Electronically Submitted August 13, 2021

Administrator
Villa St Vincent
516 Walsh Street
Crookston, MN 56716

RE: CCN: 245484
Cycle Start Date: July 23, 2021

Dear Administrator:

On July 23, 2021, survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMOVAL OF IMMEDIATE JEOPARDY

On July 23, 2021, the situation of immediate jeopardy to potential health and safety cited at F880 was removed. However, continued non-compliance remains at the lower scope and severity of F.

Also on July 23, 2021, the situation of immediate jeopardy to potential health and safety cited at F886 was removed. However, continued non-compliance remains at the lower scope and severity of F.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 28, 2021.

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

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

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 28, (42 CFR 488.417 (b)), (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 28, 2021. (42 CFR 488.417 (b)).

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

NURSE AIDE TRAINING PROHIBITION

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

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective July 23, 2021. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

DEPARTMENT CONTACT

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

Jen Bahr, RN, Unit Supervisor
Bemidji District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, MN 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104 Mobile: (218) 368-3683

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 23, 2022 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS DENIAL OF PAYMENT

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

Tamika.Brown@cms.hhs.gov

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

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

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

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

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

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

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

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245484	A. BUILDING _____ B. WING _____	C 07/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA ST VINCENT	**516 WALSH STREET CROOKSTON, MN 56716**

(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
F 000	INITIAL COMMENTS	F 000		

On 7/19/21 through 7/23/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition, a COVID-19 Focused Infection Control survey was conducted at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was determined to be not in compliance.

The following complaints were found to be substantiated:
H5484045C (MN74764) with deficiencies cited at F684 & F580.
H5484046C (MN74826) with deficiencies cited F880 & F886.

The survey resulted in two Immediate Jeopardy (IJ) situations to resident safety at F880 and F886.

The F880 IJ began on 7/19/21, when R6 displayed symptoms of COVID-19 including fever, harsh, dry cough, nasal drainage and swollen, painful lymph nodes in her neck. A rapid antigen (screening) test was obtained with presumptive negative results. While awaiting a confirmatory COVID-19 test, the facility failed to implement individualized interventions for transmission-based precautions and isolation for R6, who continued to wander throughout the unit and subsequently tested positive for COVID-19. Further, staff present on the memory care unit were not wearing appropriate eye protection, N95 respirators, gowns or gloves prior to the facility obtaining a confirmatory COVID-19 test. The

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/19/2021

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F 000	Continued From page 1	F 000		

administrator, director of nursing (DON) and registered nurse(s) (RN)-A, RN-B, RN-C, RN-D, and RN-E were notified of the IJ on 7/22/21, at 2:30 p.m. The IJ was removed on 7/23/21, at 6:00 p.m. when the facility provided evidence they had removed the immediacy.

The F886 began on 4/21/21, when the facility was notified a staff member tested positive for COVID-19 and the facility failed to ensure all active staff were immediately tested for COVID-19 prior to working (or removed from the schedule) and continued to work without testing; along with following ongoing outbreak testing to ensure no more active cases were circulating within the facility. In addition, the facility failed to ensure all unvaccinated staff were routinely tested at the minimum requirements per the county positivity rate. The administrator, director of nursing (DON) and registered nurse(s) (RN)-A, RN-B, RN-C, RN-D, and RN-E were notified of the IJ on 7/22/21, at 2:30 p.m. The IJ was removed on 7/23/21, at 6:00 p.m. when the facility provided evidence they had removed the immediacy.

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. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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F 580	Continued From page 2	F 580		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and	F 580		8/23/21

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F 580	Continued From page 3 phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the physician was notified of a significant weight gain for 1 of 1 residents (R2) who's furosemide (a diuretic medication used to treat fluid retention) was discontinued and had a significant weight gain. Findings include: R2's quarterly MDS dated 5/18/21, identified R2 had intact cognitions and required extensive assistance from staff for activities of daily living and received diuretic medication daily. Diagnoses included lymphedema (a condition that results in swelling of the arm or leg), pneumonia, diabetes mellitus, kidney failure, polyneuropathy, obesity and edema. R2's Physician Order Report dated 6/16/21, included furosemide 40 milligrams (mg) by mouth (po) daily with a start date of 4/5/21. R2's June 2021, Medication Administration Record (MAR) included orders to administer furosemide 40 mg every morning and was	F 580	F580 Notify of Changes (Injury/Decline/Room, etc.) 1. Corrective Action for Resident Affected: R2 was discharged from facility on 6/23/21. 2. Actions as it applies to others: All Residents receiving a diuretic have been identified. Weights have been obtained. Parameters are in place for weight gains and licensed nurses will update MD when applicable. 3. Measures put into place to prevent further issues: Licensed Nursing staff will be provided education on ensuring the physician is notified of significant changes in resident condition with special attention towards Diuretic Medical Management and protocol of weight changes per parameters set forth by MD and updating of MD. 4. How the facility will monitor: Audits will be completed weekly on 5 residents who receive diuretics x 90 days by DON/ designee and then reviewed by Quality Council, and if acceptable performance,	

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F 580	Continued From page 4 initialed as administered daily, 6/1/21 through 6/18/21, with a discontinue date of 6/18/21. The MAR also included physician orders to remind R2 to elevate her legs and left arm every shift, and for daily weights. The order directed staff to monitor daily weights and notify the physician if R2's weight was greater or less 3 pounds (lbs) in one day or 5 lbs in one week. The weights were recorded on the MAR 6/1/21 through 6/20/21, ranged within 2 lbs, from 367 lbs to 369 lbs; however, the recorded weights from 6/21/21 through 6/23/21, ranged 375 lbs to 379.4 lbs. R2 gained a total of 11 lbs. by 6/23/21. R2's Weights and Vitals summary indicated the following weights: -6/14/21, 367/9 lbs. -6/18/21, 368.9 lbs. -6/19/21, 367.4 lbs. -6/20/21, 368.3 lbs. -6/21/21, 376.3 lbs. -6/22/21, 375.4 lbs. -6/23/21, 379.4 lbs. R2's progress notes identified the following: - 6/18/21, at 4:22 p.m. an order was received by the facility to discontinue R2's furosemide due to a decline in her kidney function and to encourage R2 to elevate her legs and arm and reduce her sodium intake. - 6/23/21, at 5:00 p.m. R2 discharged from the facility. Discharge plan of care, medications and medication list were explained. R2's clinical record lacked documentation of physician notification of R2's 11 lbs. weight gain in one week as ordered. During interview on 7/21/21, at 11:18 a.m.	F 580	will reduce to 3 resident audits per week x 30 days, after 30 days review by Quality Council, and if acceptable then audit 1 resident who receives diuretics weekly, x 30 days then to Quality Council to determine continuance. 5. Date Corrected 8/23/21	

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F 580	Continued From page 5	F 580		

licensed practical nurse (LPN)-B stated the nursing assistants would tell her the daily weights and she would record them on the MAR. If LPN-B noticed a weight gain when she entered the weight she would let the unit manager know. The resident would be re-weighed and if it was a true weight gain, the unit manger would notify the primary physician.

When interviewed on 7/21/21, at 11:30 a.m. the primary care physician (PCP)-I stated he was aware R2's furosemide had been discontinued; however, he was not aware of R2's 11 lbs. weight gain in one week. He would not have just restarted her diuretic medication prior to her discharge without some lab work being done.

On 7/21/21, at 1:50 p.m. a joint interview was conducted with the director of nursing (DON) and registered nurse (RN)-K. RN-K stated the nursing assistants were to get the daily weights and report them to the team leader. The team leader would then enter them on the MAR. The DON indicated if a weight was out of set perimeters it would flag and the unit manager would get a message in resident messages. The system had not flagged R2's weight gain for some reason and she was going to look into it.

The undated facility policy Change In Condition, indicated when a significant change was identified or when there was a need to alter treatment significantly, the licensed nursing associate would consult with the attending provider and notify the resident/resident representative. The need to alter treatment significantly meant to stop a form of treatment because of adverse consequences or commence a new form of treatment to deal with a problem. Notify the attending provider of

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F 580	Continued From page 6 the change in condition and implement orders for treatment and appropriate monitoring as directed.	F 580		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a focused nursing assessment and/ or monitoring occurred for potential fluid overload for 1 of 3 residents (R2) reviewed who were taking diuretic medication. Findings include: R2's quarterly MDS dated 5/18/21, identified R2 had intact cognitions and required extensive assistance from staff for activities of daily living and received diuretic medication daily. Diagnoses included lymphedema (a condition that results in swelling of the arm or leg), pneumonia, diabetes mellitus, kidney failure, polyneuropathy, obesity and edema. R2's Physician Order Report dated 6/16/21, included furosemide 40 milligrams (mg) by mouth (po) daily with a start date of 4/5/21. R2's June 2021, Medication Administration	F 684	F684 Quality of Care 1. Corrective Action for Resident Affected: R2 was discharged from facility on 6/23/21. 2. Actions as it applies to others: All Residents receiving a diuretic have been identified. Weights have been obtained. Parameters are in place for weight gains and licensed nurses will update MD when applicable. 3. Measures put into place to prevent further issues: Licensed Nursing staff will be provided education on ensuring the physician is notified of significant changes in resident condition with special attention towards Diuretic Medical Management and updating MD. 4. How the facility will monitor: Edema checks daily for residents identified as receiving a diuretic. Audits will be completed weekly on 5 residents who receive diuretics x 90 days by DON/	8/23/21

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F 684	Continued From page 7 Record (MAR) included orders to administer furosemide 40 mg every morning and was initialed as administered daily, 6/1/21 through 6/18/21, with a discontinue date of 6/18/21. The MAR also included physician orders to remind R2 to elevate her legs and left arm every shift, and for daily weights. The order directed staff to monitor daily weights and notify the physician if R2's weight was greater or less 3 pounds (lbs) in one day or 5 lbs in one week. The weights were recorded on the MAR 6/1/21 through 6/20/21, ranged within 2 lbs, from 367 lbs to 369 lbs; however, the recorded weights from 6/21/21 through 6/23/21, ranged 375 lbs to 379.4 lbs. R2 gained a total of 11 lbs. by 6/23/21. R2's Weights and Vitals summary indicated the following weights: -6/14/21, 367/9 lbs. -6/18/21, 368.9 lbs. -6/19/21, 367.4 lbs. -6/20/21, 368.3 lbs. -6/21/21, 376.3 lbs. -6/22/21, 375.4 lbs. -6/23/21, 379.4 lbs. R2's medical record lacked documentation of physician notification of R2's 11 lbs. weight gain in one week as ordered. R2's progress notes identified the following: - 6/18/21, at 4:22 p.m. an order was received by the facility to discontinue R2's furosemide due to a decline in her kidney function and to encourage R2 to elevate her legs and arm and reduce her sodium intake. - 6/23/21, at 5:00 p.m. R2 discharged from the facility. Discharge plan of care, medications and medication list were explained.	F 684	designee and then reviewed by Quality Council, and if acceptable performance, will reduce to 3 resident audits per week x 30 days, after 30 days review by Quality Council, and if acceptable then audit 1 resident who receives diuretics weekly, x 30 days then to Quality Council to determine continuance. 5. Date Corrected 8/23/21	

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R2's medical record lacked evidence of any monitoring or assessment following the discontinuation of R2's furosemide medication. The record lacked assessment of R2's edema, or lung sounds. There was no evidence R2 was aware her diuretic had been discontinued or that she was instructed on side effects, low sodium diet and symptoms to monitor and report if noted, such as increase swelling, weight or shortness of breath.

