

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted October 21, 2020

Administrator River Valley Health And Rehabilitation Center LLC 200 South Dekalb Street Redwood Falls, MN 56283

RE: CCN: 245237

Cycle Start Date: September 29, 2020

Dear Administrator:

On September 29, 2020, survey was completed at your facility by the Minnesota Department 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.

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 widespread deficiencies that constituted immediate jeopardy (Level L) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On September 16, 2020, 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.

On September 19, 2020, the situation of immediate jeopardy to potential health and safety cited at F725 was removed. However, continued non-compliance remains at the lower scope and severity of G.

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 November 5, 2020.
- 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 November 5, 2020, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 5, 2020, (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 November 5, 2020. 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), and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Nicole Osterloh, RN, Unit Supervisor Marshall District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 1400 East Lyon Street, Suite 102 Marshall, MN 56258-2504

Email: nicole.osterloh@state.mn.us

Office: 507-476-4230

Mobile: (507) 251-6264 Mobile: (605) 881-6192

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 March 29, 2021 (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,

Kamala Fiske-Downing

Kumalu Fiske Downing

Minnesota Department of Health Licensing and Certification Program

Program Assurance Unit Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: kamala.fiske-downing@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered October 21, 2020

Administrator
River Valley Health And Rehabilitation Center LLC
200 South Dekalb Street
Redwood Falls, MN 56283

Re: State Nursing Home Licensing Orders

Event ID: TN4F11

Dear Administrator:

The above facility was surveyed on September 21, 2020 through September 29, 2020 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 <u>only a suggestion</u> 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:

Nicole Osterloh, RN, Unit Supervisor Marshall District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 1400 East Lyon Street, Suite 102 Marshall, MN 56258-2504 Email: nicole.osterloh@state.mn.us

Office: 507-476-4230

Mobile: (507) 251-6264 Mobile: (605) 881-6192

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,

Kamala Fiske-Downing

Minnesota Department of Health

Kamala Fishe Downing

Licensing and Certification Program Program Assurance Unit Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: kamala.fiske-downing@state.mn.us

PRINTED: 11/06/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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ABORATOR\	/ DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGI	VATURE	•	TITLE		(X6) DATE	

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

Electronically Signed

10/30/2020

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG	CON	(X3) DATE SURVEY COMPLETED		
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E 024	care for. We attem soon as possible. contingency staffin plan had not been non-certified staff sfloor. C-B also con residents who miss staffing. All resider meals a day with nother evening meal a would expect med treatments comple physician. He would the needs of the residents at risk repositioning compounting compou	pted to get staff into work as The C-B confirmed the g plan and emergency staffing fully implemented and should not have worked the firmed there had been sed breakfast due to short ats were to be provided three o more than 14 hours between and breakfast the next day. He cations to be given and ted as ordered by the d expect staffing levels to meet esidents to ensure repositioning for skin breakdown or and bleted. C-B identified the Performance Improvement should have provided oversight as in place in case of a COVID disease outbreak. It was the ty of the administrator to eccive the care and services	E 0:	24				
	director (MD) ident that the facility had basic care needs a hygiene, reposition residents, and resi with meals receive MD would expect medications are tir confirmed the facil non-certified or no care to the resident followed their contishould not have pr	20 at 12:38 p.m., with medical ified his expectation would be adequate staffing to ensure are being met such as personal ing, meals provided to dents who require assistance that assistance. Further, the enough staffing to ensure nely and given. The MD ity should not have had n-licensed staff providing direct ts. The facility should have ngency staffing plan and staff ovided direct care without any otified about the immediate						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
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E 024	jeopardy situation at the facility, however concerns or issues jeopardy. The facility residents to a sister manageable level. notify him of the inaresidents. Review of the unda During an Emerger written plan for emerger written plan for emerger written plan for emerger written plan for emerger wolunteers would as If additional staff ar be called in. The demay also contact contact sister facility assistance. Review of the 9/3/2 identified the facility conscientious, and resident 24 hours proculinary, and maintant adequately staffed necessary to stay of could report for dutithe designee person contact the corporar facilities in the com Critical staffing should had the potential to and post-traumatic potential staffing shoulicensed person recruited and trainer	ge 5 Ind care was compromised at r, was not made aware of any before the immediate ry was discharging some r facility to reduce census to The MD expected the facility ibility to provide care to Ited, Volunteers and Staffing recy Event policy revealed the ergency included the use of all be checked in and directed charge of facility. Non-medical resist with non-medical needs, are needed off duty staff were to resignated person in charge or prorate office in order to resignate a person in charge or additional staff O, Emergency Staffing policy r was to give competent, consistent quality care to each reday. Nursing, laundry, renance departments must be and therefore, it may be no duty until replacements related the office to contact sister pany for staff assistance. The result in staff injury or illness stress. In order to prepare for ortages, licensed and reland volunteers were to be red for emergency assistance. To engage in non-credentialed	E	024			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		LE CONSTRUCTION	COMPLETED	
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	PROVIDER OR SUPPLIER	REHABILITATION CENTER LLC		2	STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283	1 00/1	20/2020
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E 024	Review of the 8/26/ Contingency Staffin training plan to cros	ge 6 eers for direct resident care. 20, Long-Term Care g Plan policy identified a es-train staff to fulfill different imary staff responsible for a	E()24			
F 000	given function was situations, direct ca facility staff, then th agencies, and lastly other departments. the highest practica needs of residents	not available. In emergency re would be performed by e corporate float pool, outside via cross-trained staff from Quality of care was deemed able level of care to meet the with proactive steps to have a crisis occurs to minimize the g.	F (000			
	was conducted on syour facility by the Mealth to determine Infection Control. TNOT to be in complabbreviated survey H5237022C, H5237 The facility was NO	sed Infection Control survey 9/21/20 through 9/29/20, at Minnesota Department of e compliance with §483.80 he facility was determined liance. Additionally, an for complaints H5237021C, 7023C was also conducted. T in compliance with 42 CFR tents for Long Term Care					
	SUBSTANTIATED: cited at F880, H523	laints were found to be H5237021C with deficiency 37022C with deficiency cited at d H5237023C with deficiency					
	Jeopardy (IJ) to res	d in two findings of Immediate ident health and safety. An IJ 1/16/20, when the the facility					

