Linen 12.0 policy and procedure identified linen was to be handled in a way to prevent contamination with dirty linen. Once linen was removed from the resident room it was considered dirty. Linen was to be placed in placed in clear plastic bags and marked with the resident's name. Contaminated linen was not to come into contact with uniforms or the environment. Review of the November 2018, Hand Hygiene policy and procedure identified staff were to perform hand hygiene even when gloves were used. Staff were to wash hands after removing personal protective equipment (PPE), and after	F 880	recur: Infection Preventionist, or designee, will conduct observational audits to ensure staff are following appropriate IC measures discussed above. Audits will occur weekly for one month and then monthly for three months. The results of those audits will be taken to QAPI for review to determine compliance or the need for further monitoring. The date that each deficiency will be corrected. 5/8/20	

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F 880	Continued From page 5 contact with contaminated objects and surfaces.	F 880		