R2's Discharge Assessment dated 6/23/21, identified R2 was independent with activities of daily living, except with putting her footwear on and off. The discharge summary identified R2 was at the facility for therapy. She had no pertinent lab work or consults and no outstanding events. Her final diagnoses and condition on discharge was documented as stable.

R2's Discharge Plan of Care dated 6/23/21, identified R2 was discharged to her home, accompanied by a friend. No equipment was needed, nursing home care was needed with agency names listed without phone numbers, for the patient to contact to make arrangements. Medications were reconciled and a medication list was given to R2. Scheduled appointments were listed.

R2's discharge documentation lacked any evidence R2 was aware her diuretic medication had been discontinued or if she had received instruction to limit her sodium intake, elevate her extremities or monitor signs and symptoms related to increase fluid retention and what to do if symptoms were identified.

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During interview on 7/21/21, at 8:30 a.m. family member (FM)-J stated R2 was in bad shape. A friend who had visited with R2 had told him R2's legs were swelling and were not being wrapped. The facility stated R2 was in good health and discharged her. FM-J called R2 the evening of discharge and R2 was crying and said she had made a mistake and she could not be at home. FM-J told R2 she had to call an ambulance and R2 went into the hospital. The facility did not do any type of assessment on her before she discharged. There was no way they could not have seen that her swelling was worse and that she was deteriorating. They could not have done any assessment for them to have missed that.

During interview on 7/21/21, at 11:18 a.m. licensed practical nurse (LPN)-B stated the nursing assistants would tell her the daily weights and she would record them on the MAR. If LPN-B noticed a weight gain when she entered the weight she would let the unit manager know. The resident would be re-weighed and if it was a true weight gain, the unit manger would notify the primary physician.

When interviewed on 7/21/21, at 11:30 a.m. the primary care physician (PCP)-I stated he was aware R2's furosemide had been discontinued; however, he was not aware of her 11 lbs. weight gain in one week. He saw R2 on rounds on 6/18/21; however, her weight gain had not been noted until 6/21/21. The PCP-I stated R2 was insistent on going home and had refusals of cares related to wrapping her legs. The facility did not feel it was safe and home care had refused to take her on in the past. The had canceled her discharge and kept her there because of that, but she was determined to go

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home and had a number of appointments set up for her to be seen after discharge. PCP-I would not have just restarted her diuretic medication prior to her discharge without some lab work being done.

On 7/21/21, at 1:50 p.m. a joint interview was conducted with the director of nursing (DON) and registered nurse (RN)-K. RN-K stated R2 was non-compliant with a lot of things, such as her lymphedema wraps and her diet and her goal was to go home. The nursing assistants were to get the daily weights and report them to the team leader. The team leader would then enter them on the MAR. RN-K indicated she did not do any assessment/ monitoring related to discontinuing R2's furosemide.

- The DON indicated she would have to look and see if there was any policy on monitoring with medication changes. The DON indicated if a weight was out of set perimeters it would flag and the unit manager would get a message in resident messages. The system had not flagged R2's weight gain for some reason and she was going to look into it. The DON verified a blood pressure and pulse had not been documented since 6/17/21, and stated she would look into that as well.

The undated facility policy Change In Condition, indicated when a significant change was identified or when there was a need to alter treatment significantly, the licensed nursing associate would consult with the attending provider and notify the resident/resident representative. The need to alter treatment significantly meant to stop a form of treatment because of adverse consequences or commence a new form of treatment to deal

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F 684	Continued From page 11 with a problem. Procedures were listed for the licensed nursing associate to assess significant change in the resident's condition through direct observation, interview, or report from other staff. Obtain a set of vital signs and repeat as needed or ordered. Open a matrix event and conduct a symptom review and assessment, as condition warrants. Notify the attending provider of the change in condition and implement orders for treatment and appropriate monitoring as directed. Notify the interdisciplinary team and resident or resident representative and document symptoms, assessment, observations, and resident and provider notification.	F 684		
F 880 SS=K	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following	F 880		8/23/21

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F 880	Continued From page 12 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 (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.	F 880		

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F 880	Continued From page 13 §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 implement the Centers for Disease Controls (CDC) guidance for individualized transmission-based precautions including appropriate personal protective equipment (PPE) and isolation precautions to prevent the spread of COVID-19 for 1 of 1 resident (R6) who displayed symptoms of COVID-19, resided on the dementia unit, wandered throughout the unit and subsequently tested positive for COVID-19. This practice resulted in an immediate jeopardy (IJ) situation which had the high likelihood to cause serious illness and/or death for 2 of 23 residents (R7, R8) who resided on the memory care unit and were not fully vaccinated; 2 of 67 residents (R9, R10) who were not fully vaccinated against COVID-19 and resided in other units of the facility, whose staff included unvaccinated employees who were assigned to alternating units throughout the building. In addition,this deficient practice had the potential to affect all 85 remaining vaccinated residents residing in the the facility that did not rise to the level of immediate jeopardy. The IJ began on 7/19/21, when R6 displayed symptoms of COVID-19 including fever, harsh, dry cough, nasal drainage and swollen, painful lymph nodes in her neck. A rapid antigen (screening) test was obtained with presumptive negative results. While awaiting a confirmatory COVID-19 test, the facility failed to implement individualized interventions for	F 880	F880 Infection Prevention & Control 1. Corrective Action for Resident Affected: R6 was placed in a semi private room without a roommate. Enhanced Respiratory Precautions were put in place. Staff were placed in full PPE. Care plan was reviewed to include individualized actions to promote social distancing and quarantine efforts. MD appointment and chest X-ray were completed on 7/23/21. PCR test was completed 7/22/21 with an additional test 7/23/21. Family was updated. 2. Actions as it applies to others: A general risk assessment was completed on 7/20/21 by IDT after PCR test for R6 was found positive. It was determined to immediately close the MCU into a temporary COVID Unit with dedicated staff. Entrances and processes to ensure no traffic between MCU and the rest of the building. All families and Medical Director was notified the evening of 7/20/21 of COVID outbreak. Because of the challenges inherent to a MCU in terms of ensuring strict isolation while managing complex dementia conditions we had designated MCU as a COVID Unit. All MCU residents were in quarantine status. All MCU residents had Covid monitoring and a full set of vitals daily x 14 days, then temp, respiration and oxygen saturation monitoring daily ongoing. The three	

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F 880	Continued From page 14 transmission-based precautions and isolation for R6, who continued to wander throughout the unit and subsequently tested positive for COVID-19. Further, staff present on the memory care unit were not wearing appropriate eye protection, N95 respirators, gowns or gloves prior to the facility obtaining a confirmatory COVID-19 test. The administrator, director of nursing (DON) and registered nurse(s) (RN)-A, RN-B, RN-C, RN-D, and RN-E were notified of the IJ on 7/22/21, at 2:30 p.m. The IJ was removed on 7/23/21, at 6:00 p.m. but noncompliance remained at the lower scope and severity level of F, widespread, which indicated no actual harm with potential for more than minimal harm that was not immediate jeopardy. Findings include: The CDC guidance People with Certain Medical Conditions dated 5/13/21, identified older adults were more likely to get seriously ill from COVID-19. More than 80 percent of COVID-19 deaths have occurred in people over the age of 65, and more than 95 percent of COVID-19 deaths have occurred in people older than 45. Further, among adults, the risk for severe illness from COVID-19 increases with age, with older adults at highest risk. Severe illness means that the person with COVID-19 may require hospitalization, intensive care, or a ventilator to help them breathe, or they may even die. The CDC guidance SARS-CoV-2 Antigen Testing in Long Term Care Facilities dated 1/7/21, directed symptomatic people who test antigen negative should have a confirmatory test performed. Confirmatory test should be performed with nucleic acid amplifications tests	F 880	unvaccinated residents in MCU will be monitored ongoing each shift for s/s of COVID infection including vitals and O2 saturations per ETAR. We will encourage and assist with the use of a mask ongoing with R6, R7, R8. If symptoms are noted the MD and family will be updated. All MCU residents were antigen tested on 7/20/21 and PCR tested with all returning negative. Facility will review CDC□s Considerations for Memory Care Units in Long Term Care Facilities (dated 5/12/2020) on how to best manage residents living in memory care units when there is a suspected or confirmed case of COVID-19 in the memory care unit and adopt as necessary in accordance with the risks and benefits in how that would affect individual residents specific to their needs. All residents who had the potential to have high risk exposure on the memory care unit had another PCR test obtained on 7/26, 5 days following potential exposure on 7/20 to R6. The facility policy on our COVID-19 protocols has been reviewed to ensure protocols are in place for quarantining symptomatic residents and use of appropriate PPE according to current CDC guidance, regardless of vaccination status. The policy Guidance on Caring for Confirmed Cases of Covid was updated to include information on Memory Care. Education was provided to all nursing staff on when to quarantine and what PPE to wear with symptomatic residents. Post tests were maintained to ensure understanding. All residents in the long term care and patients in short term care	

