DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 3, 2020

Administrator
MN Veterans Home - Luverne
1300 North Kniss, PO Box 539
Luverne, MN 56156

RE: CCN: 245631
Cycle Start Date: April 1, 2020

Dear Administrator:

On May 29, 2020, the Minnesota Department(s) of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

Electronically delivered
April 22, 2020

Administrator
MN Veterans Home - Luverne
1300 North Kniss, PO Box 539
Luverne, MN 56156

SUBJECT: SURVEY RESULTS
CCN: 245631
Cycle Start Date: Cycle Start Date: April 1, 2020

Dear Administrator:

SUSPENSION OF SURVEY AND ENFORCEMENT ACTIVITIES

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

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

SURVEY RESULTS

On April 1, 2020, a survey was completed at your facility by the Minnesota Department of Health completed a COVID-19 Focused Survey at Mn Veterans Home - Luverne to determine if your facility was in compliance with Federal requirements related to the implementing proper infection prevention and control practices to prevent the development and transmission of COVID-19. The survey revealed that your facility was not in substantial compliance. The findings from this survey are documented on the electronically delivered CMS 2567.

PLAN OF CORRECTION

You must submit an acceptable plan of correction (POC) for the enclosed deficiencies that were cited during the April 1, 2020 survey. Mn Veterans Home - Luverne may choose to delay submission of a POC until after the survey and enforcement suspensions have been lifted. The provider will have ten

days from the date the suspensions are lifted to submit a POC. An acceptable POC will serve as your allegation of compliance. Upon receipt of an acceptable POC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. Please note that if an onsite revisit is required, the revisit will be delayed until after survey and enforcement suspensions are lifted. The failure to submit an acceptable POC can lead to termination of your Medicare and Medicaid participation.

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

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

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

Nicole Osterloh, Unit Supervisor
Marshall District Office
Health Regulation Division
Licensing and Certification
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230 Cell: 218-340-3083
Fax: 507-537-7194

INFORMAL DISPUTE RESOLUTION

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

Nicole Osterloh, Unit Supervisor
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230 Cell: 218-340-3083
Fax: 507-537-7194

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

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;

- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

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

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

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

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES

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

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245631	A. BUILDING _____ B. WING _____	04/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME - LUVERNE	1300 NORTH KNISS, PO BOX 539 LUVERNE, MN 56156

(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 3/30/20 through 4/1/20, 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 the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control survey was conducted 3/30/20 through 4/1/20, at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was determined NOT to be in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, a revisit of your facility will be conducted to validate substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 880	Infection Prevention & Control	F 880		4/28/20

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

Electronically Signed | 04/28/2020

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 SS=F	Continued From page 1 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 accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a	F 880		

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F 880	Continued From page 2 resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to cancel communal dining and scheduled group activities, implement active screening of staff upon entry to the facility and source control masks, and daily ongoing surveillance of all infectious processes in accordance with Centers for Disease Control (CDC) and Centers for Medicare and Medicaid Services (CMS) guidelines for COVID-19.	F 880	F880 How corrective action will be accomplished for those residents found to have been affected by the deficient practice. 1. Failed to Cancel Communal Dining and scheduled group activities • All scheduled group activities have been cancelled until further notice. The facility	

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F 880	Continued From page 3 Findings include: COMMUNAL DINING AND ACTIVITIES Interview on 3/30/20 at 11:10 a.m., with the life enrichment coordinator (LEC) identified communal resident activities continued to be offered but had been limited to 10 residents or less. Dining had been changed to keep residents in the unit they reside with meals continued to be served communally in each dining room located down Green hallway, main dining room, and special care unit. Each table has anywhere from 2 to 4 residents. Observation on 3/30/20 at 11:30 a.m., in the dining room of the Green hall identified residents were seated together for the noon meal. Tables were less than 6 feet apart and there were 3 to 4 residents seated at each table. Observation on 3/20/19 at 11:45 a.m., identified residents in the Red hall were congregating at the nurse station to wait for meal service to begin. Residents sat in close proximity, some shoulder to shoulder, in the entrance of the dining room near the nurses desk. Interview on 3/30/20 at 11:45 a.m., with TMA-A identified residents continued communal dining on the halls they resided. Residents were placed near the nurses station to wait for their meal and get their medication. Observation on 3/30/20 at 11:55 a.m., of special unit dining room identified 2 to 4 residents sitting at a table. Interview and document review on 3/30/20 at	F 880	recreation department continues to offer individual recreational opportunities for residents. Recreation staff are also using facility iPads to facetime and keep connections between residents and their loved ones. • The facility has separated all residents during meals at the appropriate social distance guidelines with 1 resident per table. Residents with any symptoms are receiving meals in their rooms and being monitored. 2. Failed Implement active screening of staff upon entry to the facility • All facility staff are being screened prior to each of their shifts at the employee entrance of the building by a designated staff member 3. Failed to Use of source control masks • All facility staff are wearing masks. Staff providing direct care to our residents are wearing surgical masks and ancillary staff are wearing cloth masks for source control. All visitors are screened and required to use a source control mask while in the facility. 4. Failed to monitor daily ongoing surveillance of all infectious processes • The facility infection control preventionist has a daily line list for residents and staff at the home. All staff and visitors are screened daily. The screening logs are being reviewed and monitored by the infection preventionist or designee. Daily tracking reports are sent to our agency senior director. The nurses are	

