DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 4, 2021

Administrator
Fairview Care Center
702 10th Avenue Northwest, Po Box 10
Dodge Center, MN 55927

RE: CCN: 245344
Cycle Start Date: December 10, 2020

Dear Administrator:

On December 22, 2020, we notified you a remedy was imposed. On January 20, 2021 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of January 15, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective February 5, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of December 22, 2020, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 5, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on January 15, 2021, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

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
December 22, 2020

Administrator
Fairview Care Center
702 10th Avenue Northwest, Po Box 10
Dodge Center, MN 55927

RE: CCN: 245344
Cycle Start Date: December 10, 2020

Dear Administrator:

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

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective February 5, 2021.

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

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective February 5, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 5, 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.

NURSE AIDE TRAINING PROHIBITION

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

If you have not achieved substantial compliance by February 5, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Fairview Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 5, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.
However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.

- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

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 June 10, 2021 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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 (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic 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,

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
	245344	A. BUILDING _____ B. WING _____	C 12/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRVIEW CARE CENTER	**702 10TH AVENUE NORTHWEST, PO BOX 10 DODGE CENTER, MN 55927**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A COVID-19 Focused Infection Control survey was conducted on 12/10/20, at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.73(b)(6). The facility is IN 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 the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control survey was conducted on 12/10/20, at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was determined NOT to be in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, a revisit of your facility will be conducted to validate substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		1/15/21

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

Electronically Signed | 12/31/2020

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	F 880		

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F 880	Continued From page 2 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: Based on interview and document review the facility failed to implement CDC (Centers for Disease Control) and CMS (Centers for Medicaid and Medicare Services) guidance/recommendations for 2 of 2 residents (R1, R2) when the facility failed to separate a symptomatic resident from a healthy resident roommate to prevent and/or mitigate the risk of an outbreak of COVID-19. This deficient practice	F 880	Deficiency with ID Prefix Tag 880 shall be corrected. Facility shall separate a symptomatic resident from a healthy roommate to prevent and/or mitigate the risk of an outbreak of COVID-19. R1 was placed on isolation in the COVID Unit when the facility was informed of a positive COVID-19 PCR test. R2 was placed on isolation at this time. R2 tested	

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F 880	Continued From page 3 had the potential to affect all residents residing in the facility and staff who were at risk for contracting COVID-19. Findings include: According to the census reports R1 and R2 resided in the same room on unit one. R1's Admission Record, indicated R1 Diagnoses included chronic obstructive pulmonary disease, chronic lymphocytic leukemia of b-cell type not having achieved remission and chronic kidney disease. R1's annual Minimum Data Set (MDS) assessment dated 11/2/20 indicated R1 had intact cognition. R1's progress note dated 11/30/2020, at 7:10 a.m. included, "This morning the resident was c/o [complaining] not feeling well. Upon presentation he was pale, shivering, clear thin nasal drainage, c/o [complaints of] being cold, and SOB [shortness of breath]. VS [vital signs]: 98.9 at mid-forehead/100.1 at side forehead temporal vein. His skin is warm to touch. Bp [blood pressure] 143/70, HR [heart rate] 113, SpO2 [oxygen saturation] 89% 2L [liters], R [respirations] 32 and labored. LS [lung sounds] diminished all fields. Productive cough noted. Loss of apatite {sik}, refused breakfast. Fluids strongly encouraged. POC [point of care] Covid test negative. He was given morphine, Tylenol, nebulizer, and a warm blanket. All interventions somewhat helpful. [Family Member (FM-A)] was updated and appreciated the call and wants to be updated later today or if symptoms worsen.	F 880	positive on 12/5/2020 and was placed in the COVID Unit immediately upon notification. R2 has recovered and is out of the COVID Unit. All residents are screened twice a day for any signs or symptoms of COVID-19. Any resident exhibiting signs of COVID-19 shall be placed on isolation. If there is a room mate, they shall be placed on isolation also. All residents testing positive for COVID-19 shall be moved to the COVID Unit. All nursing personnel shall be re-educated on the signs and symptoms of COVID-19, the need to immediately report these symptoms and to place resident(s) involved on isolation. Facility policies and procedures for COVID-19 screening for residents and Transmission Based Precautions have been reviewed and updated and nursing personnel will be re-educated on these policies. The Director of Nursing or designee shall monitor compliance with this Plan of Correction through audits of resident records to ensure COVID Evaluations were completed and isolation procedures were followed properly, if necessary. Three charts on each wing, 5 days a week, will be audited for 2 weeks. This Plan of Correction and audit findings shall be reviewed at the January QAPI Meeting.	