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F 000	surveillance to iden COVID-19, implem mitigate COVID-19 appropriate (PPE) testing positive for and director of nurs IJ on 9/23/20 at 3:3 9/24/20 at 2:35 p.m. The IJ at F725 beg. facility failed to provensure residents' be ensure scheduled right dressings were adrof 41 residents (R3 R33, R24, R20, R2 the facility failed to 17 of 41 residents (R28, R11, R17, R44 R23) between the cand failed to ensure to prevent pressure (R28). The facility anon-certified staff to without training and staffing plan to cross to an emergency of administrator and E9/24/20 at 2:45 p.m. 9/25/20 at 6:36 p.m. The above findings substandard quality extended survey was the facility's plan of the facility is plan of the fa	tem for daily cummulative tify potential symptoms of ent droplet precautions to transmission, and wear resulting in 39 of 41 residents COVID-19. The administrator ing (DON) were notified of the 0 p.m. The IJ was removed on an on 9/19/20, when the vide sufficient nursing staff to asic care needs were met and nedications and wound ministered or completed for 14, R6, R8, R14, R29, R15, R13, 7, R12,R15, R18). In addition, provide a breakfast meal for R31, R30, R5, R33, R32, R38, D, R7, R12, R8, R21, R25, R9, lates of 9/19/20 and 9/23/20 a repositioning was completed alcores for 1 of 1 resident also engaged non-licensed and of perform direct care duties implement their emergency as train non-certified staff prior a COVID outbreak. The DON were notified of the IJ on The IJ was removed on did NOT constitute of care, therefore, an as NOT performed.	FO				

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F 000	Continued From pa	ge 8 nrolled in ePOC, your	FO	00			
	signature is not req	uired at the bottom of the first 567 form. Your electronic POC will be used as					
F 725	on-site revisit of you validate that substa	acceptable electronic POC, an ur facility may be conducted to ntial compliance with the an attained in accordance with	F 7	'25			9/29/20
SS=L	CFR(s): 483.35(a)(1)(2)	F/	25			9/29/20
	the appropriate comprovide nursing and resident safety and practicable physical well-being of each resident assessment and considering the diagnoses of the factors.	nt Staff. ve sufficient nursing staff with npetencies and skills sets to I related services to assure attain or maintain the highest I, mental, and psychosocial esident, as determined by nts and individual plans of care number, acuity and cility's resident population in e facility assessment required					
	by sufficient number types of personnel of nursing care to all resident care plans (i) Except when waithis section, license	ved under paragraph (e) of d nurses; and ersonnel, including but not					

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F 725	§483.35(a)(2) Exceparagraph (e) of the designate a license nurse on each tour. This REQUIREME by: Based on observareview, the facility for nursing staff to ensoverall care and neensuring scheduled blood sugar [insuling pressure, and seize failed to ensure wo for 14 of 41 resider. R15, R13, R33, R2 R18). The facility awas provided for 1 R5, R33, R32, R38 R12, R8, R21, R25 of 9/19/20 and 9/23 repositioning was oulcers for 1 of 1 resto implement their cross-train non-ceremergency and be duties. This affecte in the facility and rejeopardy (IJ) for all The IJ began on 9/10 ensure sufficient treatment and mediate repositioning. The IJ house of the IJ began on 9/10 ensure sufficient treatment and mediate repositioning. The IJ house of the IJ began on 9/10 ensure sufficient treatment and mediate repositioning. The IJ house of the IJ began on 9/10 ensure sufficient treatment and mediate repositioning. The IJ house of the IJ began on 9/10 ensure sufficient treatment and mediate repositioning. The IJ house of the IJ began on 9/10 ensure sufficient treatment and mediate repositioning. The IJ house of the IJ began on 9/10 ensure sufficient treatment and mediate repositioning. The IJ house of the IJ began on 9/10 ensure sufficient treatment and mediate repositioning. The IJ house of the IJ began on 9/10 ensure sufficient treatment and mediate repositioning. The IJ began on 9/10 ensure sufficient treatment and mediate repositioning. The IJ began on 9/10 ensure sufficient treatment and mediate repositioning. The IJ began on 9/10 ensure sufficient treatment and mediate repositioning. The IJ began on 9/10 ensure sufficient treatment and mediate repositioning. The IJ began on 9/10 ensure sufficient treatment and mediate repositioning. The IJ began on 9/10 ensure sufficient treatment and mediate repositioning treatment	ept when waived under is section, the facility must ad nurse to serve as a charge of duty. NT is not met as evidenced at ion, interview and document failed to provide sufficient sure residents' safety and eeds were maintained by a medications to treat pain, and, blood thinners, blood unes were administered, and and dressings were completed at (R3, R6, R8, R14, R29, r4, R20, R27, R12,R15, and lso failed to ensure breakfast and failed to ensure breakfast and failed to ensure breakfast and failed to ensure completed to prevent pressure sident (R28). The facility failed emergency staffing plan to an after performing direct care and all 41 residents who resided esulted in an immediate residents. 19/20, when the facility failed a staffing to provide meals, lication administration, and administrator and director of the notified of the IJ on 9/24/20 was removed on 9/25/20 at a perity level of G, isolated, actual	F 7	R17, R19, and R21 were alread admitted to the hospital. R5, R R29, R33, R37, and R38 were immediately sent out to Redwo Carris hospital on 9/24/20 to recare. R18, R23, and R24 were Redwood area hospital on 9/25 change in condition. R25 and F placed at another skilled nursir 9/25/20, leaving total in-house 20. Residents, families, provide Medical Director were all notificapproved transfers. The facility a tracking log and documented residents medical record, to appropriately track all resident ensure that that resident where status were known, tracked, an appropriately communicated to care. All remaining in house reprovided with 24-hour qualified and related services to assure safety according to the facility of resident population that is be All residents have the potential affected by insufficient nursing non-licensed/uncertified staff wallowed to provide direct care tunless they have been trained Tasks non-licensed/uncertified potentially be trained to assist includes feeding assistants. Emergency Staffing policy, Pla	7, R8, R11, od area oceive safe sent out to 6 due to 826 were ng facility on census of ers and ed and ocompleted I in the transfers to eabouts and ocoordinate esidents are nursing resident assessment eing served. to be staff. All rill not be o residents to do so. staff can with		