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F 880	Continued From page 15 (NAAT) such as reverse transcriptase polymerase chain reaction (RT-PCR). If an antigen test is presumptive negative, perform NAAT immediately (e.g., within 2 days). Symptomatic residents should be kept on transmission-based precautions until NAAT results return. The CDC guidance Interim Infection Prevention and Control Recommendation to Prevent SARS-CoV-2 Spread in Nursing Homes dated 3/29/21, directed residents with suspected SARS-CoV-2 infections should be prioritized for testing, should be cared for by healthcare personnel (HCP) using an N95 or higher-level respirator, eye protection (i.e. goggles or a face shield that covers the front and sides of the face) gloves and a gown. Ideally, the resident should be moved to a single-person room with a private bathroom while test results were pending. In general, it was recommended the door to the room remain closed to reduce transmission of SARS-CoV-2. However, in some circumstances such as memory care units, keeping the door closed may pose safety risks and the door might need to remain open. If doors remain open, implement strategies to minimize airflow into the hallway. Increase monitoring of residents with suspected or confirmed SARS-CoV-2 infection, including assessment of symptom, vital signs, oxygen saturation via pulse oximetry, and respiratory exam, to at least three times daily and quickly manage serious infection. The CDC guidance Considerations for Memory Care Units in Long-term Care Facilities dated 5/12/20, recommended facilities dedicate personnel to work only on memory care units when possible and try to keep staffing consistent.	F 880	and rehab (Station 240 and 230) will be observed, assessed and monitored for COVID-like symptoms, temp, respiration and O2 saturation daily per ETAR ongoing. We will encourage and instruct on the use of masks for the 2 unvaccinated residents, R 9 and R 10 when they are out of their room. We will monitor for COVID symptoms and vital/O2 saturations every shift ongoing for R 9 and R10. All activities and visitation were immediately stopped on 7/20/21 house-wide. All residents were antigen and PCR tested. 7/21/21 all tests have returned negative. We will proceed with the updated testing guidance and quarantine as conditions indicate and per policy. Infection Identification. If IDT determines any resident has had a high risk exposure further testing/quarantine will be deployed per protocol. 3. Measures put into place to prevent further issues: All staff have been educated regarding Infection Prevention and Control. Continued on hire, annual, and prn education for Infection Prevention and Control. 4. How the facility will monitor: Random audits of Infection Prevention and Control will be reviewed 5 times weekly x 90 days. Results of the audits will be reviewed by Quality Council, and if acceptable, will reduce to 3 random audits for 30 days, Results will be reviewed again by Quality Council, and if acceptable, audits will be on a 1 random audits/weekly ongoing. Infection Control Nurse and Director of Nursing will review completed audits. 5. Date of Correction 8/23/21	

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Limit personnel on the unit to only those essential for care. Limit the number of residents or space residents at least 6 feet apart as much as feasible when in a common area, and gently redirect The guidance directed when residents on a memory care unit are suspected or confirmed to have COVID-19: As it may be challenging to restrict residents to their rooms, implement universal use of eye protection and N95 or other respirators (or facemasks if respirators are not available) for all personnel when on the unit to address potential for encountering a wandering resident who might have COVID-19.
Consider potential risks and benefits of moving residents out of the memory care unit to a designated COVID-19 care unit.

During entrance conference on 7/19/21, at 10:00 a.m. the licensed social worker (LSW) stated the facility census included 90 residents and there were no active or suspected COVID-19 cases in the building.

During interview on 7/19/21, at 4:21 p.m. documentation provided was reviewed with the infection preventionist, RN-A who indicated it included undated lists of vaccinated and unvaccinated residents and staff. The resident list identified 93% of the facility residents had received the COVID-19 vaccine and identified five residents (R7, R8, R9, R10 and R6) who were not vaccinated as of 7/19/21. A handwritten note on the report indicated staff were to wear surgical masks at all times and eye protection if they were not vaccinated. Facility staff were not required to wear eye protection if they were vaccinated. The note also indicated a county positivity rate of 1.3%. The employee list identified 93 employees had declined vaccination, 111 employees

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received vaccination and 17 employees entries on the report were blank with no declination or vaccination status identified.

R7's quarterly Minimum Data Set (MDS) dated 7/8/21, indicated R7 was greater than 100 years of age and had diagnoses which included Alzheimer's disease, hypertension, chronic kidney disease, and a history of other diseases of the circulatory system. R7's medical record identified R7 was not fully vaccinated.

R8's quarterly MDS dated 7/5/21, indicated R8 was greater than 95 years of age and had diagnoses which included vascular dementia with behavioral disturbance, chronic kidney disease, stage 4, hypertension, and a history of myocardial infarction (heart attack). R8's R7's medical record identified R7 was not fully vaccinated.

R9's quarterly MDS dated 2/21/21, indicated R9 was greater than 90 years of age and had diagnoses which included coronary artery disease, hypertension, heart failure, nonrheumatic mitral valve insufficiency, diabetes mellitus, kidney disease, and Guillain-Barré syndrome (an autoimmune disorder). R7's medical record identified R7 was not fully vaccinated.

R10's admission MDS dated 6/14/21, indicated R10 was greater than 85 years of age and had diagnoses which included coronary artery disease, heart failure, ischemic cardiomyopathy, nonrheumatic mital valve insufficiency, kidney disease, hypertension, cardiac pacemaker respiratory failure, COPD, and cancer. The MDS also indicated R10 had shortness of breath or trouble breathing when lying flat. R7's medical

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record identified R7 was not fully vaccinated.

R6's admission Minimum Data Set (MDS) dated 6/21/21, indicated R6 was greater than 95 years of age, had severe cognitive impairment and diagnoses which included dementia, anxiety disorder, and hypertension. R6 did not display behavioral symptoms or rejection or care but did experience delusions and wandering behaviors which occurred 1-3 days of the assessment period. R6 required extensive assistance with all activities of daily living except only required supervision with eating. R6's medical record identified R6 was not fully vaccinated.

R6's behavioral symptoms Care Area Assessment (CAA) dated 6/21/21, indicated R6 had recently admitted from assisted living to memory care. She had a history of wandering and would need time to adjust to the new environment.

R6's care plan dated 6/14/21, identified R6 was at risk for infection due to COVID-19 pandemic with confirmed cases reported in the community and directed staff to observe for, document, and promptly report signs and symptoms of COVID-19, follow facility protocols for COVID-19 screening/precautions, and educate staff, resident, family and visitors of COVID-19 signs, symptoms and precautions. The care plan also identified R6 was non-compliant with wearing a mask for protection from COVID-19 due to cognitive deficits and directed staff to attempt to provide another mask if the fit was contributing to non-compliance; educate on the importance of wearing a mask; provide frequent reminders and assistance to wear a facemask; adhere to federal and state visiting restrictions and staff in the

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community were to wear appropriate PPE.

R6's Resident Progress Notes dated 7/19/21 to 7/20/21, included the following:
-7/19/21 at 7:58 p.m. Noted to have a dry harsh cough. Resident was flushed, had clear drainage from nose. Temperature (T) 100.6, would not allow any other vital signs to be taken. Lymph nodes in the neck were swollen, and R6 reported they were painful. Rapid COVID test was negative.
-7/20/21 at 10:49 a.m. R6 continued to have a runny nose and occasional cough. T 98.8, O2 [oxygen saturation] 90% on room air.
-7/20/21 at 2:54 a.m. Return fax from PCP [primary care physician]. She can be evaluated. I believe I'll be there a.m. 7/22.
-7/20/21 at 2:55 p.m. Call placed to daughter to update her to status. Daughter will take R6 into clinic to be evaluated
-7/20/21 at 3:03 p.m. Would not be able to get in until tomorrow, plan is to continue to monitor status, update family and PCP with any changes. Will be seen by PCP on 7/22.
-7/20/21 at 5:17 p.m. COVID-19 nasopharyngeal test completed at 4:40 p.m.
-7/20/21 at 5:30 p.m. Called the lab to ask about COVID-19 PCR, test results was positive. Update to team leader immediately, directed R6 to her room, enhanced respiratory precautions initiated.

R6's Event Report dated 7/19/21 at 8:12 p.m. Infection Control - Potential Upper Respiratory Tract Infection SBAR (Situation Background Assessment Recommendation) Nurse to IP Communication completed by LPN-C identified R6 met criteria for upper respiratory tract infection with symptoms of runny nose or sneezing, dry

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cough and swollen or tender glands in neck. The form also included sections to indicate if lab, imagine, anti-infective medications, or isolation precautions were ordered or initiated; however, all sections were blank.

R6's medical record lacked documentation of any additional special accommodations made by the facility or individualized interventions implemented due to R6 residing on a memory care unit and her need for transmission-based precautions and isolation. Further, R6's medical record lacked evidence R6 was fully vaccinated from COVID-19.

During observations of the Memory Care Unit on 7/20/21, from 1:30 p.m. until approximately 2:00 p.m. approximately twelve unmasked residents were seated in chairs which lined the perimeter of the common entry area of the unit, along the wall of the nursing office, the sitting area by the courtyard door and along a curved wall in front of the enclosed television room. The chairs were placed side by side and were touching each other. Chairs were not spaced for adequate social distancing. R7 who was unvaccinated, and not wearing a facemask, was seated in a wheelchair near the door to the nursing office in the sitting area near the door to the outside courtyard. Other residents were seated in the area; however, were not wearing masks. R8 who was also unvaccinated and not wearing a mask, was seated in a wheelchair sleeping. R8's wheelchair was positioned very close to another vaccinated resident's chair along the curved wall. The chair was within touching distance without R8 having to extend her arm.

- R6 ambulated with the use of a walker through

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the common area. R6 wore a mask which was positioned underneath her chin. RN-B approached R6, touched her shoulder and prompted her to pull the surgical mask over her nose and take a seat in a chair in the row of chairs along the wall in front of the nursing office. R6 was hard of hearing so RN-B leaned forward closely, approximately 8 inches from R6's face, and gestured, as well as, verbally again prompted her to raise the mask over her nose and mouth. RN-B wore a laboratory jacket over street clothing, a surgical mask over her mouth and nose and prescription glasses; however, was not wearing any other form of PPE such as gown, gloves or eye protection (i.e. goggles or a face shield that covered the front and sides of the face) or an N95 respirator. RN-B prompted R6 to sit in a chair directly next to a female vaccinated resident. The chairs were touching and R6 and the resident could touch each other by just extending their hands. R6 was the only resident in the common area wearing a face mask. RN-B did not direct R6 back to her room to isolate her from the other residents in the unit, nor were any prompts to encourage social distancing attempted with R6 or any of the residents seated in the area.

- During interview on 7/20/21, at approximately 1:40 p.m. RN-B stated when she saw a mask around the neck, she automatically prompted the resident to pull it up. She wasn't sure why R6 had a surgical mask on but would check. RN-B guessed R6 just liked to wear a surgical mask as R6 came from a family of nurses that come and go and R6 just preferred to wear a mask.

- At approximately 1:45 p.m. R6 stood up independently from her chair with the use of her

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walker and crossed the common area and sat next to R11, another unvaccinated, unmasked resident. There were no staff in the area to intervene or provide redirection. R6 pulled her surgical mask beneath her nose and fell asleep in the chair. NA-Q and NA-R were observed working throughout the unit assisting other residents to lay down. Both NAs were dressed in scrubs and wore surgical masks, they were not wearing gowns, gloves or appropriate eye protection.

- During the observation, a tour of the unit there was no signage of any kind R6's room door, nor were there any isolation carts for PPE storage and disposal, to identify transmission-based precautions were in place or any isolation or quarantine measures had been implemented. Nor were there any signs anywhere on the unit. No carts with PPE such as gowns, gloves, or eye protection, were noted to be available in patient care areas. Residents moved throughout the unit, in the common areas, or in their rooms, per their usual manner.

