



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 16, 2020

Administrator
Good Samaritan Society - Pine River
518 Jefferson Avenue, Po Box 29
Pine River, MN 56474

RE: CCN: 245476
Cycle Start Date: September 9, 2020

Dear Administrator:

On September 22, 2020, we notified you a remedy was imposed. On October 15, 2020 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of October 14, 2020.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective December 9, 2020 did not go into effect. (42 CFR 488.417 (b))

In our letter of September 22, 2020, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 9, 2020 due to denial of payment for new admissions. Since your facility attained substantial compliance on October 14, 2020, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Joanne Simon', with a horizontal line extending to the right.

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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September 22, 2020

Administrator
Good Samaritan Society - Pine River
518 Jefferson Avenue, Po Box 29
Pine River, MN 56474

RE: CCN: 245476
Cycle Start Date: September 9, 2020

Dear Administrator:

On September 9, 2020, a survey was completed at your facility by the Minnesota Department(s) of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMEDIES

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

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.
- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective December 9, 2020.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective December 9, 2020. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 9, 2020.

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.

You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION (Delete this section if SQC tags are cited and this note)

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

If you have not achieved substantial compliance by December 9, 2020, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Good Samaritan Society - Pine River will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 9, 2020. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

DEPARTMENT CONTACT

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

Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Phone: (218) 302-6151

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 9, 2021 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

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

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

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

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

Nursing Home Informal Dispute Process

Good Samaritan Society - Pine River

September 22, 2020

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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/lrc_idr.cfm

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

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

Feel free to contact me if you have questions.

Sincerely,



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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/26/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245476	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/09/2020
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - PINE RIVER			STREET ADDRESS, CITY, STATE, ZIP CODE 518 JEFFERSON AVENUE, PO BOX 29 PINE RIVER, MN 56474		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
E 000	Initial Comments A COVID-19 Focused Infection Control survey was conducted 9/9/20, at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.73(b)(6). The facility was in full compliance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000			
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control survey was conducted on 9/9/20, at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was not in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an revisit of your facility will be conducted to validate substantial compliance with the regulations has been attained in accordance with your verification.	F 000			
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		10/14/20	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

09/30/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 880	<p>Continued From page 1</p> <p>§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.</p> <p>§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:</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <ul style="list-style-type: none"> (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: <ul style="list-style-type: none"> (A) The type and duration of the isolation, 	F 880			

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F 880	<p>Continued From page 2</p> <p>depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(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</p> <p>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§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 recommended COVID-19 infection control procedures related to the use of gowns when in direct contact for 1 of 2 residents (R1) who was put on transmission based precautions due to exhibiting potential symptoms of COVID-19. This deficient practice had the potential to affect all 24 residents who resided in the facility and staff.</p> <p>Findings include:</p>	F 880	<p>Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation,</p>		