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F 725	Findings include: Interview on 9/21/2 anonymous staff (unlicensed and unhad worked all we 9/20/20) caring for training on how to "overwhelmed". Interview on 9/21/2 of nursing (DON)-positive case had (NA)-D who report positive. The DON been notified that at the emergency had returned a cound was positive. was unaware R30 hospital for COVID 9/15/20 to report the limmediately isolative results. The facility wide testing for 9/3 started coming in the DON stated pon isolation, positive facility and everyor came in. During interview we 9/21/20 at 12:27 puncertified or no resident care. All resident care. All resident care. All resident care. All resident care.	age 10 20 at 9:36 a.m., with AS)-B identified they were certified to provide cares, but ekend (9/19/20 through the residents. They had no provide direct care and felt 20 at 10:19 a.m., with director B identified the first COVID been from nursing assistant ted on 9/15/20 she tested I stated the facility had also a resident (R30) who had been room for stroke symptoms and uple days prior, had been tested The DON verified the facility had been tested while at the D until the hospital had called on the positive results. R30 was to her room following the y already had planned facility 16/20, and positive results on Thursday afternoon 9/17/20.	F 7	25	Additional Staffing Needs policy, Farisk assessment, and Contingency Staffing Plan template have been reviewed and updated, as needed, reflect outreach to additional resou secure staff during an emergency scrisis to ensure safe staffing levels. Additional staffing resources may in outside agency companies and loc colleges. Emergency evacuation plan has be reviewed and updated to reflect sowhen it would be necessary to tran residents out of facility. The facility determines staffing needentified through the facility assess of resident population, which is determined based on evaluation of resident assessments, and plan of needs. The facility assessment of the resident population will drive staffind decisions and determine the qualifications and determine the qualifications and determine the qualifications are required by the resident population will drive staffing decisions and determine the qualifications and determine the qualifications are required by the resident populate will be utilized as it pertain sufficient staffing with any changes COVID-19 status at the facility. The Administrator/DON is responsionally and the provide safe cares to residents to early be a safe cares to residents to early be a safe care and the residents to early be a safe care and the residents are sufficient to meet the residents needs on all shifts. The Administrator/DON or designer as sufficient to complete visual and the residents of the provide and the residents of the provide and the provide	to roes to staffing noclude al een enarios sfer ds sment care he g cations idents ency as to to the ble for one ensure ing vels basic	

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F 725	stated there had be "normally do not as is in the same room was "slow", but the Interview on 9/21/2 identified they were had no training to peen told by consu "step up" and was providing direct car used a mechanical worked "alone on the residents did not go residents deserve I unaware of "what is for the residents" we Corporate had bee residents were not residents were not residents did not go been the best staffidays". Interview on 9/21/2 (DD) identified seven breakfast this morn residents who did residents who did residents who did residents who need that there were appalso did not get bre Sunday 9/20/20 ho recall who they wer following residents	age 11 O at 12:32 p.m., with R26 een three staff working who esist" her or her husband [who n] helping them. Care service y "thought they did get help". O at 12:38 p.m., with AS-D e not certified or licensed and brovide direct care. AS-D had litant administrator (C)-A to "expected to work on the floor re to the residents". AS-D had lift, provided personal cares, the upper west wing. The et the care they needed. The cetter than this". AS-D was the was doing" or "how to care while working on the floor. In told staff "need help as getting cared for. Half of the et breakfast today. Today had ing the facility has had for O at 1:10 p.m., dietary director enteen residents missed their hing. DD provided list of not get breakfast. Those R31, R30, R5, R33, R32, R38, O, R7, R12, R8, R21, R25, R9, enough staff to assist these d help to eat". DD identified broximately eight residents who eakfast Saturday 9/19/20 or wever, stated she could not re. Additionally, on 9/23/20, the did not receive their breakfast to, R11, R40, R7, R25. DD	F 7	725	observations, record review, and interviews with residents, and staff, confirm that: Residents are getting provided, Medications administered timely, wound treatments complete indicated, Meals are being provided residents needing assistance with rare provided with assistance. Administrator/DON or designee to conduct audits daily times 7 days, vimes 4 weeks, then monthly for 2 months. Audit results will be review QAPI Committee and the scope and frequency of the audits will be adjust according to the results.	cares d d as d, and meals weekly red by	

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F 725	confirmed R7, R25 the residents who n being monitored for residents were iden assistance to eat. Interview on 9/21/2 member (FM)-A ide wait times for call lift longer, the facility "a and staff are overw been told she is "no when she requeste started to allow visit parent was observe over one half hour a bottom. Interview on 9/21/2 identified themselve no formal training to provided personal of to use both hoyer a themselves and rep getting bathed. AS- how to run lift one t several times. Ther utilized during trans documentation was unaware of how to medical record. AS with the residents of administrator-CA-(A had to work the flood did not "feel comfor instructed they "had they did not get an	ge 12 b, and R28 who were among nissed their breakfast, are ridentified weight loss. These stiffed as needing staff O at 1:11 p.m., with family entified there have been long ght to be answered ½ hour or does not have enough staff, orked". FM-A's parent had of the only one here" by staff d help. When the facility tors with precautions, FM-A's end to have sat on the toilet for at that time and got a "sore" O at 2:48 p.m., with AS-B as as a non-certified staff with provide direct care. AS-B as as a non-certified staff with provide direct care. AS-B as as a non-certified staff with provide direct care. AS-B as as a non-certified staff with provide direct care. AS-B as as a non-certified staff with provide direct care. AS-B as as a non-certified staff with provide direct care. AS-B as as a non-certified staff with provide direct care. AS-B as as a non-certified staff with provide direct care. AS-B as as a non-certified staff with provide direct care. AS-B as as a non-certified staff with provide direct care in electronic and then was on their own the had not been two staff and running the lift. No arecorded as AS-B was document cares in electronic and place of the consulting and the care for the residents so by table or safe" and had been at to care for the residents so by table or safe" and had been at to care for the residents so by table or safe" and had been at the care for the residents so by table or safe" and had been at the care for the residents so by table or safe" and had been at the care for the residents so by table or safe" and had been at the care for the residents so by table or safe. As p. C. identified the care for the residents so by table or safe. As p. C. identified the care for the residents so by table or safe.	F 7	725			

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F 725	couple residents wibathroom but could or if they were able manner. AS-C assi last evening on 9/2 feeding residents o worked 9/19/20 and others how to "do s"something they co CA-A they had to "s Friday 9/18/20. AS-resident walk with a do it anymore. "The care for the resider care, they wait for ligetting to bed timel she had not checked had crusted bowel incontinent this mo they had "no medic morning R30 had fow "did not have to checked R30's tem "seemed okay". Will R30's neck, it regis unidentified nurse. residents are warm place to check a tem R30's progress not (7:54 p.m.) identifies shift. Temperature administered and edecreased to 98.4. documentation that	second person for sfers. They had to assist a th a gait belt to walk to the I not remember who they were to be transferred safely in that sted residents to eat including 0/20. AS-C had no training in r ambulating residents. AS-C d 9/20/20, and would ask tuff" to see if it was uld do". Staff were told by step up and do more" on C felt "unsafe after helping a a gait belt" so they would not be is not enough staff here to eats. Some residents did not get ong times, some are not y. One resident looked like end before bed at all she as she dried on her and was rning (R4)". AS-C identified all background" however, ""this selt warm so she told the nurse ime" to check R30. AS-C perature and her forehead nen the thermometer was over tered 102.2. AS-C told the AS-C was advised "all and that was not a good imperature". Les dated 9/21/20 at 19:54 and R30 had been lethargic this 103.6 Tylenol suppository ffective temperature	F 7	'25			