During interview in the common sitting area, on 7/20/21, at approximately 1:50 p.m. LPN-C stated R6 came from the assisted living, and they had to wear masks there, so R6 was used to wearing a mask. R6 had a cough yesterday, so they were trying to have her wear the mask all the time. The doctor had been notified of her cough. LPN-C was dressed in scrubs and wore a surgical mask with no other PPE such a gown, gloves, or eye protection or N95 respirator. Upon completion of the interview, LPN-C returned to the nursing office and did not direct R6 to her room to isolate her from the other residents in the unit, nor were any prompts to encourage social

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distancing attempted with R6 or any of the residents seated in the area.

- During this time, NA-R entered the common area on two separate occasions to assist two different residents from the sitting area back to their rooms. At no time did NA-R redirect R6 to her room to isolate her from the other residents in the unit, nor were any verbal prompts or reminders made to encourage social distancing among any of the residents including R6 and R8 who were unvaccinated and seated within close proximity to other residents. R6 remained seated next to R11 sleeping with her mask beneath her nose. R6 and R11's chairs were touching. The residents were seated in close proximity and could touch each other without extending their arms.

On 7/20/21, at 4:11 p.m. the DON was notified of the need to obtain an PT-PCR test for R6. Then during interview outside the DON office RN-A was requested to obtain an RT-PCR test for R6 as soon as possible. RN-A stated she was not sure about the ability to obtain the test results today as the local hospital completed all their testing and she would have to check with them to see. She would try to get it in today if able. She felt R6's symptoms were related to the recent air quality issues and smoke haze rather than COVID-19 infection.

R6's SARS CoV2 (COVID-19) laboratory report dated 7/20/21, indicated the SARS-CoV-2 (COVID-19) by NAAT (nucleic acid amplifications test) value was detected. The report indicated a "detected" result was positive and indicated a presence of target viral nucleic acids which were generally detectable in upper respiratory

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specimens during the acute phase of infection. The positive result was reported to the facility at 6:22 p.m.

On 7/21/21 at 8:00 a.m. upon entry to the facility, the DON was observed at the facility entrance. Signage was in place in the entrance announcing no visitation was allowed due to positive COVID-19 status in the building. DON was conducting education with staff as they entered the building which included a post-test. Additional nursing staff conducted symptom screening and rapid antigen testing on all in-coming staff. The DON stated R6 had tested positive on her PCR test so they were educating staff and going into outbreak mode.

During interview on 7/21/21, at 11:16 a.m. nursing assistant (NA)-P stated staff were to wear a mask, gown, and goggles if a resident had COVID-19. NA-P did not identify the type of mask staff were supposed to wear.

During interview on 7/21/21, at 11:22 a.m. trained medication assistant (TMA)-A stated she would report symptoms such as fever, cough or chills to the unit manager or nurse so they could swab the resident (obtain a test for COVID-19) and have them stay in their room until they were tested. Residents who had symptoms were to stay in their room. She also stated they had a lot of staff that worked in both the memory care unit and on the long-term care units of the facility.

During interview on 7/21/21, at 11:30 a.m. NA-G stated they watched residents for symptoms such as cough, monitored their oxygen saturations every shift, signs of them "not being themselves" or fever and would report these findings to the

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nurse. She indicated they performed a rapid test on these residents and kept them in their room and used PPE such as gown, gloves, mask, and eye protection until the test results were back and they were cleared to use less stringent measures.

During interview on 7/21/21, at 11:37 a.m. RN-J stated if residents displayed respiratory or other symptoms of potential COVID-19 she would expect staff to put the resident in respiratory isolation, obtain a rapid test, notify the physician, resident family, and administration. Pending the results would then do a follow up PCR test and would confer with the infection preventionist.

During interview on 7/21/21, at 11:53 a.m. licensed practical nurse (LPN)-B stated if a resident displayed potential symptoms of COVID-19 she would complete an assessment, obtain vital signs, notify the nurse, and obtain a test if indicated. She also stated she would quarantine the resident and implement transmission-based precautions.

During interview on 7/21/21, at 1:56 p.m. NA-S stated she worked in the memory care unit and they had three unvaccinated residents in that unit. They tried to keep the residents away from others. R7 and R8 were better than R6 at staying in their room. R6 was not good about staying in her room and they had to redirect her or sit with her or provide her with one-to-one supervision. She was working with R6 all week. R6 developed symptoms on Monday evening (7/19) and they had tried to keep her away from others as much as possible. R6 didn't understand why she had to stay in her room, so it was difficult to get her to do so. The next day she was out like every other day. After they learned of R6's positive COVID

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test they were told to move her to an empty room on the unit; however, she didn't really sleep or even go in her room and usually slept in a recliner in the main area. There were a couple of residents on the unit who would wear masks but didn't know why they were wearing them so weren't consistent. NA-S normally worked in the memory care unit; however, other staff floated between units frequently.

During interview on 7/21/21, at 2:03 p.m. NA-A stated she was working 7/19/21, when R6 began showing symptoms. LPN-C did a rapid test and the result were negative and they had a difficult time getting an assessment. R6 was fatigued, having behaviors, a runny nose, a dry, bad cough and was running a temperature. They put a mask on her and tried to give her Tylenol, but she would not take it. She kept pacing and wouldn't sit down. They tried to put her in her room, but she wouldn't go in there and kept pacing. The other residents on the unit were pretty much in their rooms at this time, only two other residents were up so they kept her away from everyone. You could tell she was sick. The next morning (7/20), she remembered seeing her when she walked in for her shift. She was seated in the common area and was tired and was wearing a mask but would take it off. NA-A reminded her to keep it on. R6 was very sleepy. She didn't like staying in her room and was still out and about in the unit because her test had come back negative. She added without prompting that she knew there could be false negatives with the rapid test. She also indicated she had been picking up extra shifts and worked in both the memory care unit and long-term care units of the facility. NA-A did not identify any interventions implemented upon the onset of R6's illness to address transmission

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based precautions other than attempted social distancing of R6 from the other residents on the unit the evening of 7/19/20.

During interview on 7/21/21 at 4:10 p.m. RN-A stated R6 became symptomatic on Monday night, 7/19/21, at approximately 8:00 p.m. Staff completed a rapid antigen test which was negative. She had a temperature of 100.6. R6 usually always wore a mask. They did try to redirect her to her room; however, it was very difficult for her. They would ordinarily try to quarantine with a symptomatic resident but was very difficult in the memory care unit. After they had received R6's positive test results, they had talked about moving her to an empty room; however, they ended up moving the roommate instead due to R6's behaviors. Further, the facility had not obtained the confirmatory PCR test on 7/20/21, prior to surveyor request. The plan had been to do that during an appointment with R6's primary care provider (PCP) on 7/22/21. She asked staff to arrange for an earlier appointment but was unaware they were not able to arrange an appointment prior to 7/22/21.

- RN-A did not identify any updated interventions related to transmission-based precautions such as isolation carts for PPE storage and disposal, signage to identify precautions were in place or any isolation/quarantine measures had been implemented upon onset of R6's symptoms, nor were staffing practices changed at that time. She indicated they had utilized dedicated staff for the memory care unit for a while; however, after residents had received vaccinations, they had opened that up and allowed staff to work throughout the building. They stopped that practice as soon as R6's positive test result

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returned and again dedicated staff to the unit.

During group interview with the administrator, DON, RN-B, RN-A, RN-K, and RN-C on 7/21/21 at 5:45 p.m. the DON stated R6 was symptomatic on Monday, 7/19/21, received a rapid screening test and was negative. She expected staff to observe the resident's vitals signs and ensure the resident was wearing a mask which was difficult on the unit, but they tried. R6 liked to wear a facemask sometimes; however, it was difficult with dementia residents. They could never stay put, it was a memory care unit and is all of their home. The antigen test was not a confirmatory test, so you get a PCR test to confirm. If a resident was symptomatic, you would also quarantine unless a physician has provided an alternative diagnosis or until a PCR stated the result was negative. However, it was very difficult to quarantine in a memory care. The administrator stated it was impossible to quarantine in a memory care unit due to the wandering behaviors. RN-B stated they did the best they could to keep residents apart and tried to get them to wear a mask. DON stated she would expect them to do that. PCR should be obtained the next day and they had planned to do the test it had just not been done yet. It had been their intention all long to get the confirmatory PCR test. None of the faciliy staff present for the interview could identify what interventions discussed, attempted, or implemented in an effort to provide isolation status for R6 and minimize the risk of spread of COVID-19 on the unit.

During follow-up interview on 7/22/21, at 5:17 p.m. NA-A stated LPN-C and NA-A obtained the rapid test on R6 and she really struggled with it. She kept turning her head and her eyes were

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watering. It was really hard to get it. R6 fought it. R6 was in the common area and there were about 4 other residents there throughout the night to NA-A's knowledge. The residents didn't like staying in their rooms and the masks really made their behaviors worse. When NA-A came in the a.m. R6 was sleeping in the chair in common area. Her mask was down and laying on her chest. Another resident was in the common area at that time too, but she could not recall if the other resident wore a mask. Normally, they put a symptomatic person in isolation for 14 days.

During follow up interview on 7/22/21, at 6:15 p.m. NA-S stated the night R6 became ill was like any other night. After supper, R6 started coughing more, getting more sniffily and she wouldn't eat her supper. They got a rapid test and that was negative. She really wasn't around the other residents, but she wouldn't stay in her room, and she wouldn't keep the mask on. NA-S was wearing their surgical mask and goggles like usual. NA-S did not identify any interventions implemented after the onset of R6's symptoms. She was notified of R6's positive COVID-19 test result when she came to work the evening of 7/20/21. At that time, they moved R6 to an open room which made R6's behaviors worse, so they put her back and moved her roommate to the open room instead. They really didn't tell me to do anything different with her roommate or any of the other residents. When I was working with R6 I needed to wear a gown, surgical mask, goggles, and gloves, but anyone else it was just the surgical mask, goggles, and gloves but no gown. We put a cart outside R6's room. Otherwise for other residents it was nothing special. When someone was symptomatic, they tell us what to do.