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F 880	Continued From page 4 12:20 p.m., infectious control (IC) identified residents continued to have communal dining and group activities and were not canceled as it was felt to have a potential negative effect of and depression and potential increased behaviors. Group sizes were decreased to a limit of 10 residents at each activity and social distancing was to be practiced. She was aware staff would push residents in wheelchairs into groups by the nursing station for medication pass while remaining ambulatory residents would wait in the same line for medication and agreed that failed to follow guidelines for appropriate COVID-19 related precautions. Interview on 3/30/20 at 12:52 p.m., with director of nursing (DON) identified staff were to keep residents as far apart as possible and avoid placing residents next to each other within 6 feet. DON identified canceling communal dining had been discussed but was not implemented as management felt it would be a "burden for the resident's during this difficult time". The DON agreed staff the facility had not followed CMS guidelines to cancel all communal dining and group activities. There was the potential for an asymptomatic (no signs or symptoms) resident to spread the highly contagious infectious disease COVID-19 when dining activities were not canceled. Interview on 3/30/20 at 1:00 p.m., with activities director (AD) identified activities do not have a policy in place to stop all group activity and continued those activities. She had limited them to 10 or less residents. Interview on 3/30/20 at 1:05 p.m., with dietary manager (DM) identified dining room seating was	F 880	completing631941 resident assessments daily and trends reviewed by the facility assistant director of nurses. How the facility will identify other residents having the potential to be affected by the same deficient practice • All residents who reside in the facility had the potential to be affected by the deficient practice. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur • The facility changed our systems around communal dining and scheduled activities during the pandemic period following the current guidance from CMS. • Daily screening was moved from the nurses' stations to the employee entrance of the facility for all staff. • All staff were assigned a mask • The facility implemented line listing forms, screening logs, and resident assessment sheets to track ongoing surveillance How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. * The facility will complete audits of * facility dining and activities during the pandemic. * Daily screening process * Facility masking procedure and staff compliance * Infection control surveillance	

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F 880	Continued From page 5 the DM's responsibility. The DON had planned to space resident's further apart or even stagger meals but had not implemented any changes. The DM was unaware of CMS guidance to cancel communal dining. Review of the 3/20/20, COVID-19 Precautions Update email identified Red and Green halls and Special Care Unit residents were to dine at separate meal times in their own hall. Communal social hour was canceled in the main dining area. Activities staff were to reduce group sizes and conduct activities separately on each wing. Staff screening was to be moved to the employee entrance. SCREENING Observation on 3/30/20 at 10:30 a.m., of nurse aid (NA)-C identified she left the facility out of the Green Hall door exit and entered her car to leave for lunch break. Interview and observation on 3/30/20 at 11:04 a.m., with NA-A identified staff were to enter and exit the facility through the employee door located in the basement (lower level). Residents continued to have group activities. Residents come out to the dining room for communal meals with 2 to 3 residents seated at each table. Interview on 3/30/20 at 11:10 a.m., with the life enrichment coordinator (LEC) identified staff had been directed to use the Employee Entrance door downstairs to enter and exit facility. Each worker before starting their shift are to enter the building and proceed to either the Red or Green hall nurses station for screening before starting their shift. No staff were actively screened occurred at	F 880	process. * Audits will continue until as determined by the facility QAPI Committee. * The audit results will be reviewed during the facility QAPI Meetings and the QAPI Committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process base on the compliance noted from the audits • The facility Director of Nurses or designee are responsible for monitoring compliance The date that each deficiency will be corrected	

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F 880	Continued From page 6	F 880		

the entrance prior to walking into the building.