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F 880	Continued From page 4 Hospice has been called, message left and awaiting a return call for update. R1's progress note dated 12/1/2020, at 9:20 a.m. included, "Resident sitting up for breakfast this AM. During interaction resident sleepy and eating only few bites for breakfast in between dosing. Temp [temperature]-100.4, bp [blood pressure]-115/65, p [pulse] -100, resp [respirations]-20 and regular, spo2 [oxygen saturations]-90% NC [nasal cannula]. Resident given PRN [as needed] Morphine for SOB [shortness of breath] and general discomfort. Lung sounds continue diminished x4, bronchi wet. His skin pale, eyes dull, nose draining clear per normal. Offered no c/o [complaints of] pain, discomfort or [shortness of breath]. R1's progress note dated 12/1/2020, at 10:00 p.m. included, "Resident was swabbed for COVID on 11/30. Results came back positive." R1's progress note dated 12/1/2020, at 11:23 p.m. included, "Resident temp was 97.2 this evening. Resident didn't hardly eat any thing {sik} this evening. Resident around 1700 was having a hard time breathing. This nurse admin his scheduled MS [morphine sulfate]. Then this nurse checked his O2 [oxygen] stats [saturations] they were 78% on 2.5 L [liters]. This nurse called the unit manager and she told this nurse to bump up his oxygen until his stats [saturations] raised, offer a {sik} inhaler, neb [nebulizer], and morphine if the inhaler and neb [nebulizer], didn't work. Resident's oxygen stats dropped to 63% on 2.5 L [liter]. This nurse admin the resident's Albuterol neb [nebulizer], at 1749. This brought the resident Oxygen up to 73% on 3L [liters]. This	F 880		

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F 880	Continued From page 5 nurse did complete his neb [nebulizer], This brought the resident's O2 up to 85% on 4L [liters]. This nurse consulted with the other nurse on the floor and about what else this nurse could do. This nurse admin another dose of morphine at 1813. This was effective and brought the resident up to 94% on 4L. The resident was later in the evening dropped down to 3L [liters]. R1's progress note dated 12/2/2020, at 1:05 a.m. included, "Informed from Mayo Clinic lab that resident had positive covid test, was moved from his room to covid unit in facility, is resting comfortably at this time, will administer morphine as per orders." R2 R2's Admission Record indicated R2 diagnosis hypertension and major depressive disorder. R2's quarterly Minimum Data Set (MDS) assessment dated 10/9/20 indicated R2 had intact cognition. R2's progress note dated 12/2/2020, at 3:24 p.m. included, "Late Entry: Note Text: Resident was swabbed for COVID on 11/30. Results came back negative. R2's progress note dated 12/2/2020, at 8:00 p.m. included, "Resident was upset about supper and didn't like the bean soup. Resident stated he wanted fresh fruit. The kitchen didn't have fresh fruit to offer. The aide offered a sandwich and the resident was fine with that. Then the resident thinks that he should not having any of his roommate belongings left in his room because it	F 880		

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F 880	Continued From page 6	F 880		

should be put in storage. Then the resident is upset that he can't have a mug in his room. This nurse explained to the resident that since he is on isolation that he has to have paper cups to prevent the spread of what he possibly could have."

R2's progress note dated 12/4/2020, at 10:07 a.m. included, "Resident continues in his room-isolation. Sleepy but responsive and engaging in conversation. Denied pain, SOB [shortness of breath] aches or chills. No SOB [shortness of breath] observed. Resident sitting up in recliner feet elevated. Ate well for breakfast. VS [vital signs]- BP [blood pressure]-137/62, p [pulse]-72, resp [respirations]-18 and easy, spo2 [oxygen saturations]-94% RA [room air], temp [temperature]-99.8-oral and lung sound slight wheeze throughout (4) [quadrants]. CNM [clinical nurse manger] updated. Will monitor. Residents {sik} room was very warm, he was cover in blankets and curtains open and sunlight warming room considerably. Will encourage ice with fluids and monitor."

R2's progress note dated 12/4/2020, at 10:50 a.m. included, "CNP [certified nurse practitioner] notified of resident increased temp and wheezing in bilateral lungs. she says to continue isolation at this time and wait for COVID test results from Thursday 12/3/2020."