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F 880	Continued From page 30 The 2019 Novel Coronavirus policy dated 5/8/20, directed if any resident were to present with fever or symptoms, implement recommended IP [infection prevention] practices: a. Standard, Contact and Droplet Precautions b. Restrict resident with respiratory symptoms to their room c. If they need to leave their room for a medical reason, they will have a facemask in place d. Contact primary provider for further direction on what tests to perform e. Contact family to notify them of change in condition. The policy identified preventive measures to include: remind residents to practice social distancing - maintaining a distance of 6 feet of another - while performing frequent hand hygiene. The policy did not address staffing considerations. The Guidance on Caring for a Confirmed Case of COVID-19 policy dated 7/2/20, directed if a resident was presenting with respiratory symptoms, the resident must remain in room on standard, contact and droplet precautions while waiting for diagnostic laboratory results. The policy also directed if a resident diagnosed with COVID or pending test results leaves room, they should have on a facemask, perform hand hygiene, limit their movement in the community, and perform soical distancing - staying a minimum of 6 feet away from others. The IJ which began on 7/19/21, was removed on 7/23/21 at 6:00 p.m. when it could be verified through observation, interview and document review the facility: conducted a general risk	F 880		

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VILLA ST VINCENT	516 WALSH STREET CROOKSTON, MN 56716

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F 880	Continued From page 31 assessment for those potentially exposed to R6 and immediately closed the Memory Care Unit and converted it into a temporary COVID unit with dedicated staff, entrances and processes to ensure no traffic between the unit and the rest of the building. The facility reviewed the CDC's Considerations for Memory Care Units in Long Term Care Facilities dated 5/12/20, on how to best manage residents living in memory care units when there was a suspected or confirmed case of COVID-19 and adopt as necessary in accordance with the risks and benefits in how that would affect individual residents specific to their needs. The facility reviewed and revised their COVID-19 protocols for quarantine/isolation of symptomatic residents and use of appropriate PPE according to CDC guidance and updated their policy to include information for the Memory Care unit. The facility identified monitoring and testing plans for all facility residents, suspended all activities and visitation and educated their staff regarding this plan.	F 880		
F 886 SS=K	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency;	F 886		8/23/21

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F 886	Continued From page 32 (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who	F 886		

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F 886	Continued From page 33 refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to test staff for COVID-19 according to Centers for Disease Control (CDC) guidance for outbreak and routine resting requirements. In addition, the facility failed to ensure a confirmatory, RT-PCR (real-time reverse transcription polymerase chain reaction [rRT-PCR] test) was obtained for 1 of 1 resident (R6) after a presumptive negative rapid antigen (screening) and was displaying signs and symptoms of COVID-19. This practice resulted in an immediate jeopardy (IJ) situation which had the high likelihood to cause serious illness and/or death for 2 of 23 residents (R7, R8) who resided in the locked memory care unit and were not fully vaccinated against COVID-19; and 2 of 67 residents (R9, R10) who were not fully vaccinated against COVID-19 and resided in other units of the facility whose staff included unvaccinated employees who were assigned to alternating units throughout the building. In addition, this deficient practice had the potential to affect all 85 remaining vaccinated residents residing in the the facility that did not rise to the level of immediate jeopardy. The IJ began on 4/21/21, when the facility was notified a staff member tested positive for COVID-19 and the facility failed to ensure all	F 886	F886 COVID-19 Testing-Residents & Staff 1. Corrective Action for Resident Affected: R6 was placed in a semi private room without a roommate. Enhanced Respiratory Precautions were put in place. Staff were placed in full PPE. Care plan was reviewed to include individualized actions to promote social distancing and quarantine efforts. MD appointment and chest X-ray were completed on 7/23/21. PCR test was completed 7/22/21 with an additional test 7/23/21. Family was updated. 2. Actions as it applies to others: All staff were tested prior to their next shift or immediately, whichever came first. If they refuse to test they were be removed from the schedule. As in outbreak, all staff were antigen and PCR tested upon arrival for their first shift after R6 had a positive PCR. Testing and 1:1 education was continued for all shifts ongoing. Outbreak testing continued until deemed no longer in outbreak per CDC guidance. The next testing date was July 26th for all staff. All testing dates will include a minimum of 2 makeup dates to accommodate staff as well as the opportunity for point of care	

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F 886	Continued From page 34 active staff were immediately tested for COVID-19 prior to working (or removed from the schedule) and continued to work without testing; along with following ongoing outbreak testing to ensure no more active cases were circulating within the facility. In addition, the facility failed to ensure all unvaccinated staff were routinely tested at the minimum requirements per the county positivity rate. The administrator, director of nursing (DON) and registered nurse(s) (RN)-A, RN-B, RN-C, RN-D, and RN-E were notified of the IJ on 7/22/21, at 2:30 p.m. The IJ was removed on 7/23/21, at 6:00 p.m. but noncompliance remained at the lower scope and severity level of F, widespread, which indicated no actual harm with potential for more than minimal harm that was not immediate jeopardy. Findings include: The CDC guidance People with Certain Medical Conditions dated 5/13/21, identified older adults were more likely to get seriously ill from COVID-19. More than 80 percent of COVID-19 deaths have occurred in people over the age of 65, and more than 95 percent of COVID-19 deaths have occurred in people older than 45. Further, among adults, the risk for severe illness from COVID-19 increases with age, with older adults at highest risk. Severe illness means that the person with COVID-19 may require hospitalization, intensive care, or a ventilator to help them breathe, or they may even die. During entrance conference on 7/19/21, at 10:00 a.m. the licensed social worker (LSW) stated the facility census included 90 residents and there were no active or suspected COVID-19 cases in the building. Documentation regarding the	F 886	antigen test prior to scheduled shift. Staff were informed of each test via phone tree communications. The IP will track to ensure all staff had been tested prior to working. The facility policy, “Benedictine Testing Guidance Minnesota” has been reviewed and revised to reflect protocol for routine testing of staff, to ensure all staff are tested at the minimum frequency as indicated by the county positivity rate. Policy has been updated to reflect ability for staff to have access to make up dates for testing. PCR test will be completed when any staff or resident is displaying signs and symptoms of COVID-19.Education was being provided on current and updated COVID protocols to staff during testing prior to scheduled shifts and did continue on all required testing dates. Completion of testing and training will be tracked, analyzed and acted on to ensure compliance. Staff were educated on expectations regarding routine and outbreak testing and when we would utilize a PCR test. All employees are screened and any employee showing signs/symptoms of COVID will receive an antigen test followed by a PCR test. Return to work based on test results, symptoms and/or primary care provider involvement. 3. Measures put into place to prevent further issues: On hire, annual, and as needed education will be provided on Testing-Residents and Staff. 4. How the facility will monitor: Weekly audits will be completed by IP or IP designee for compliance with testing of residents and staff.	

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F 886	Continued From page 35 facility's COVID-19 policies and procedures, resident and staff vaccination information and testing tracking records were requested. Outbreak and Routine Testing: The CDC Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination dated 4/27/21, identified COVID-19 testing was required regardless of vaccination status during an outbreak. In nursing homes with an outbreak of COVID-19, healthcare personnel (HCP) and residents regardless of vaccination status should have a viral test immediately and every 3-7 days until no new cases were identified for 14 days. The CDC expanded screening testing of asymptomatic HCP recommendations further identified in nursing homes located in counties with <5% positivity of viral tests in the past week, unvaccinated HCP should have a viral test once a month. If unvaccinated HCP work infrequently at these facilities, they should ideally be tested within the 3 days before their shift (including the day of the shift). During interview on 7/19/21, at 4:21 p.m. the infection preventionist, RN-A indicated the last positive COVID-19 case at the facility was for an employee in April which had placed the facility in outbreak testing which concluded the beginning of May. The facility had been in routine testing status since that time with the last round of testing completed 6/22/21, and the next round of routine testing due 7/27/21. Untitled, undated documentation was provided and was reviewed with RN-A who indicated it included undated lists of vaccinated and unvaccinated residents and staff.	F 886	5. Date of Correction: 8/23/21	

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- The resident list identified 93% of the facility residents had received the COVID-19 vaccine and identified five residents (R6, R7, R8, R9 and R10) who were not vaccinated as of 7/19/21. A handwritten note on the report indicated staff were to wear surgical masks at all times and eye protection if they were not vaccinated. Facility staff were not required to wear eye protection if they were vaccinated. The note also indicated a county positivity rate of 1.3%. The employee list identified 93 employees had declined vaccination, 111 employees received vaccination and 17 employees entries on the report were blank with no declination or vaccination status identified.

R7's quarterly Minimum Data Set (MDS) dated 7/8/21, indicated R7 was greater than 100 years of age and had diagnoses which included Alzheimer's disease, hypertension, chronic kidney disease, and a history of other diseases of the circulatory system. R7's medical record identified R7 was not fully vaccinated.

R8's quarterly MDS dated 7/5/21, indicated R8 was greater than 95 years of age and had diagnoses which included vascular dementia with behavioral disturbance, chronic kidney disease, stage 4, hypertension, and a history of myocardial infarction (heart attack). R8's medical record identified R8 was not fully vaccinated.

R9's quarterly MDS dated 2/21/21, indicated R9 was greater than 90 years of age and had diagnoses which included coronary artery disease, hypertension, heart failure, nonrheumatic mitral valve insufficiency, diabetes mellitus, kidney disease, and Guillain-Barré syndrome (an autoimmune disorder). R9's

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medical record identified R9 was not fully vaccinated.

R10's admission MDS dated 6/14/21, indicated R10 was greater than 85 years of age and had diagnoses which included coronary artery disease, heart failure, ischemic cardiomyopathy, nonrheumatic mital valve insufficiency, kidney disease, hypertension, cardiac pacemaker respiratory failure, COPD, and cancer. The MDS also indicated R10 had shortness of breath or trouble breathing when lying flat. R10's medical record identified R10 was not fully vaccinated.

R6's admission Minimum Data Set (MDS) dated 6/21/21, indicated R6 was greater than 95 years of age, had severe cognitive impairment and diagnoses which included dementia, anxiety disorder, and hypertension. R6 did not display behavioral symptoms or rejection or care but did experience delusions and wandering behaviors which occurred 1-3 days of the assessment period. R6 required extensive assistance with all activities of daily living except only required supervision with eating. R6's medical record identified R6 was not fully vaccinated.

During interview on 7/20/21, at 9:47 a.m. RN-A stated the facility had a contract with Mayo Clinic for their COVID-19 testing. They completed their testing onsite, sent the tests to Mayo and Mayo returned the results electronically. RN-A downloaded the lab results from Mayo, reviewed them and sent the results to Human Resources (HR). Due to a county positivity rate of 0.6% on 6/22/21, the facility met monthly routine testing requirements. The last routine testing was completed 6/22/21. RN-A opened the 6/22/21, testing spreadsheet with the attached clinical

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laboratory test results file and indicated the spreadsheet was color coded based on employee vaccination status and test result. Staff identified in purple were vaccinated and were not required to be tested. Staff identified in green were unvaccinated and had a negative test. Staff identified in red were unvaccinated and did not test.