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F 725	identified the facility send our resident's cared for". There we this morning these assistance to eat a staff to help with the director and human floor doing everything do use lifts, feed rand we still do not lappropriate cares. medication for all rebeen given late or sugar (BS) and was did not get breakfast breakdown as R28 had time to update apply a dressing to that they have not gonurses desk". They "increased temperate concentrators". Fact tanks but only "hav A-A and DON-B are staff "literally cannot residents at this pokeys and gowe can having enough staff relieve us, staff did Corporate staff have floor that no one is fast". Interview on 9/22/2 identified there was her after her twelve up at 10:00 a.m. the	age 14 0 at 3:58 p.m., with AS-A y needed "to shut down or comeplace else in order to be ger eresidents who "did not eat se residents needed and we just do not have enough is". The facility had the" activity a resources staff working the ang a nursing assistant would residents and provide cares have enough staff to provide Nurses have had to pass residents and medications have not at all". R32 had a low blood as given orange juice, but she set. There has been new skin has a "new area. We have not the doctor but did clean and the wound. They have orders gotten to that are sitting on the re have several residents with atures and no more oxygen's cility staff were using portable the trying to help on the floor as to do itwe cannot care for the int. I would like to throw in my annot provide care due to not f. Today there is no one to not show up at 2:00 p.m the not notified any of us on the coming in and we are sinking 0 at 7:56 a.m., with LPN-B to no one scheduled to relieve thour shift that was finishing at day. LPN-B was scheduled thours at 6:00 p.m., for another	F 7	25		

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F 725	cared for appropria showed, rooms are not have enough scame in at 4:00 a.r residents up so the not being up anyward to get everyone up staff to assist the results and to do the best and to do the best literview on 9/22/2 identified there are for the uncertified of working on the floor literview on 9/22/2 identified receiving system about a postaff. FM-B was to name), there was appositive and they do was placed to CA-under control and a several positive cathe results". FM-B not being "very tradifferent information for his family who were residents at the factor of 9/22/20 at 10:4 reached out to the Department of Head County Emergency dates of 9/17/20 at assistance with no	The residents are not getting ately, no one here is getting ately, no one here is getting ately, residents smell, we do taff. The two day shift girls m., so they could start to get by did not miss breakfast for ay's. There is not enough staff on time to eat and not enough esidents who need help to eat. The residents who need staff that are for the resident and positive resident and positive and by one of the staff (unknown as of residents and 22 staff and have enough help. A call have reassured things were confirmed that there were sees but they "did not believe identified he felt the facility was insparent" and gave him and aily. FM-B was concerned was a resident, along with other	F 7	725			

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F 725	Nursing today to se any way." Interview on 9/22/2 identified she had riser "normally help her land land land land land land land land	ge 16 ge if they are able to assist in 0 at 2:19 p.m., with R4 not been out of her recliner in for the day. Staff that have not helped her". 0 at 3:10 p.m., C-A and RN-C orking on finding staff to fill the ge day person had agreed to gere still working on filling the 0 at 3:14 p.m., with RN-D is, "What can we do to get these re? They need care". 0 at 3:14 p.m., with A-A ot know what the plan for the gas they had "no one to work". A was still trying to work on it. 0 at 3:55 p.m., with NA-D (9/12/20) night during work tarted to feel like she had a on. Sunday (9/13/20) she felt a ntinued to work as she thought gies. On 9/14/20, she was orted she did not have a d have a headache, dry cough wheezing when breathing out, ges. LPN-C was unaware of let NA-D work regardless of ms. LPN-C advised NA-D she ges between 99.0 and 99.7 with made like isolation to their	F7	25		