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F 880	<p>Continued From page 3</p> <p>R1's Face Sheet printed 9/9/20, indicated R1's diagnosis included arthritis, chronic pain, and age related osteoporosis.</p> <p>R1's care plan dated 8/19/20, indicated R1 required extensive assistance to complete activity of daily living tasks (ADLs). The care plan lacked indication R1 was on transmission based precautions related to COVID-19 symptoms.</p> <p>On 9/5/20, at 9:49 p.m. progress notes indicated R1 had symptoms of a dry cough. R1 placed on isolation for COVID-19 symptoms, and clinical monitoring was started.</p> <p>On 9/9/20 at 11:00 a.m. a personal protective equipment (PPE) cart was observed in the hallway next to R1's room. A droplet precautions sign on was on the top of the PPE cart, however, R1's door lacked any precaution signage.</p> <p>At 11:41 a.m. registered nurse (RN)-A was observed in the hallway, outside of R1's door, donning an isolation gown, in preparation of entering R1's room. RN-A stated R1 was on precautions because of symptoms of cough and upper respiratory infection.</p> <p>-At 12:40 p.m. nursing assistant (NA)-A was observed to enter R1's room to answer the call light. NA-A entered R1's room without donning an isolation gown. NA-A was in R1's room for one minute, then exited R1's room and walked across the hall to obtain a Hoyer (mechanical) lift. NA-A was overheard to request assistance from licensed practical nurse (LPN)-A. NA-A entered R1's room with the Hoyer lift. NA-A did not don a gown. LPN-A approached the PPE cart outside of R1's room, sanitized her hands with alcohol based hand rub (ABHR), donned an isolation gown, and entered R1's room.</p>	F 880	<p>this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual.</p> <ol style="list-style-type: none"> The staff members were educated on 9/10/2020 via OnShift message to ensure proper use of PPE for R1 when entering rooms for residents who are on transmission based precautions All residents are at risk for this deficient practice. Staff member were educated on 9/10 via OnShift message and training packet was assigned to all staff with posttest to verify understanding of training completed on 9/11/2020. Competency completed with nursing staff to ensure understanding of isolation precautions and what is expected for residents on isolation. Continued education and reinforcement of the isolation precautions will be completed by DON/Infection preventionist and all other facility managers. All Staff in-service set to be completed on 10/6/2020 addressing expectations set with all staff to have all staff be aware of PPE requirements and allowed to address PPE expectations, Correct masking, correct eye protection, review of Root Cause Analysis, transmission based precautions, Aerosolized generating procedures and also education on accountability. Nurses to be reminded of authority to address all staff when there are concerns with proper PPE use and then report the concerns to the 		

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F 880	<p>Continued From page 4</p> <p>-At 12:46 LPN-A was observed to be in R1's doorway, doffing and disposing of her isolation gown and gloves in the garbage container in R1's room. LPN-A exited the room. NA-A exited R1's room directly behind LPN-A, however, was observed not to have an isolation gown on. Upon exiting R1's room, NA-A immediately entered the resident room next door to respond to a call light.</p> <p>-At 12:48 p.m. LPN-A stated she was aware R1 was on isolation precautions because of the sign on top of the PPE cart next to R1's room. LPN-A stated she was aware NA-A had not donned an isolation gown to enter R1's room, and verified NA-A should have been wearing an isolation gown because of cares they had just provided to R1.</p> <p>-At 12:55 p.m. NA-A was interviewed and stated she had used the Hoyer lift to assist R1 into her bed, and provided her with a bed pan with LPN-A's assistance. LPN-A stated R1 was currently on the bedpan, and they left the Hoyer lift in the room, so they could remove her off of the bedpan when she was done. NA-A stated she was aware R1 was on transmission based precautions, and she should have been wearing an isolation gown to provide care to R1, but had been in a hurry and had forgotten. NA-A stated she had made a mistake.</p> <p>On 9/9/20 at 4:30 p.m. in a joint interview, both the administrator and the director of nursing (DON) stated they would expect an isolation gown to be worn for direct patient care in the isolation rooms. The DON stated if assisting with direct cares, an isolation gown should be worn.</p> <p>The facility's policy Infection Prevention: Emerging Threats-Acute Respiratory Syndromes Coronavirus (COVID)-19 Enterprise dated</p>	F 880	<p>DON/infection preventionist vs waiting for DON/designee to address these concerns at a later date. Facility initiated written education communication form to track these encounters. This form is provided to the manager of that employee for further follow up as indicated. Self and peer accountability initiated at the center. Competency of PPE application completed with staff during this in-service as well. Signs were moved to the doors vs sitting on the isolation carts to make it easier for staff to identify residents who are on isolation. The signs were changed as well to make expectations clearer to all staff. Increased signage was provided throughout the facility to improve education. The facility utilized the CDC training on PPE.</p> <p>Families and resident educated on 10/6/2020 on the facilities infection prevention control program as it related to them.</p> <p>4. We will be auditing source control masking, donning and doffing PPE in isolation rooms, and the appropriate utilization of PPE and signage for aerosolizing procedures. Audits will be done daily for 3 weeks or until 100% compliance is achieved, whichever is longer. And then 4 times weekly for 2 weeks, or until 100% compliance is achieved, whichever is longer. Auditing will be completed on all 3 shifts to ensure that all staff are observed throughout the auditing process. Results of audits will be tracked on a spreadsheet and reviewed</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 880	Continued From page 5 8/14/20, directed staff to isolate residents with suspected or positive COVID-19 to their room and post a droplet precaution sign on their door. The policy directed staff to limit only essential personnel to enter the room, wearing appropriate PPE. The policy indicated appropriate PPE to include gloves, gowns, eye protection and mask.	F 880	daily at leadership stand-up and referred to QA committee for further recommendation.		