- Upon opening the untitled, undated spreadsheet, the spreadsheet was not up to date and RN-A began to make entries for staff not tested as she reviewed them and stated she knew the information in her head. RN-A also identified some of the employees on the spreadsheet worked solely at the assisted living facility as she made entries into the spreadsheet. RN-A stated they tested on a Tuesday; however, would test anytime between the scheduled date of testing and the day before. She tried to make it reasonable and convenient for staff to test and left testing kits at the facility so the night shift could test during their shift as staff had been trained to test themselves. She also tried to accommodate with multiple times for casual staff. She sent reminders of the testing times and if staff did not test would notify HR.

- The untitled, undated spreadsheet identified 31 unvaccinated staff tested negative; however, there were 42 unvaccinated staff who were not tested. RN-A stated not all staff were available at the time of testing as some were on medical leave, some were on vacation and one staff member was not eligible for testing due to a previous positive test less than 90 days prior. If staff missed outbreak testing they were taken off the schedule until they were tested but she was not sure what the policy directed for the routine

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testing. They did not require staff to test for someone who traveled or took vacation unless they were symptomatic. Vaccinated staff were not required to be tested for routine testing. However, all staff would be tested for outbreak testing.

During interview on 7/20/21, at 11:09 a.m. RN-A identified the last outbreak period was due to an employee positive test which occurred 4/20/21 and the outbreak ended 5/5/21. There was only one positive test result. All staff were clear prior to discontinuation of outbreak testing and staff were not allowed to work if they missed testing.

During interview on 7/21/21, at 9:46 a.m. human resources manager (HRM) stated she assisted RN-A with tracking of declinations of staff vaccinations. She identified of the 17 blanks noted on the staff vaccination report, 8 of the staff members had not returned a declination, were not vaccinated and currently worked at the facility.

During interview on 7/21/21, at 11:10 a.m. health unit coordinator (HUC)-A stated vaccinated employees were not required to test for COVID-19 and indicated they had been testing monthly prior to a recent outbreak. He was not aware of any make up days for missed tests; however, HUC-A never needed to make up a test. HUC-A thought RN-A notified staff to let her know if they couldn't make it for scheduled testing and arrangements could be made. HUC-A was not aware of any requirements which needed to be followed if staff missed testing.

During interview on 7/21/21, at 11:16 a.m. nursing assistant (NA)-P stated staff were notified via text regarding testing times and indicated testing was

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offered on one day. Further, NA-P was vaccinated so was not required to test.

During interview on 7/21/21, at 11:22 a.m. trained medication assistant (TMA)-A stated she had not received the COVID-19 vaccination and the testing frequency depended "on the numbers". Staff were notified via email, on the board or by the phone tree of the testing date and they could test during certain hours but could not remember the specifics. TMA-A was not sure what would happen if testing was missed. She didn't think she had been present for the facility testing in June and was not required to complete a test prior to returning to work. She wore a face mask and goggles all the time while in the facility due to her unvaccinated status.

During interview on 7/21/21, at 11:30 a.m. NA-G stated routine testing was once a month and was only for unvaccinated staff. The testing was only on one day and they were notified of the testing through their phone tree; however, they could go see RN-A and she would do a test in her office. She did not think they would let her go back to work without being tested if she had missed a test.

During interview on 7/21/21, at 11:37 a.m. RN-J stated routine testing was based on county positivity rates and most recently was completed monthly. Staff would be notified via text, phone, and email and information was also posted next to the facility time clock. Testing was usually arranged over a couple of days. If staff couldn't make it RN-A would make arrangements to accommodate. All they would have to do is contact RN-A or RN-C and they would address getting the testing completed. RN-J didn't believe

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staff were allowed to work if they had not tested or neglected to test.

During interview on 7/21/21, at 4:10 p.m. RN-A stated 48% of the staff were vaccinated and 52% of the staff were unvaccinated at this time. The unvaccinated, untested staff identified on the routine testing spreadsheet dated 6/22/21, were reviewed with RN-A, 30 of the previously identified 42 untested staff (RN-F, RN-G, RN-H, RN-I, trained medication aid (TMA)-A, nursing assistant (NA)-A, NA-B, NA-C, NA-D,NA-E,NA-F,NA-G,NA-H,NA-I,NA-J,NA-K,NA-L,NA-M,NA-N,NA-O, cook (C)-A, C-B, culinary services aid (CSA)-A, CSA-B, CSA-C, CSA-D, CSA-E, CSA-F, laundry assistant (LA)-A, and beautician (B)-A) were determined to have required testing. RN-A stated she did not do any type of follow-up with staff who missed testing, nor did she ensure these staff received a test prior to returning to work.

During group interview with the administrator, DON, RN-B, RN-A, RN-K, and RN-C on 7/21/21 at 5:45 p.m. the administrator and DON both stated that while formal COVID-19 testing was offered on a specific day, staff could come in for testing at any time. The administrator indicated it was her understanding the facility needed to provide testing per the county positivity rate but not that staff had to be tested as staff had the right to refuse testing. She indicated their facility policy allowed for staff to continue to work after refusal to test when in routine testing status and she believed these aforementioned 30 staff had refused testing.

- When asked if all staff would have been tested at the time of the facility's last outbreak from

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4/20/21 to 5/5/21, the administrator stated yes. When asked if staff, last tested during outbreak (which ended 11 weeks prior) yet continued to work in the facility, had met the minimum monthly testing requirements, the administrator reiterated staff's right to refuse testing and stated they could not force staff to test. When asked if she would expect monitoring of staff testing adherence and follow up of staff who had not tested, she stated yes.

Individual Mayo Clinic Laboratories SARS Coronavirus 2 RNA, PCR, V reports for the 30 aforementioned employees who were not tested during the round of routine testing on 6/22/21, were reviewed with the facility master schedules and identified the following information:

Kitchen staff:
CSA-A: no previous test result provided, worked 6 days during the outbreak period
CSA-B: no previous test result provided, worked 5 days during the outbreak period
CSA C: last tested 3/9/21, worked 8 days during the outbreak period
CSA-D: last tested 11/27/20, worked 5 days during the outbreak period
CSA-E: last tested 3/9/21 worked 7 days during the outbreak period
C-B: last tested 3/9/21 worked 9 days during the outbreak period

Laundry Staff
LA-A: no previous test result provided, worked 2 days during the outbreak period

Nursing Staff
RN-F: last tested 3/2/21, worked 4 days during the outbreak period

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RN-G: last tested 11/10/20, worked 2 days during the outbreak period
RN-H: last tested 12/1/20, worked 8 days during the outbreak period

During group interview with RN-A, RN-B, culinary services manager (CSM) and DON on 7/23/21, at 4:31 p.m. RN-A stated all staff were required to be tested during outbreak status and if staff did not show up for testing, they were not supposed to work while the facility remained in outbreak status. The facility campus included a nursing home and attached assisted living which were both serviced by a single kitchen. Kitchen staff may have duties primarily assigned to the nursing home or assisted living; however, all kitchen staff worked out of the same kitchen space.

- RN-A stated CSA-A and CSA-B never completed a COVID-19 test yet continued to work at the facility and worked during the most recent outbreak and were not removed from the schedule as required. CSM stated kitchen staff were not tested and had worked during the outbreak as described above. CSM and DON stated exposure to the nursing home would be limited for kitchen staff identified due to assignments in the assisted living, never leaving the kitchen or only brief deliveries in the nursing home. However, RN-A indicated no risk assessment for kitchen staff had been completed. RN-B and DON stated the nursing staff were not tested during outbreak as required and had worked the identified dates. The DON stated the facility policy directed staff could not work if they had not completed testing during a COVID-19 outbreak.

The Centers for Medicare and Medicaid (CMS)

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VILLA ST VINCENT	**516 WALSH STREET CROOKSTON, MN 56716**

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QSO-20-38-NH memo revised 4/24/21, directed, " An outbreak is defined as a new COVID-19 infection in any healthcare personnel (HCP) or any nursing home-onset COVID-19 infection in a resident. In an outbreak investigation, rapid identification and isolation of new cases is critical in stopping further viral transmission. For outbreak testing, all staff and residents should be tested, regardless of vaccination status, and all staff and residents that tested negative should be retested every 3 days to 7 days until testing identifies no new cases of COVID-19 infection among staff or residents for a period of at least 14 days since the most recent positive result. Routine testing of unvaccinated staff should be based on the extent of the virus in the community. Fully vaccinated staff do not have to be routinely tested. Facilities should use their county positivity rate in the prior week as the trigger for staff testing frequency." Routine testing intervals should be conducted as follows: less than 5 percent, once a month- 5 to 10 percent, once a week and greater than 10 percent twice a week. "The guidance above represents the minimum testing expected. Facilities must have procedures in place to address staff who refuse testing. Procedures should ensure that staff who have signs or symptoms of COVID-19 and refuse testing are prohibited from entering the building until the return to work criteria are met. If outbreak testing has been triggered and a staff member refuses testing, the staff member should be restricted from the building until the procedures for outbreak testing have been completed. The facility should follow its occupational health and local jurisdiction policies with respect to any asymptomatic staff who refuse routine testing." However, the state and local jurisdiction have no guidance on refusing

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routine testing.

Resident PCR Testing:

The CDC guidance SARS CoV-2 Antigen Testing in Long Term Care Facilities dated 1/7/21, identified symptomatic people who test antigen negative should have a confirmatory test performed. Confirmatory test should be performed with nucleic acid amplifications tests (NAAT) such as reverse transcriptase polymerase chain reaction (RT-PCR). As the sensitivity of antigen tests is generally lower than RT-PCR, negative POC antigen tests should be considered presumptive. Testing of symptomatic residents or HCP
If an antigen test is presumptive negative, perform NAAT immediately (e.g., within 2 days). Symptomatic residents should be kept on transmission-based precautions until NAAT results return.
If a confirmatory NAAT is performed within 2 days, people should be assumed to be infectious until the confirmatory test results are completed. For instance, in general, if a symptomatic resident tests presumptive negative by antigen test and a NAAT is performed, the resident should remain in Transmission-Based Precautions until the NAAT result is available.

R6's Behavioral Symptoms Care Area Assessment dated 6/21/21, indicated R6 had recently admitted from assisted living to memory care. She had a history of wandering and would need time to adjust to the new environment.

R6's care plan dated 6/14/21, identified R6 was at risk for infection due to COVID-19 pandemic with confirmed cases reported in the community and

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directed staff to observe for, document, and promptly report signs and symptoms of COVID-19, follow facility protocols for COVID-19 screening/precautions, and educate staff, resident, family and visitors of COVID-19 signs, symptoms and precautions. The care plan also identified R6 was non-complaint with wearing a mask for protection from COVID-19 due to cognitive deficits and directed staff to attempt to provide another mask if the fit was contributing to non-compliance, educate on the importance of wearing a mask, provide frequent reminders and assistance to wear a facemask, adhere to federal and state visiting restrictions and staff in the community were to wear appropriate PPE.