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	COM	E SURVEY PLETED
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	PROVIDER OR SUPPLIER ALLEY HEALTH AND	REHABILITATION CENTER LLC		20	TREET ADDRESS, CITY, STATE, ZIP CODE 00 SOUTH DEKALB STREET EDWOOD FALLS, MN 56283	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 725	and reported she "aches and a temper decided to go to the test came back position on the test came back positions are was a new addiagnosed with Costaff did not have to staff had to do is clother residents ide facility nursing staff interventions were information from mappening and the Observation on 9/2 identified they were covers off, bed is in coughing and pullir had not been dress unkempt. Observation on 9/2 registered nurse (Fineal tray into R28 to eat. R28 was lay side. RN-B raised I assist with noon meat poorly. RN-E lo room at 12:32 p.m. position. At 12:35 proom again and sh RN-E attempt to reobservation. There support R28 had be that day. Continuous	In the morning she left work slept a little". NA-D had body erature of 101.5 degrees F, and e local clinic on 9/15/20. Her sitive on 9/15/20, and she right away. NA-D identified dmission, R11 who was liff. He was in a room alone but to gown to go in the only thing nange their mask. There were notified with loose stools, and f were notified. No new placed. "It is hard to get anagement about what is staff are overworked". 23/20 at 11:21 p.m., of R28 e laying in bed, had oxygen on, in lowest position, was awake, ing at their oxygen tubing. R28 sed for the day and was 23/20 at 12:03 p.m., of RN)-E identified they carried a room and told R28 it was time ring twisted slightly to the left nead of bed, and attempted to eal which R28 was observed to lowered bed to floor and left with R28 remaining in same of lowered bed to floor and left with R28 remaining in same of lowered bed to floor and left with R28 remaining in same of lowered bed to floor and left with R28 remaining in same of lowered bed to floor and left with R28 remaining in same of lowered bed to floor and left with R28 remaining in same of lowered bed to floor and left with R28 remaining in same of lowered bed to floor and left with R28 remaining in same of lowered bed to floor and left with R28 remaining in same of lowered bed to floor and left with R28 remaining in same of lowered bed to floor and left with R28 remaining in same of lowered bed to floor and left with R28 remaining in same of lowered bed to floor and left with R28 remaining in same of lowered bed to floor and left with R28 remaining in same of lowered bed to floor and left with R28 remaining in same of lowered bed to floor and left lowered bed lowered l	F 7	25			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED			
		245237	B. WING				C 29/2020
	PROVIDER OR SUPPLIER	REHABILITATION CENTER LLC		20	REET ADDRESS, CITY, STATE, ZIP CODE 0 SOUTH DEKALB STREET EDWOOD FALLS, MN 56283	1 03/1	25/2020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725	medication aid (TM. usually does the dre unaware R28 had a Observation and int p.m., with RN-E whorders for Aspart insbefore meals. There medication cart. RN R15's insulin yet tha R15's insulin from the returned with insulin staff currently in R1 down. RN-E entered administer R15 their that morning prior to insulin was late and within thirty minutes. Observation on 9/20 verified R32 at a nocunits of Novolog for prior to administration of Novolog for prior to administration of the pen. RN-E of insulin pen. RN-E of also late.	O at 12:56 p.m., with trained A)-B identified the nurse essing changes and was any wound dressings. Derview on 9/23/20 at 1:00 ille reviewing R15's physician sulin 10 units subcutaneous e was no insulin pen in the I-E had not administered at day. RN-E went to retrieve the medication room, and in pen for R15. She waited for 5's room to finish laying R15 d the room at 1:44 p.m., to it insulin that was due earlier to lunch. RN-E confirmed I should have been given	F 7	25	DEFICIENCY)		
	155. The insulin per expired date identificulties obtained a new insulin per expired to the control of the cont	n did not have an open date or ed RN-E disposed and ulin pen. RN-E confirmed I should have been given					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION DING			E SURVEY PLETED
		245237	B. WING				C 29/2020
	PROVIDER OR SUPPLIER ALLEY HEALTH AND	REHABILITATION CENTER LLC		STREET ADDRESS, CITY, STATE, ZIP 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD E APPROPI	BE	(X5) COMPLETION DATE
F 725	preparing R14's Hu with meals, with no RN-E disposed and confirmed R14's insadministered. Observation and intp.m. with nursing as thought RN-E had proon but was unsurbave head of beded edgrees and was stody slightly twisted room after being and had not been reposed R28 to the side to othat time. R28 was bowel. R28 had a bow was soiled with bow through an area appliameter. TMA-B can RN-E entered R28's left gluteal unstaged 4.8 centimeters (cm reddened boarders measured 1.5 cm x was an area was a cm x 2 cm. RN-E idpressure ulcers not RN-E described an measured 0.5 cm x on her right buttock cm x 0.8 cm x 0.1 cm on the control of t	3/20 at 2:18 p.m., RN-E malog 24 units subcutaneous labeled open date identified. obtained new insulin. RN-E	F 7	'25			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION NG	CON	(X3) DATE SURVEY COMPLETED	
		245237	B. WING _			C / 29/2020
	PROVIDER OR SUPPLIER	REHABILITATION CENTER LLC		STREET ADDRESS, CITY, STATE, ZIP C 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 725	updating hospice fithe family. RN-E con have been repositing pressure were ider breakdown was observed were to notify the right wound orders, rounds, complete a begin skin assessor. Review of R28's properties of R28's properties and four pressure requesting the facion of R28's with a four pressure requesting the facion of R28's with a four pressure requesting the facion of R28's with a four pressure requesting the facion of R28's with a four pressure requesting the facion of R28's with a four pressure requesting the facion of R28's with a four pressure requesting the facion of R28's with a four pressure requesting the facion of R28's with a four pressure requestion of R28's current, and had potential for skinfrequent self-molinicontinence. Interfoam covering on the facion of R28's current, and had potential for skinfrequent self-molinicontinence. Interfoam covering on the facion of R28's current, and had potential for skinfrequent self-molinicontinence. Interfoam covering on the facion of R28's current, and had potential for skinfrequent self-molinicontinence. Interfoam covering on the facion of R28's current, and had potential for skinfrequent self-molinicontinence. Interfoam covering on the facion of R28's current, and had potential for skinfrequent self-molinicontinence.	ified she would also be or an air mattress and notifying onfirmed that resident should oned when new areas of ntified. Any time skin oserved direct care staff, they nurse to assess, notify doctor, place resident on wound a Braden skin assessment, ments, and notify family. Togress notes dated 9/23/20 at d the R28's primary doctor was t R28 had four pressure ulcers. It is son was updated that R28 sores on her bottom with family lity keep her comfortable. Togress notes dated 9/23/20 at d the R28's primary doctor was to son was updated that R28 had four pressure ulcers. It is son was updated that R28 to on 8/28/20, identified R28 to on 8/26/20. There was not on 8/26/20, identified R28 to outlocks wounds, that were not overrier cream was to be son mention of the new open fold. Review of R28's disfound no pressure wound	F 7:	25		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		245237	B. WING			/ 29/2020
	PROVIDER OR SUPPLIER	REHABILITATION CENTER LLC		STREET ADDRESS, CITY, STATE, ZIP COE 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 725	every shift, pressu wheelchair and in mattress when she reposition every 2-observations by lice mention R28's care to identify the need repositioning related. Review of the Med Treatment Administ R36, R12, R22, R120, R6, R18, R35 had not received in varied dates and ti 9/25/20. Of those a following critical madministered such R13, heart medical R20, R3, R27, R13 supplements R22, medication for R25 R24, R3, R6, and R13. There were a that were not admitime frame. Addition wound dressing children we did needed help. MDH according to the reneeds were unable transfer residents accare for. We attemsoon as possible.	r red area under left breast re reducing cushion in recliner, pressure reducing e chooses to use bed, turn and 3 hours, with weekly skin ensed nurse. There was no e plan had ever been updated	F 72			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	RIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245237	B. WING		00	C 9/ 29/2020
	PROVIDER OR SUPPLIER	REHABILITATION CENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283		720/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 725	non-certified staff siloor. C-B also confresidents who miss staffing. All resident meals a day with not the evening meal a would expect mediatreatments complete physician. He would the needs of the reof residents at risk repositioning compountity Assurance (QAPI) committees to ensure a plan was or other infectious overall responsibilitiensure residents rethey require. Interview on 9/29/2 director (MD) identified the facility had basic care needs a hygiene, reposition residents, and residents, and residents, and residents, and residents are time confirmed the facility non-certified or nor care to the resident followed their continuous the facility, however the facility however the facility, however the facility however the facility however the facility, however the facility however the facility however the facility, however the facility has a facility however the facility however the facility has a facility however the facility however the facility has a facility however the facility has a facility however the facility has a facility	fully implemented and should not have worked the firmed there had been sed breakfast due to short its were to be provided three of more than 14 hours between and breakfast the next day. He cations to be given and ited as ordered by the did expect staffing levels to meet sidents to ensure repositioning for skin breakdown or and leted. C-B identified the Performance Improvement should have provided oversight as in place in case of a COVID disease outbreak. It was the try of the administrator to exceive the care and services O at 12:38 p.m., with medical ified his expectation would be adequate staffing to ensure re being met such as personal ing, meals provided to dents who require assistance that assistance. Further, the enough staffing to ensure nely and given. The MD try should not have had in-licensed staff providing direct its. The facility should have negency staffing plan and staff ovided direct care without any officed about the immediate and care was compromised at r, was not made aware of any before the immediate		25		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI	FIPLE CONSTRUCTION NG	COM	E SURVEY IPLETED
		245237	B. WING			C 29/2020
	PROVIDER OR SUPPLIER	REHABILITATION CENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283	1 03/	23/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRIDEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 725	residents to a sister manageable level. notify him of the inaresidents. Review of the 9/20 the facility was to shours between the the breakfast meal. Review of the July Ulcers/Injuries policing resident for existing admission and for a assessment weekly condition. Reposition the care plan. Staff interventions, monipotential changes interventions and san ongoing basis. Review of the 9/3/2 identified the facility conscientious, and resident 24 hours poulinary, and maint	ty was discharging some r facility to reduce census to The MD expected the facility ability to provide care to 12, Meal times policy identified erve meals no more than 14 evening meal of one day and	F 7	,		
	could report for dut the designee perso contact the corpora facilities in the com Critical staffing sho had the potential to and post-traumatic potential staffing sh	on duty until replacements y. If more staff were needed, on in charge of the facility will ate office to contact sister pany for staff assistance. ortages during an emergency oresult in staff injury or illness stress. In order to prepare for nortages, licensed and nel and volunteers were to be				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SLIPPLIER/CLIA