DIRECTED PLAN OF CORRECTION

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

DIRECTED PLAN OF CORRECTION - Personal Protective Equipment (PPE)

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

POLICIES/PROCEDURES/SYSTEM CHANGES:

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

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

- Review policies and procedures for donning/doffing PPE during COVID-19 with current guidelines to include crisis standard of care, contingency standard of care and standard care.
- Develop and implement a policy and procedure for source control masks.
- Review policies regarding standard and transmission based precautions and revise as needed.

TRAINING/EDUCATION:

As a part of corrective action plan, the facility must provide training for the Infection Preventionist, the Director of Nursing, all staff providing direct care to residents, and all staff entering resident's rooms, whether it be for residents' dietary needs or cleaning and maintenance services. The training must cover standard infection control practices, including but not limited to, transmission-based precautions, appropriate PPE use, and donning and doffing of PPE.

- The training may be provided by the Director of Nursing, Infection Preventionist, or Medical Director with an attestation statement of completion.
- The training must include competency testing of staff and this must be documented.
- Residents and their representatives should receive education on the facility's Infection Prevention Control Program as it related to them and to the degree possible/consistent with resident's capacity.
- Online infection prevention training courses may be utilized. The CDC and MDH websites have several infection control training modules and materials.

CDC RESOURCES:

Infection Control Guidance: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html>

CDC: Isolation Precautions Guideline:

<https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html>

CDC: Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007): <https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html>

CDC: Personal Protective Equipment: <https://www.cdc.gov/niosh/ppe/>

Healthcare Infection Prevention and Control FAQs for COVID-19:

https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control-faq.html

MDH RESOURCES:

Personal Protective Equipment (PPE) for Infection Control:

<https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/ppe/index.html>

MDH Contingency Standards of Care for COVID-19: Personal Protective Equipment for Congregate Care Settings (PDF): <https://www.health.state.mn.us/communities/ep/surge/crisis/ppegrid.pdf>

Interim Guidance on Facemasks as a Source Control Measure (PDF):

<https://www.health.state.mn.us/diseases/coronavirus/hcp/masksource.pdf>

Interim Guidance on Alternative Facemasks (PDF):

<https://www.health.state.mn.us/diseases/coronavirus/hcp/maskalt.pdf>

Aerosol-Generating Procedures and Patients with Suspected or Confirmed COVID-19 (PDF):

<https://www.health.state.mn.us/diseases/coronavirus/hcp/aerosol.pdf>

Droplet Precautions:

<https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html>

Airborne Precautions:

<https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html>

MONITORING/AUDITING:

- The Director of Nursing, the Infection Preventionist, and other facility leadership will conduct audits of donning/doffing PPE with Transmission Based Precautions i.e. Droplet precautions.
- The Director of Nursing, Infection Preventionist, and other facility leadership will conduct routine audits on all shifts four times a week for one week, then twice weekly for one week once compliance is met. Audits should continue until 100% compliance is met on source control masking for staff, visitors and residents.
- The Director of Nursing, Infection Preventionist, and other facility leadership will conduct real time audits on all aerosolized generating procedures to ensure PPE is in use.
- The Director of Nursing, Infection Preventionist, or designee will review the results of audits and monitoring with the Quality Assurance Program Improvement (QAPI) program.

In accordance with 42 CFR § 488.402(f), this remedy is effective 15 calendar days from the date of the enforcement letter. The DPOC may be completed before or after that date. The effective date is not deadline for completion of the DPOC. However, a revisit will not be approved prior to receipt of documentation confirming the DPOC was completed. To successfully complete the DPOC, the facility must provide all of the following documentation identified in the chart below. Documentation should be uploaded as attachments through ePOC.

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

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

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