R6's Resident Progress Notes dated 7/19/21 to 7/20/21 included the following:
-7/19/21 at 7:58 p.m. Noted to have a dry harsh cough. Resident was flushed, had clear drainage from nose. Temperature (T) 100.6, would not allow any other vital signs to be taken. Lymph nodes in the neck were swollen, and R6 reported they were painful. Rapid COVID test was negative.
-7/20/21 at 10:49 a.m. R6 continued to have a runny nose and occasional cough. T 98.8, O2 (oxygen saturation) 90% on room air.
-7/20/21 at 2:54 a.m. Return fax from PCP (primary care physician). She can be evaluated. I believe I'll be there a.m. 7/22.
-7/20/21 at 2:55 p.m. Call placed to daughter to update her to status. Daughter will take R6 into clinic to be evaluated
-7/20/21 at 3:03 p.m. Would not be able to get in until tomorrow, plan is to continue to monitor status, update family and PCP with any changes. Will be seen by PCP on 7/22.
-7/20/21 at 5:17 p.m. COVID-19 nasopharyngeal

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test completed at 4:40 p.m.
-7/20/21 at 5:30 p.m. Called the lab to ask about COVID-19 PCR, test results was positive. Update to team leader immediately, directed R6 to her room, enhanced respiratory precautions initiated.

R6's Event Report dated 7/19/21 at 8:12 p.m. Infection Control - Potential Upper Respiratory Tract Infection SBAR (Situation Background Assessment Recommendation) Nurse to IP Communication completed by LPN-C identified R6 met criteria for upper respiratory tract infection with symptoms of runny nose or sneezing, dry cough and swollen or tender glands in neck. The form also included sections to indicate if lab, imagine, anti-infective medications, or isolation precautions were ordered or initiated, however, all sections were blank.

R6's medical record lacked documentation of any additional special accommodations made by the facility or individualized interventions implemented due to R6 residing on a memory care unit and her need for transmission-based precautions and isolation or need for a follow up PCR test.

During observations of the Memory Care Unit on 7/20/21, from 1:30 p.m. until approximately 2:00 p.m. approximately twelve unmasked residents were seated in chairs which lined the perimeter of the common entry area of the unit and was in close proximity of R7 and R8. R6 ambulated with the use of a walker through the common area. R6 wore a mask which was positioned underneath her chin and at times staff approached her to put the mask up over her nose, but was not redirected to isolate, nor were

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any prompts to encourage social distancing attempted with R6 or any of the residents seated in the area. During a tour of the unit there was no signage of any kind R6's room door, nor were there any isolation carts for PPE storage and disposal, to identify transmission-based precautions were in place or any isolation or quarantine measures had been implemented. Nor were there any signs anywhere on the unit. No carts with PPE such as gowns, gloves, or eye protection, were noted to be available in patient care areas. Residents moved throughout the unit, in the common areas, or in their rooms, per their usual manner.

On 7/20/21, at 4:11 p.m. the DON was notified by the surveyor of the need to obtain an PT-PCR test for R6, as she was symptomatic and had not had a confirmation test completed. RN-A who was outside the DON's office was also informed of the need for a PCR test for R6 as soon as possible. RN-A stated she would collect the sample today; however, she was not sure about the ability to obtain the confirmatory test results today as the local hospital completed all their testing and she would have to check with them to see. Further, RN-A felt R6's symptoms were related to the recent air quality issues and smoke haze rather than COVID-19 infection.

R6's SARS CoV2 (COVID19) laboratory report dated 7/20/21, identified the SARS-CoV-2 (COVID-19) by NAAT (nucleic acid amplifications test) value was detected. The report indicated a "detected" result was positive and indicated a presence of target viral nucleic acids which were generally detectable in upper respiratory specimens during the acute phase of infection. The positive result was reported to the facility at

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6:22 p.m.

On 7/21/21, at 8:00 a.m. upon entry to the facility, the DON was observed at the facility entrance. Signage was in place in the entrance announcing no visitation was allowed due to positive COVID status in the building. DON was conducting education with staff as they entered the building which included a post-test. Additional nursing staff conducted symptom screening and rapid antigen testing on all in-coming staff. DON stated R6 had tested positive on her PCR test so they were educating staff and going into outbreak mode.

During interview on 7/21/21, at 11:37 a.m. RN-J stated if residents displayed respiratory or other symptoms of potential COVID-19 she would expect staff to put the resident in respiratory isolation, obtain a rapid test, notify the physician, resident family, and administration. Pending the results would then do a follow up PCR test and would confer with the infection preventionist.

During interview on 7/21/21 at 4:10 p.m. RN-A stated R6 became symptomatic on Monday night, 7/19/21, at approximately 8:00 p.m. Staff completed a rapid antigen test which was negative. She had a temperature of 100.6. R6 usually always wore a mask. They did try to redirect her to her room; however, it was very difficult for her. They would ordinarily try to quarantine with a symptomatic resident but was very difficult in the memory care unit. After they had received R6's positive test results, they had talked about moving her to an empty room, however, they ended up moving the roommate instead due to R6's behaviors. They had not obtained the confirmatory PCR test on 7/20/21,

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prior to surveyor request. The plan had been to do that during an appointment with R6's primary care provider (PCP) on 7/22/21. She had asked staff to arrange for an earlier appointment but was unaware they were not able to arrange an appointment prior to 7/22/21.

During group interview with the administrator, DON, RN-B, RN-A, RN-K, and RN-C on 7/21/21 at 5:45 p.m. the DON stated R6 was symptomatic on Monday, 7/19/21, received a rapid screening test and was negative. The DON expected staff to observe the resident's vitals signs and ensure the resident was wearing a mask which was difficult on the unit, but they tried. The resident liked to wear one sometimes however, it was difficult with dementia residents. They could never stay put, it is a memory care unit and is all of their home. The antigen test was not a confirmatory test, so you get a PCR test to confirm. If a resident was symptomatic, you would also quarantine unless a physician has provided an alternative diagnosis or until a PCR stated the result was negative. However, it was very difficult to quarantine in a memory care until. The administrator stated it was impossible to quarantine in a memory care unit due to the wandering behaviors. RN-B stated they did the best they could to keep residents apart and tried to get them to wear a mask. DON stated she would expect them to do that. PCR should be obtained the next day and they had planned to do the test it had just not been done yet. It had been their intention all long to get the confirmatory PCR test; however, the facility did not implement transmission based precautions and isolation while awaiting a confirmatory test.

The Benedictine COVID-19 Testing Procedure dated 10/12/20, directed outbreak testing would

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be performed for all residents and associates and weekly testing repeated of all previously negative residents and associates until no new cases were identified over a period of at least 14 days. Associates refusing to participate in outbreak testing would be restricted from the building until procedures for outbreak testing were completed. Routine (screening) testing of associates was required by CMS (and state) regulation in the SNF [skilled nursing facility] with frequency based on county positivity rate and not required in the ALF [assisted living facility]. When an associated routinely worked in both the SNF and ALF (crosses over), the associate should be included in routine SNF testing. When an associate worked only in the ALF the associate did not need to be included in routine SNF testing. Further the minimum testing frequency for a county positivity <5% was identified as monthly.

The COVID-19 Testing of Associates - Protocols for When Associates Choose Not to Test dated 9/14/20 directed when a community was conducting routing COVID-19 testing, but there was no outbreak within the community, associates who refused to participate in the testing may do so and continue to work provided they complied with all health screening protocols and utilized all prescribed PPE during their work hours on campus. The policy also directed in situations where there was an active outbreak of COVID-19 on campus, either with associates or residents, associates still had a choices of whether to be tested. However, those associates who refused to be tested would not be allowed to reenter the community during the outbreak testing timeframe. The community must go 14 days without a positive COVID test before the associate could return to work. This may result in

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extended time off of work if there was a positive case in either associate or resident during outbreak testing.

The undated Benedictine Preferred Testing Approach for Residents and Associates flow diagram identified if a resident point of care POC [point of care] nasal antigen test was negative, confirm with PT-PCR. Then if positive, begin outbreak testing.

The 2019 Novel Coronavirus policy dated 5/8/20, directed if any resident were to present with fever or symptoms, implement recommended IP [infection prevention] practices:
a. Standard, Contact and Droplet Precautions
b. Restrict resident with respiratory symptoms to their room
c. If they need to leave their room for a medical reason, they will have a facemask in place
d. Contact primary provider for further direction on what tests to perform
e. Contact family to notify them of change in condition.
The policy identified preventive measures to include: remind residents to practice social distancing - maintaining a distance of 6 feet of another - while performing frequent hand hygiene. The policy did not address staffing considerations.

The Guidance on Caring for a Confirmed Case of COVID-19 policy dated 7/2/20, directed if a resident was presenting with respiratory symptoms, the resident must remain in room on standard, contact and droplet precautions while waiting for diagnostic laboratory results. The policy also directed if a resident diagnosed with COVID or pending test results leaves room, they

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F 886	Continued From page 53 should have on a facemask, perform hand hygiene, limit their movement in the community, and perform social distancing - staying a minimum of 6 feet away from others. The IJ which began on 4/21/21, was removed on 7/23/21, at 6:00 p.m. when it could be verified through observation, interview and document review the facility policies were reviewed and revised to reflect protocol for routine testing of staff to ensure all staff are tested at the minimum frequency as indicated by the county positivity rate and access to makeup testing dates. A PCR test will be given when any resident or staff display signs or symptoms of COVID-19. The facility ensured all active staff had negative symptom screening and antigen testing prior to working in the facility and developed an outbreak testing plan which included two additional makeup dates to each scheduled testing date to accommodate staff, as well as the opportunity for point of care antigen testing prior to their scheduled shift. Education was provided on current and updated COVID protocols to staff during testing prior to scheduled shifts and will continue on all required testing dates. Completion of testing and training will be tracked, analyzed, and acted on to ensure compliance.	F 886		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 13, 2021

Administrator
Villa St Vincent
516 Walsh Street
Crookston, MN 56716

Re: State Nursing Home Licensing Orders
Event ID: SVJI11

Dear Administrator:

The above facility was surveyed on July 19, 2021 through July 23, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Jen Bahr, RN, Unit Supervisor
Bemidji District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, MN 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104 Mobile: (218) 368-3683

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

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

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 7/19/21 through 7/23/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00815	A. BUILDING: _____ B. WING _____	C 07/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA ST VINCENT	516 WALSH STREET CROOKSTON, MN 56716

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2 000	Continued From page 1 The following complaints were found to be SUBSTANTIATED: H5484045C (MN74764) with licensing order(s) issued at MN Rule 4658.0800 Subp. 4 and 4658.0520 Subp. 1 H5484046C (MN74826) however, no licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will	2 000		