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLETED	
		245237	B. WING _			29/ 2020
NAME OF PROVIDER OR SUPPLIER RIVER VALLEY HEALTH AND REHABILITATION CENTER LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283	1 00/1	20/2020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725	The facility was not or untrained volunted or untrained volunted. Review of the 8/26/2 Contingency Staffin training plan to cross roles in case the prigiven function was a situations, direct cat facility staff, then the agencies, and lastly other departments. The highest practical needs of residents where taken before a risk of crisis staffing. The IJ was removed p.mwhen it could be interview and docur steps to remove the residents to the local care, with an addition the hospital for a characteristic and a census of 16. Poli reviewed and revises were verified and at non-licensed staff were staffing the staff was not a consultation of the staff was not a consultation o	d for emergency assistance. to engage in non-credentialed eers for direct resident care. 20, Long-Term Care g Plan policy identified a estrain staff to fulfill different mary staff responsible for a not available. In emergency re would be performed by e corporate float pool, outside via cross-trained staff from Quality of care was deemed ble level of care to meet the with proactive steps to have a crisis occurs to minimize the	F 72	25		
F 880 SS=L	Infection Prevention CFR(s): 483.80(a)(** §483.80 Infection C	1)(2)(4)(e)(f)	F 88	30		9/29/20
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245237	B. WING			C / 29/2020	
NAME OF PROVIDER OR SUPPLIER RIVER VALLEY HEALTH AND REHABILITATION CENTER LLC				STREET ADDRESS, CITY, STATE, Z 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 5628	ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 880	designed to provide comfortable enviror development and tr diseases and infect §483.80(a) Infection program. The facility must es and control program a minimum, the followed staff, volunteers, visproviding services arrangement based conducted accordin accepted national services for the but are not limited to (i) A system of surver possible communication infections before the persons in the facility (ii) When and to whom to be followed to providing the followed to provide the providence of the persons in the facility (iii) Standard and tr to be followed to provide the providence of the persons in the facility (iii) Standard and tr to be followed to provide the providence of the persons in the facility (iii) Standard and tr to be followed to provide the providence of the persons in the facility (iii) Standard and tr to be followed to provide the providence of the persons in the facility (iii) Standard and tr to be followed to providence of the persons in the facility (iii) Standard and tr to be followed to providence of the persons in the facility (iii) Standard and tr to be followed to providence of the persons in the facility (iii) Standard and tr to be followed to providence of the persons in the facility (iii) Standard and tr to be followed to providence of the persons in the facility (iii) Standard and tr to be followed to providence of the persons in the facility (iii) Standard and tr to be followed to providence of the persons in the facility of the persons i	and control program a safe, sanitary and ament and to help prevent the ansmission of communicable ions. In prevention and control tablish an infection prevention in (IPCP) that must include, at owing elements: Item for preventing, identifying, ting, and controlling infections diseases for all residents, sitors, and other individuals under a contractual I upon the facility assessment ing to §483.70(e) and following tandards; en standards, policies, and program, which must include, o: eillance designed to identify able diseases or ey can spread to other ty; iom possible incidents of ase or infections should be ansmission-based precautions event spread of infections; solation should be used for a	F8	80			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245237			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED C 09/29/2020	
		245237					
NAME OF PROVIDER OR SUPPLIER RIVER VALLEY HEALTH AND REHABILITATION CENTER LLC				200	REET ADDRESS, CITY, STATE, ZIP CODE SOUTH DEKALB STREET DWOOD FALLS, MN 56283	00/1	-0,2020
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	FIX (EACH CORRECTIVE ACTION SHOUL		D BE COMPLÉTION	
F 880	least restrictive poscircumstances. (v) The circumstance must prohibit emploidisease or infected contact with resider contact will transmit (vi) The hand hygier by staff involved in \$483.80(a)(4) A sysidentified under the corrective actions to \$483.80(e) Linens. Personnel must had transport linens so infection. §483.80(f) Annual ransport linens so infection.	nat the isolation should be the sible for the resident under the sible for the resident under the ces under which the facility byees with a communicable skin lesions from direct at the disease; and the procedures to be followed direct resident contact. Stem for recording incidents facility's IPCP and the taken by the facility. Indle, store, process, and the taken by the spread of the eview. Iduct an annual review of its their program, as necessary. In is not met as evidenced to follow Centers for DC) and Centers for Medicare ces (CMS) guidelines for	F8	F F F F F F F F F	R1, R2, R3, R4, R5, R6, R7, R8, R R10, R11, R12, R13, R14, R15, R6 R18, R19, R12, R21, R22, R23, R2 R27, R28, R20, R30, R31, R32, R3 R34, R35, R36, R38, R38, R39, R4 R42's plans of care and orders wer reviewed and updated to reflect appropriate COVID-19 monitoring. Residents are currently being moni for signs and symptoms of COVID- least daily and treated according to and physicians' orders. Signs and symptoms of COVID-19 are assess residents daily and documented in	tored 19 at policy	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245237	B. WING			C 29/2020	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	•	23/2020	