An observation on 3/20/20 at 11:15 a.m., trained medication aid (TMA)-A entered through the Red-Wing's north entrance close to the staff parking lot. This entrance was not a designated entrance during COVID-19 infection prevention practices.

Interview and observation on 3/30/20 at 11:20 a.m., with licensed practical nurse (LPN)-A identified staff were screened prior to the beginning of each work shift by entering the facility and reporting to the nurse's station at the hall they are scheduled to work on (Red or Green).

Interview on 3/30/20 at 11:25 a.m., with housekeeper (H)-A identified all the facility doors were locked from the outside to prevent persons from entering the building. Staff were able to enter all doors using their name badges but were to enter through the basement or main entrance and report to their assigned nurse station to be screened. If a nurse was not available on their assigned hall, staff could go to the other hall to be screened.

Interview on 3/30/20 at 11:35 p.m., with NA-B identified staff have been directed to enter and exit facility from employee entrance and report to a nurse's station for screening. There was a table at the employee entrance for staff to take their own temperature prior to coming into the facility to be actively screened at nursing station.

Interview on 3/30/20 at 11:45 a.m., with TMA-A identified staff were were to enter the building through the basement entrance. Staff were

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F 880	Continued From page 7	F 880		

screened for signs and symptoms of COVID-19 once inside the facility at the nurse station in their assigned hall at the beginning of their shift. During breaks and other times during the shift, staff were permitted to exit the building through the other doors during the shift because they were close to the parking lot.

Interview on 3/30/20 at 12:52 p.m., with director of nursing (DON) identified staff were to enter and exit through the employee entrance and were not to use any other entrance. If staff left the facility for their break, it was her expectation they would reenter the building at the employee entrance. The DON agreed the above observation of staff using alternate doors other than the employee entrance was a concern.

Interview on 3/30/20 at 2:15 p.m., with NA-C identified staff have been directed to enter and exit facility at employee entrance. NA-C had used the Green hall exit door to leave for lunch and return as she was "running late".

Observation and interview on 3/30/20 at 2:23 p.m., identified registered nurse (RN)-C entered the facility at the beginning of the shift through the Red hall entrance, walked through the wing to the nurse station, and took her own temperature. RN-C confirmed she entered through the Red hall door at the beginning of the shift. She verified resident rooms were located near that entrance. Staff used their name badges to unlock the doors to enter the building and were permitted to use the Red hall entrance to enter the building.

Further interview on 3/30/20 at 2:45 p.m., with RN-B, the infection prevention nurse (RN-B), identified 2 entrances to the facility were utilized.

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F 880	Continued From page 8	F 880		

The main entrance and the basement employee entrance. The main entrance had COVID-19 screening area where staff were to be screened prior to entering the building by administration staff. The employee entrance connected to the upper level by an elevator and a stairway. Both opened in the Red wing corridor. If staff used that door, they would have to walk past resident rooms in the Red hall to reach that nurses station. If they were to work in the Green hall, they would continue on across the common area to reach that nurses station.

RN-B was unaware staff were required to be actively screened at the point of entry to the facility. All staff recorded their own respiratory symptom screening located on a roster in each hall. If a staff member was found to have a temperature, staff would be sent to the Green hall of the facility for additional screening. No oversight or monitoring was in place to ensure staff were actively screened at the point of entry. The nurses at each station were responsible to report to management any staff found to have a temperature greater than 100.0 degrees Fahrenheit (F) or respiratory symptoms of infection. No audits were completed to ensure staff were appropriately screened upon entrance or denied entry if those symptoms were present. The facility does not record temperature when staff were screened. It only included staff names, the date, and an "X" but no other information was documented.

Review of the 3/30/20, Staff Accountability Roster identified staff documented an "X" in a box labeled "COVID Temp. Please "X" DO NOT record temp." There was no indication on the form if an X indicated staff had or had not had a

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F 880	Continued From page 9	F 880		

temperature over the recommended CDC guideline. The roster also included staff names and the times they entered and exited the building.

Review of the 3/26/20, Screening Guide by Nurse/Clinical Staff policy identified all staff were to be stopped at the entrance of the building.
1) Staff or visitors were to be asked respiratory symptom questions and perform active screening for possible exposure to COVID-19.
2) Staff and visitors were required to supply the information. If refused, they were not permitted to enter the facilty. 3) If staff had a temperature over 100.0 degrees Fahrenheit (F), or answered "Yes" to any questions, A second-level screening was to be conducted.
4) The second level screening included the type and longevity of symptoms or if symptoms were of new onset, if staff had been on a cruise, in a level -3 COVID affected region in the past 14 days or in contact with a person who tested positive for COVID-19 in the past 14 days.
5) If staff or visitors answered 'Yes" to any second-level questions, a third-level screen was to be completed.
6) Information identified during screening a document was to be kept on file at the facility.