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2 000	Continued From page 2 be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for	2 265		8/23/21

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2 265	Continued From page 3 example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the physician was notified of a significant weight gain for 1 of 1 residents (R2) who's furosemide (a diuretic medication used to treat fluid retention) was discontinued and had a significant weight gain. Findings include: R2's quarterly MDS dated 5/18/21, identified R2 had intact cognitions and required extensive assistance from staff for activities of daily living and received diuretic medication daily. Diagnoses included lymphedema (a condition that results in swelling of the arm or leg), pneumonia, diabetes mellitus, kidney failure, polyneuropathy, obesity and edema. R2's Physician Order Report dated 6/16/21, included furosemide 40 milligrams (mg) by mouth (po) daily with a start date of 4/5/21. R2's June 2021, Medication Administration Record (MAR) included orders to administer furosemide 40 mg every morning and was initialed as administered daily, 6/1/21 through 6/18/21, with a discontinue date of 6/18/21. The MAR also included physician orders to remind R2	2 265	Corrected	

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2 265	Continued From page 4 to elevate her legs and left arm every shift, and for daily weights. The order directed staff to monitor daily weights and notify the physician if R2's weight was greater or less 3 pounds (lbs) in one day or 5 lbs in one week. The weights were recorded on the MAR 6/1/21 through 6/20/21, ranged within 2 lbs, from 367 lbs to 369 lbs; however, the recorded weights from 6/21/21 through 6/23/21, ranged 375 lbs to 379.4 lbs. R2 gained a total of 11 lbs. by 6/23/21. R2's Weights and Vitals summary indicated the following weights: -6/14/21, 367/9 lbs. -6/18/21, 368.9 lbs. -6/19/21, 367.4 lbs. -6/20/21, 368.3 lbs. -6/21/21, 376.3 lbs. -6/22/21, 375.4 lbs. -6/23/21, 379.4 lbs. R2's progress notes identified the following: - 6/18/21, at 4:22 p.m. an order was received by the facility to discontinue R2's furosemide due to a decline in her kidney function and to encourage R2 to elevate her legs and arm and reduce her sodium intake. - 6/23/21, at 5:00 p.m. R2 discharged from the facility. Discharge plan of care, medications and medication list were explained. R2's clinical record lacked documentation of physician notification of R2's 11 lbs. weight gain in one week as ordered. During interview on 7/21/21, at 11:18 a.m. licensed practical nurse (LPN)-B stated the nursing assistants would tell her the daily weights and she would record them on the MAR. If LPN-B noticed a weight gain when she entered the	2 265		

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2 265	Continued From page 5	2 265		

weight she would let the unit manager know. The resident would be re-weighed and if it was a true weight gain, the unit manger would notify the primary physician.

When interviewed on 7/21/21, at 11:30 a.m. the primary care physician (PCP)-I stated he was aware R2's furosemide had been discontinued; however, he was not aware of R2's 11 lbs. weight gain in one week. He would not have just restarted her diuretic medication prior to her discharge without some lab work being done.

On 7/21/21, at 1:50 p.m. a joint interview was conducted with the director of nursing (DON) and registered nurse (RN)-K. RN-K stated the nursing assistants were to get the daily weights and report them to the team leader. The team leader would then enter them on the MAR. The DON indicated if a weight was out of set perimeters it would flag and the unit manager would get a message in resident messages. The system had not flagged R2's weight gain for some reason and she was going to look into it.

The undated facility policy Change In Condition, indicated when a significant change was identified or when there was a need to alter treatment significantly, the licensed nursing associate would consult with the attending provider and notify the resident/resident representative. The need to alter treatment significantly meant to stop a form of treatment because of adverse consequences or commence a new form of treatment to deal with a problem. Notify the attending provider of the change in condition and implement orders for treatment and appropriate monitoring as directed.

SUGGESTED METHOD OF CORRECTION: The DON or designee could inservice nursing staff on

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2 265	Continued From page 6 ensuring the physician is notified timely of significant changes in resident conditions, then audit charts to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 265		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a focused nursing assessment and/ or monitoring occurred for potential fluid overload for 1 of 3 residents (R2) reviewed who were taking diuretic medication. Findings include: R2's quarterly MDS dated 5/18/21, identified R2 had intact cognitions and required extensive assistance from staff for activities of daily living and received diuretic medication daily. Diagnoses	2 830	Corrected	8/23/21

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2 830	Continued From page 7 included lymphedema (a condition that results in swelling of the arm or leg), pneumonia, diabetes mellitus, kidney failure, polyneuropathy, obesity and edema. R2's Physician Order Report dated 6/16/21, included furosemide 40 milligrams (mg) by mouth (po) daily with a start date of 4/5/21. R2's June 2021, Medication Administration Record (MAR) included orders to administer furosemide 40 mg every morning and was initialed as administered daily, 6/1/21 through 6/18/21, with a discontinue date of 6/18/21. The MAR also included physician orders to remind R2 to elevate her legs and left arm every shift, and for daily weights. The order directed staff to monitor daily weights and notify the physician if R2's weight was greater or less 3 pounds (lbs) in one day or 5 lbs in one week. The weights were recorded on the MAR 6/1/21 through 6/20/21, ranged within 2 lbs, from 367 lbs to 369 lbs; however, the recorded weights from 6/21/21 through 6/23/21, ranged 375 lbs to 379.4 lbs. R2 gained a total of 11 lbs. by 6/23/21. R2's Weights and Vitals summary indicated the following weights: -6/14/21, 367/9 lbs. -6/18/21, 368.9 lbs. -6/19/21, 367.4 lbs. -6/20/21, 368.3 lbs. -6/21/21, 376.3 lbs. -6/22/21, 375.4 lbs. -6/23/21, 379.4 lbs. R2's medical record lacked documentation of physician notification of R2's 11 lbs. weight gain in one week as ordered.	2 830		

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2 830	Continued From page 8 R2's progress notes identified the following: - 6/18/21, at 4:22 p.m. an order was received by the facility to discontinue R2's furosemide due to a decline in her kidney function and to encourage R2 to elevate her legs and arm and reduce her sodium intake. - 6/23/21, at 5:00 p.m. R2 discharged from the facility. Discharge plan of care, medications and medication list were explained. R2's medical record lacked evidence of any monitoring or assessment following the discontinuation of R2's furosemide medication. The record lacked assessment of R2's edema, or lung sounds. There was no evidence R2 was aware her diuretic had been discontinued or that she was instructed on side effects, low sodium diet and symptoms to monitor and report if noted, such as increase swelling, weight or shortness of breath. R2's Discharge Assessment dated 6/23/21, identified R2 was independent with activities of daily living, except with putting her footwear on and off. The discharge summary identified R2 was at the facility for therapy. She had no pertinent lab work or consults and no outstanding events. Her final diagnoses and condition on discharge was documented as stable. R2's Discharge Plan of Care dated 6/23/21, identified R2 was discharged to her home, accompanied by a friend. No equipment was needed, nursing home care was needed with agency names listed without phone numbers, for the patient to contact to make arrangements. Medications were reconciled and a medication list was given to R2. Scheduled appointments were listed.	2 830		

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2 830	Continued From page 9 R2's discharge documentation lacked any evidence R2 was aware her diuretic medication had been discontinued or if she had received instruction to limit her sodium intake, elevate her extremities or monitor signs and symptoms related to increase fluid retention and what to do if symptoms were identified. During interview on 7/21/21, at 8:30 a.m. family member (FM)-J stated R2 was in bad shape. A friend who had visited with R2 had told him R2's legs were swelling and were not being wrapped. The facility stated R2 was in good health and discharged her. FM-J called R2 the evening of discharge and R2 was crying and said she had made a mistake and she could not be at home. FM-J told R2 she had to call an ambulance and R2 went into the hospital. The facility did not do any type of assessment on her before she discharged. There was no way they could not have seen that her swelling was worse and that she was deteriorating. They could not have done any assessment for them to have missed that. During interview on 7/21/21, at 11:18 a.m. licensed practical nurse (LPN)-B stated the nursing assistants would tell her the daily weights and she would record them on the MAR. If LPN-B noticed a weight gain when she entered the weight she would let the unit manager know. The resident would be re-weighed and if it was a true weight gain, the unit manger would notify the primary physician. When interviewed on 7/21/21, at 11:30 a.m. the primary care physician (PCP)-I stated he was aware R2's furosemide had been discontinued; however, he was not aware of her 11 lbs. weight gain in one week. He saw R2 on rounds on 6/18/21; however, her weight gain had not been	2 830		

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2 830	Continued From page 10	2 830		

noted until 6/21/21. The PCP-I stated R2 was insistent on going home and had refusals of cares related to wrapping her legs. The facility did not feel it was safe and home care had refused to take her on in the past. The had canceled her discharge and kept her there because of that, but she was determined to go home and had a number of appointments set up for her to be seen after discharge. PCP-I would not have just restarted her diuretic medication prior to her discharge without some lab work being done.

On 7/21/21, at 1:50 p.m. a joint interview was conducted with the director of nursing (DON) and registered nurse (RN)-K. RN-K stated R2 was non-compliant with a lot of things, such as her lymphedema wraps and her diet and her goal was to go home. The nursing assistants were to get the daily weights and report them to the team leader. The team leader would then enter them on the MAR. RN-K indicated she did not do any assessment/ monitoring related to discontinuing R2's furosemide.

- The DON indicated she would have to look and see if there was any policy on monitoring with medication changes. The DON indicated if a weight was out of set perimeters it would flag and the unit manager would get a message in resident messages. The system had not flagged R2's weight gain for some reason and she was going to look into it. The DON verified a blood pressure and pulse had not been documented since 6/17/21, and stated she would look into that as well.

The undated facility policy Change In Condition, indicated when a significant change was identified or when there was a need to alter treatment

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2 830	Continued From page 11 significantly, the licensed nursing associate would consult with the attending provider and notify the resident/resident representative. The need to alter treatment significantly meant to stop a form of treatment because of adverse consequences or commence a new form of treatment to deal with a problem. Procedures were listed for the licensed nursing associate to assess significant change in the resident's condition through direct observation, interview, or report from other staff. Obtain a set of vital signs and repeat as needed or ordered. Open a matrix event and conduct a symptom review and assessment, as condition warrants. Notify the attending provider of the change in condition and implement orders for treatment and appropriate monitoring as directed. Notify the interdisciplinary team and resident or resident representative and document symptoms, assessment, observations, and resident and provider notification. SUGGESTED METHOD OF CORRECTION: The DON or designee could inservice nursing staff to ensuring ongoing and consistent monitoring of any changes in condition are completed with medical intervention, then audit charts to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		