RIVER V	ALLEY HEALTH AND	REHABILITATION CENTER LLC		200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 880	resulted in an immeror all residents. The IJ began on 9/identified as positive failed to have a system surveillance to ider COVID-19, implement quarantined reside (PPE) to mitigate (PPE) to m	ediate jeopardy (IJ) situation (16/20, when R30 was we for COVID-19. The facility stem for daily cumulative ntify potential symptoms of ment droplet precautions, nts, and implement appropriate COVID-19 transmission which a residents testing positive for ministrator and director of the notified of the IJ on 9/23/20 a was removed on 9/24/20 at appliance remained at the scope widespread- potential for harm	F8	resident medical record. If residentified as having signs and symptoms of COVID-19, a remade to the provider to test for COVID-19, resident will be surplicated on enhanced respirate precautions, and vital sign make increased to 3 times per discility now has a system for cumulative surveillance to ide potential symptoms of COVID implemented droplet precauti quarantined residents, and in appropriate PPE. All residents had the potential affected, so all residents are being monitored for signs and of COVID-19 at least daily an according to policy and physic Signs and symptoms of COV assessed in residents daily and documented in the resident in record. If residents are identify having signs and/or symptoms COVID-19, a request will be reprovider to test for COVID-19 be suspected as having COV results come back, placed on respiratory precautions, and monitoring will be increased to day. The facility now has a sidaily cumulative surveillance potential symptoms of COVID implemented droplet precauti quarantined residents, and in appropriate PPE. Donning and doffing audits we	d/or quest will be or uspected as a come back, ory onitoring will ay. The daily entify 0-19, has ons, enplemented I to be currently d symptoms d treated cians' orders. ID-19 are end enedical end enedical end enedical id as is of made to the end resident will ID-19 until enhanced vital sign o 3 times per ystem for to identify 0-19, has ons, enplemented		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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		245237	B. WING		09/2	9/2020	
NAME OF I	PROVIDER OR SUPPLIER	3		STREET ADDRESS, CITY, STATE, 2	ZIP CODE		
RIVER V	ALLEY HEALTH ANI	D REHABILITATION CENTER LLC		200 SOUTH DEKALB STREET	000		
				REDWOOD FALLS, MN 562	283		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 880	Continued From p	page 28	F 8	80			
	ago the entire wes diarrhea. There w implemented duri if any residents ha facility.	st wing of the facility had ere no precautions ng that time. NA-B was unaware ad COVID symptoms in the	_	conducted on all shifts f for one week, then twice compliance is 100% for Facility will audit the scr daily for five days, then weeks to ensure compli	e a week until use of PPE. eening process weekly for three ance.		
	practical nurse (LI residents were plawhen they were a home that closed facility. LPN-A was	20 at 2:00 p.m., with licensed PN)-A identified none of the 17 aced on precautions/quarantine dmitted from a local nursing and were admitted to their s unaware if any residents had /ID prior to the facility outbreak		Facility has created an a calendar for audits to incleadership to conduct at four times a week for or weekly for one week and thereafter, until 100% coachieved to ensure active being completed at the all persons who enter the	clude facility udits on all shifts, ne week, twice d biweekly ompliance is ve screening is point of entry for		
	September 2020, Surveillance docu infections treated documentation of	20, August 2020, and Infection Prevention mentation only identified with antibiotics. There was no potential COVID-19 symptoms s prior to the first identified sts on 9/16/20.		Facility has established Pathway Heath for infections consulting for a duration months. Facility has add QAPI to be reviewed with Any non-compliance of process will be brought attention and will be dealers.	tion control of at least 2 ded this DPOC to th the IDT team. the screening to the DON/NHA		
	but not limited to I subjective, cough headache, new lo or runny nose, sor (muscle aches, but he will be not subjective). Review of resident (EMRs) identified R1's nurse notes admitted to the factored. The notes quarantined R1's 7/26/20, R1's tem Fahrenheit (F) and	ptoms of COVID-19 to include ever, either 100.4 or shortness of breath, ss of taste or smell, congestion re throat, diarrhea, myalgia ody aches), tiredness or fatigue t's electronic medical records the following: identified on 7/9/20, R1 cility from the local facility that made no mention R1 was vital sign report identified on perature was 99.0 degrees d on 8/20/20, R1's temperature ween 8/4/20, and 9/7/20, R1		accordingly. COVID-19 screening too been reviewed and educ report irregularities to a COVID-19 competency screener will notify nurs are answered "yes" on t screening tool. Employe allowed in the building u the employee. Employe home after nurse asses they symptomatic. This daily by Infection Contro designee. Daily Stand UP format h to discuss infections and	ol process has cated on when to nurse to assess: training included e if any questions he COVID-19 ee will not be until nurse assess e will be sent is, and nurse feels is to be reviewed of nurse, or		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ') MULTIPLE CONSTRUCTION (X3) DATE SUR COMPLETE			
		245237	B. WING			09/2	29/ 2020
	PROVIDER OR SUPPLIER	REHABILITATION CENTER LLC		20	TREET ADDRESS, CITY, STATE, ZIP CODE 00 SOUTH DEKALB STREET EDWOOD FALLS, MN 56283		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	also complained of stools for several of positive for COVID 2020, nurse notes quarantined upon a COVID symptoms mention R1's provisymptoms of COV R2's nurses' notes from a hospital. Or hospital and return R2's vital sign reportemperature was 9 tested positive for September 2020, rR2 was placed on hospital 14 days to of COVID. R3's 9/2/20, nurses headache was fee and was unresponsign report identified temperature was 9 September 2020, pmention R3 had powas placed on preprovider was notified symptoms. R5's nurses' notes admitted from local 2020, notes made implemented. R5's temperature of 99, on 9/22/20; and 10 R5 was having loo	f intermittent explosive loose lays. On 9/17/20, R1 tested . R1's July through September made no mention R1 was admission or when potential occurred. There was no der was notified of potential	F8	880	symptoms of COVID daily with IDT. Facility Interdisciplinary Team will rescreening and surveillance daily in morning stand up meetings. Any unexpected increases in infection win communication with the Medical Director, Public Health Department, the state agency. All incoming residents discharged frospitals, or other facilities, are to bisolated for 14 days. The facility will document the reside temperature, oxygen saturation, and absence or presence of symptoms residents' EMR at least daily. The fawill complete and maintain a line list residents with respiratory symptoms. Facility has provided residents and representatives education on the fact Infection Prevention Control Programs the use of transmission-based precautions as it relates to them and the degree possible/consistent with resident's capacity. Infection Control binder and resident infection statistics forms were review and updated to include identification signs and symptoms of COVID-19. policies and procedures for COVID-emerging infectious diseases and emergency preparedness relating to testing and staffing is implemented according to CDC and MDH guideling Staff is being educated on the Coronavirus (COVID-19) policy and procedure. COVID-19 signs and symptoms surveillance has been up and added to the infection control by the Infection Preventionist is out signs and added to the infection control by the Infection Preventionist is out signs.	eview fill be and formore ent's dithe in the acility ting of s. their cility's m and dito the ent wed of All 19, ones.	