R2's progress note dated 12/4/2020, at 11:23 a.m. included, "At 1100, temp reassessed-100.00 over 1 hour after Tylenol. Resident reported to have a sore throat, No chills/aches. Eyes glossy. CNM [case nurse manager] updated, Tylenol now scheduled TID [three times

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F 880	Continued From page 7 a day]. Will continue monitored." R2's progress note dated 12/4/2020, at 1:40 p.m. included, ": At this time- resident continues with wheezes x4, "slight sore throat" bronchi clear. Temp [temperature] -99.9-see Prog [progress] noted for VS [vital signs]. No SOB [shortness of breath] reported or observed. Resident states "lll{sik} be OK." R2's progress note dated 12/4/2020, at 2:21 p.m. included, "Resident swabbed for COVID again as lab did not pick up sample last night. MedSpeed notified and will be picking up sample shortly." R2's progress note dated 12/5/2020, at 9:31a.m. included, "Resident assessed this AM. he denies SOB [shortness of breath]. Oxygen would vary 82-88% on RA [room air]. did not want to use oxygen. oxygen would drop when he began to talk, otherwise stayed at 88% at rest and RA [room air]. denied pain. did state he had a sore throat and a headache. Lung sounds ronchi in all 4 lobes. He says he is very tired and doesn't feel well. did have a discussion about Code status as resident is a full code. Writer asked resident that if he were to be positive for COVID, would he want to go to the hospital. resident stated he does not want to go to the hospital unless he starts to get worse. will continue to monitor resident at this time.' R2's progress note dated 12/5/2020, at 6:21 p.m. included, "COVID test came back detected. DON [director of nursing and administrator notified. will notify family." R2's progress note dated 12/5/2020, at 6:27 p.m.	F 880		

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	245344	A. BUILDING _____ B. WING _____	C 12/10/2020

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F 880	Continued From page 8	F 880		

included. "The facility is being notified by DON [director of nursing] and resident will be moved down to the COVID unit."

R2's progress note dated 12/6/2020, at 9:46 a.m. included, "Residents SPO2 [oxygen saturations] trending between 85 and 86 % at 0900. Refused treatment of oxygen x2 [times two]. Resident educated on severity of situation and that id {if} he continued with decreased SPO2 [oxygen saturations] he would possible need hospitalization. Resident now compliant and using O2 [oxygen]. After 20 mins [minutes] spo2 [oxygen saturations] - still 86% at 2L [liters] NC [nasal cannula]. at 0945 implemented protocol/goals of care and increased O2 [oxygen]-4L [liters] NC [nasal cannula]. At 1000 AM spo2 [oxygen saturations] - 92% 4L [liters] NC [nasal cannula]. Resident has been having loose stools and decreased fluids. At this point there is also concern for dehydration. Fluids will be pushed along with VS [vital signs] monitoring. Wife updated."

R2's progress note dated 12/6/2020, at 12:52 p.m. included, "Per [physician]-due to residents decline in O2 [oxygen] levels this AM, it is advised resident to be sent to [emergency room] at this time for further evaluation."

During an interview on 12/10/20, at 10:56 a.m. with the director of nursing (DON) and infection preventionist (IP) the DON stated R1 tested positive from 11/30/20- testing and stated facility received the tests results 12/1/20. The DON stated R1 started showing symptoms on 11-30-20, the symptoms included, pale, shivering, clear nasal drainage, complained of

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being cold and short of breath. The DON stated R1's temperature was 100.1 at side forehead temporal. The DON stated the facility did a POC (point of care) test that morning and the results were negative. The DON stated because the results were negative was thinking he had a COPD (chronic obstructive pulmonary disease) exasperation. The DON stated a PCR (polymerase chain reaction) test was also done that day and the PCR (polymerase chain reaction) test came back positive. The DON stated R1 was roommates with R2. The DON verified R1 had symptoms of COVID, R2 did not, and they were kept in same room. The DON stated facility received the PCR (polymerase chain reaction) testing back on 12/1/20 for R1 and he was positive and R1 was move to the COVID unit. The DON stated R2 stayed in their original room and was placed on isolation. The DON stated R2 started having a fever on 12/4/20. The DON stated R2 was tested for covid on 12/3/20 during the facility wide PCR (polymerase chain reaction) testing. The DON stated the lady at [name] labs did not put us down for a courier so they never came and picked up the PCR (polymerase chain reaction) tests on Thursday night like they were supposed to. The DON stated they ordered another swab for R2 on 12/4/20 because he started having covid symptoms that morning. The DON stated the facility got his test results about 6:30 p.m., Saturday evening and he was moved to the covid unit. The DON stated R2 went into the hospital on Sunday 12/6/20, because he was a full code and [physician] wanted him to receive steroids and Remdesiver iv [intravenous] infusions and stated the facility do not do IVs here. The DON stated we should not have trusted the POC [point

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F 880	Continued From page 10	F 880		

of care] test as I think that threw us off. During a subsequent interview at 12:20 p.m. the DON stated there was another room down that hall that R1 could have been moved to when he started displaying covid symptoms. The DON stated we went by the POC [point of care] test that came negative and by the fact he has a history of COPD exasperation. The DON stated I realize now we should have moved one of them.