Review of the 3/26/20, Changes to Staff Covid-19 Screenings email identified a nurse was required to screen all staff who reporting to work. Staff were assigned to the Red and Green wings. Housekeeping, nurses, and homemakers were to report to the wing they were assigned to work. Dietary and laundry staff were to report to the Red wing for screening. Maintenance was to report to the Green wing for screening. All office staff who sign in at the front entrance were to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245631	A. BUILDING _____ B. WING _____	04/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME - LUVERNE	1300 NORTH KNISS, PO BOX 539 LUVERNE, MN 56156

(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 880	Continued From page 10	F 880		

report to the business office for screening by an RN. A nurse on duty was to ask questions and take staff temperatures. All staff were responsible to sign the accountability forms as proof screening occurred. There was no mention why the facility stopped active screening upon entrance to the facility as directed in the Screening Guide above.

A 3/27/20, Changes to Staff COVID-19 Screenings email identified nurses were assigned to the main entrance starting at 7:15 a.m., Monday through Friday, to screen staff who entered though the main entrance. Staff entering the building before 7:15 a.m. were to go to the Red or Green hall nurses station to be screened. Each staff was responsible to sign the Accountability Rosters to identify they had been screened. Non-nursing staff were to sign the Accountability Rosters located in their departments. There was no mention how the facility would ensure oversight of the screenings to prevent potential symptomatic staff from entering the building.

SOURCE CONTROL

Interview on 3/30/20 at 10:45 a.m., with the administrator during the entrance conference, identified the facility had no suspected or confirmed cases of COVID-19. He received the Center for Medicare and Medicaid (CMS)'s Quality, Safety, and Oversight (QSO) memos related to COVID-19 guidelines. The facility had not initiated source control mask use in the facility as even though there was an ample supply of disposable personal protection equipment (PPE) masks. He was waiting for their new supply of cloth masks to be laundered prior to providing

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F 880	Continued From page 11 staff any source control masks. Observation on 3/30/20 at 10:45 a.m., in the Red hall identified several staff were providing care to residents. No masks were worn for source control by staff. Interview on 3/30/20 at 11:25 a.m., with housekeeper (H)-A identified staff were not required to wear masks. Interview on 3/30/20 at 11:45 a.m., with TMA-A identified staff were not required to wear masks for source control. There was no policy related to source control measure provided by the facility for the prevention of COVID-19. INFECTION SURVEILLANCE Interview on 3/30/20 at 3:20 p.m., with RN-B identified residents and staff who had potential signs or symptoms of COVID-19 were communicated to her by staff emails or verbal communication. Currently, no staff had presented with COVID-19 symptoms. Surveillance was completed by RN-B by checking with each nurse station several times daily, reviewing emails, and resident records. Although RN-B gathered information daily, it was not entered into the facility's spreadsheet to analyze patterns or trends in real time. Current data in the spreadsheet had ended February 2020. RN-B had yet to enter any data for March 2020. Her usual process was to enter data at the end of each month. The facility had no process on real-time tracking and trending or analysis of data.	F 880		

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F 880	Continued From page 12 Review of the March 2020, Infection Monitoring Surveillance Record had no data entered into the spreadsheet. Interview on 3/30/20 at 3:30 p.m., with the administrator identified staff were to enter and exit the facility through the main entrance and basement entrance of the facilty. No other doors were to be entered by staff or visitors. Staff were to follow guidance provided by the MN Veterans Affairs, Centers for Disease Control (CDC), and CMS for guidance of infection practices for COVID-19. Review of the 3/10/20, Infection Prevention and Control Program policy identified the facility was to comply with regulatory requirements by following the recommendations of the professional infection control organizations, maintaining its infection control policies and procedures, and by providing ongoing staff education. The infection preventionist (RN-B) was responsible to direct day-to-day infection control activities and complete surveillance data collection, evaluation, tracking, reporting, auditing, and coordination. The surveillance program was to include assessing the population and facility risk, selecting outcome measures, collection, analysis, and reporting data as required to analyze trends and changes in infection rates in a timely manner. Outbreak prevention and management identified RN-B was to maintain an active line list and surveillance to readily identify outbreaks as they occurred.	F 880		