The Resident Screening during COVID policy updated 10/29/20 included, "Procedure: 1. Every resident will be assessed twice daily for signs and symptoms of COVID to include the following: temperature, pulse oximeter and the following assessment date to include: presence of fever, chills cough, shortness of breath, diarrhea, new dizziness, new onset of confusion, loss of taste or smell, malaise. This data will be recorded in each resident's electronic health record daily. 2. If any resident has symptoms that correlate with the above a surgical mask will be placed on the resident, the door to the room will remain shut, droplet precautions will be initiated and the clinical nurse manager will be notified immediately. 3. If the symptomatic resident is not in a private room, then the residents roommate will be moved to a private room immediately to separate the resident with symptoms from the resident not having symptoms as well as providing a private room for the resident being moved so that in case this resident begins to have any symptoms of COVID the resident is in a private room.

The COVID-19 Resident Isolations Rooms policy reviewed 10/28/20 included, "Procedure: 1 A minimum of two rooms shall remain open to

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F 880	Continued From page 11 accommodate the need to move residents who have a roommate. Ideally, each wing will have an empty room for potential isolation needs. 2. If symptomatic resident has a roommate, the roommate shall be moved to open room and testing to be requested for the roommate as well as the symptomatic resident ..."	F 880		

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:

Cohorting Residents/Transmission Based Precaution "Isolation"

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

POLICIES/PROCEDURES/SYSTEM CHANGES:

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

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

- Grouping of residents, or "cohorting," should be done when possible to separate residents with an infectious disease (positive residents) from residents who are not affected. Plans to cohort should be carefully established in advance and should be centered on implementation of infection control practices.
- Dedicate a unit or part of a unit as the care location for residents with disease, including those with or without current symptoms of illness. Anticipate ways to close off units to prevent spread of illness from ill residents to non-ill residents (e.g., for symptomatic COVID-19, recovered COVID-19 residents, non-COVID-19 suspected residents).
- Confine symptomatic residents and exposed roommates to their rooms. If they must leave their room, ensure the resident is wearing a mask.
- Provide dedicated equipment for areas, as able.

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

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

- Clean and disinfect objects and environmental surfaces that are touched frequently (e.g., bed rails, over-bed table, bedside commode, lavatory surfaces in resident bathrooms).

TRAINING/EDUCATION:

- Provide education to residents (to the degree possible/consistent with the resident's capacity) and their representatives or visitors on the use of transmission-based precautions.
- Refer to CDC Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings. https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
- Refer to MDH COVID-19 Infection Prevention and Control and Cohorting in Long-term Care. https://www.health.state.mn.us/diseases/coronavirus/hcp/ltcipchohort.pdf
- MDH: Interim Guidance for Hospital Discharge to Home or Admission to Congregate Living Settings and Discontinuing Transmission-Based Precautions. https://www.health.state.mn.us/diseases/coronavirus/hcp/hospdischarge.pdf

CDC RESOURCES:

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

MDH RESOURCES:

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

MONITORING/AUDITING:

- The Director of Nursing, the Infection Preventionist and other facility leadership will verify the placement of each new admission and location and audit for transmission based precautions

are being appropriately implemented.

- Conduct a Root Cause Analysis (RCA) which will be done with assistance from the Infection Preventionist, Quality Assurance and Performance Improvement (QAPI) committee and Governing Body. The RCA should be incorporated into the intervention plan. Information regarding RCAs can be found in the document: Guidance for Performing Root Cause Analysis (RCA)with Performance Improvement Projects (PIPs)

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

In accordance with 42 CFR § 488.402(f), the DPOC remedy is effective 15 calendar days from the date of the enforcement letter. The DPOC may be completed before or after that date. A revisit will not be approved prior to receipt of documentation confirming the DPOC was completed. To successfully complete the DPOC, the facility must provide all of the following documentation identified in the chart below.

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

Imposition of this DPOC does not replace the requirement that the facility must submit a complete POC for all cited deficiencies (including F880) within 10 days after receipt of the Form CMS 2567.

Item	Checklist: Documents Required for Successful Completion of the Directed Plan
1	Documentation of the RCA and intervention or corrective action plan based on the results with signatures of the QAA Committee members and members of the Governing Body
2	Documentation that the interventions or corrective action plan that resulted from the RCA was fully implemented
3	Content of the training provided to staff, including a syllabus, outline, or agenda, as well as any other materials used or provided to staff for the training
4	Names and positions of all staff that attended and took the trainings
5	Staff training sign-in sheets
6	Summary of staff training post-test results, to include facility actions in response to any failed post-tests
7	Documentation of efforts to monitor and track progress of the interventions or corrective action plan

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