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NAME OF	PROVIDER OR SUPPLIER			STREET ADD	DRESS, CITY, STATE, ZIP CODE		
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(E/	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOUL SS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 880	speech, and flaccion the emergency depthe intensive care pneumonia, sepsis returned on 9/10/2 had been tested for was not identified a when he returned. and productive with On 9/15/20, R5's gotesting. The guard then be placed on allowed visitors. R6's progress note admitted from a lossign report identified was 99.1 degrees 9/16/20, R6 intermoved tinged sputum, expland productive conshortness of breath wheezy lung sound positive for COVID R6 had been placed were diagnosed with R7's vital sign recovers was 99.4 degrees through 9/15/20; 19/18/20; 99.1 on 9/18/20;	d limbs. R5 was transported to partment (ED), was admitted to partment (ICU) with diagnoses of an acute hypoxia and as being placed on precautions On 9/12/20, R5 was congested in slight yellow-tinged sputum. The part of the p	F8	this time returning reviewing All staff schedul COVID hygiened transmapproper while pure suspect COVID 9/23/20 or designate training staff to complete schedul time classified the complete schedul time classified respiral responder and respiral responder proper staff will regarding proper staff will republished by success and control of the control o	ne and will be re-educated pring to work. DON or designed ing and tracking infections of were inserviced prior to the control of the control	ee will be daily. eir next dition, hand ission of PPE who are wing gan on e, DON, or t sent to nust be r next at the isitor ection monitor will be o esults ncluding g. Any etency) eting is ed the	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245237	B. WING		C 09/29/2020
	PROVIDER OR SUPPLIER	REHABILITATION CENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLÉTION
F 880	9/14/20, R8 had in temperatures. On COVID-19. There placed on any prediagnosed with COR9's nurses' notes admitted from a lour There was mention transmission base R11's nurses' note to the facility from diagnosis of Clostrintestinal infections precautions. On 8/discontinued and whad a temp on 9/9 9/15/20, it was 99. tested positive for indication R11 had precautions until the COVID-19 R12's nurses' note was admitted to the facility that closed. degrees F on 9/8/2 R5's temperatures 102.3 degrees F on 101.0. R12's progres 9/13/20 and 9/15/2 being flushed and temperature was 90 COVID-19 on 9/18 R12 had been place they were diagnos	termittent elevated 9/20/20, R8 tested positive for was no indication R7 had been cautions until they were 0/ID-19. identified on 7/23/20, R9 cal facility that closed. R8 was placed on d precautions upon admission. s identified they were admitted a local facility that closed with ridium difficile (a contagious s) and was placed on IC 27/20, R11's precautions were were not renewed when R11 //20, of 99.5 degrees F. On 1 degrees F. On 9/17/20, R11 COVID-19. There was no been placed on any new were diagnosed with sidentified on 7/29/20, R12 e facility from another local R12's temperature was 99.5 co; 100.3 degrees F on 9/13/20. ranged from 99.1 degrees F n 9/14/20. On 9/15/20 R12's ress notes identified between co, R12 also had symptoms of was weak. On 9/16/20, R12's 19.4. R12 was diagnosed with local on any precautions until	F 880	Infection Preventionist has reviewe Monarch Healthcare Management COVID19 Policy specific to standar transmission-based precautions. Facility has provided education on transmission-based precautions, appropriate PPE use, and donning doffing of PPE for all staff providing care to residents, and all staff enteresident's rooms. Corrective action will be accomplis providing education for all staff on requirements to be screened in by another competent staff member. Competency training was initiated tensure those screening have prove competent in the screening proces. Infection Preventionist /Director of has developed, and initiated educated based on our corporate screening process, as well as our site-specific screening process to ensure an acceptant in the screening proces how to use a thermometer. All staff have received education to include the Root Cause Analysis refrom the facility QAPI Committee regarding the deficient practices, in proper use of PPE donning/doffing. The facility will document the resident temperature, oxygen saturation, an absence or presence of symptoms residents' EMR at least daily. The final complete and maintain a line list residents with respiratory symptom Facility will be auditing the resident screening process on different shift screening process on diffe	and g direct ring hed by the to be s. Nursing tion c tive tiated s and esults including . ent's in the facility sting of s.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245237	B. WING		09/2	29/2020
	PROVIDER OR SUPPLIER ALLEY HEALTH AND	REHABILITATION CENTER LLC	:	STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283	,	
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F 880	loose stools, staff relimodium for diarrh mention R13 was per time. R13 tested possible. R14's nurses' note complained of gett temperature on 9/1 99.2 degrees on 9/1 99/13/20, R15 had lemade no mention per to prevent potentian on mention R15's pregarding potential 9/17/20, R15 tested R16's nurses' note was admitted from R16's note made requarantined to prevent potential 9/17/20, R15 tested was admitted from R16's note made requarantined to prevent potential 9/17/20, R15 tested was admitted from R16's note made requarantined to prevent potential 9/17/20, R17 has admitted from 9/13/20, R17 was returned to the facilimade no mention returned to the facilimade no mention reduction graphs of the province of the facilimade no mention returned to the facilimate r	nospital. On 8/21/20, R13 had requested a stool culture and ea. The notes made no placed on precautions at that positive for COVID on 9/17/20. Is identified on 9/13/20, R14 ing a chest cold. R14's 3/20 was 99.1 degrees F and (15/20. R14 tested positive for There was no mention as were implemented until they	F 880	to ensure compliance. Facility has this DPOC to QAPI to be reviewe the IDT team. Any staff who fail the post- test (competency) will repeat the train the testing is successful. The facility has provided training Infection Preventionist, the Direct Nursing, nursing leadership/mana and facility administration. The tracovered standard infection control practices, active surveillance, tractrending for a comprehensive infecontrol program. The facility used resources made available by the for Disease Control and Preventic program developed by well-estab centers of geriatric health service education, such as schools of menursing, centers for aging, and an health education centers with estaprograms in geriatrics. Audits will continue to be conduct monthly times one year. Audit reside reviewed by QAPI Committee scope and frequency of the audits adjusted according to the results.	d with ing until for the for of agement, aining I sking and action training Centers on or a lished s dicine or ea ablished ed ults will and the s will be	

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(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 880	had a temperature 9/12/20 through 9/1 upset stomach, not and wanted to see made no mention FCOVID precautions symptoms were ide tested positive for CR22's nurses' notes and 9/16 20, R22 h vomiting. On 9/22/2 COVID. R22's note placed on quarantin were implemented symptoms were ide admitted from a loc R23's notes made quarantined at the potential transmiss 8/24/20, and 9/15 // loose stools, a red, cough, and elevate her lungs. On 9/17/COVID. R23's note quarantined and dr to prevent potential time potential COV R24's nurses' notes admitted to the hos pneumonia. R24 w continued to have a notes made no me	s identified on 9/11/20, R19 of 100.8 degrees F. On 4/20, R19 complained of feeling well, poor appetite, her provider. R19's notes R19 was quarantined and swere implemented when entified. On 9/17/20 R19 COVID. Is identified between 8/19/20 ad symptoms of cough and 20, R20 tested positive for s made no mention he was ne or that droplet precautions when potential COVID	F 88	30		

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	PROVIDER OR SUPPLIER ALLEY HEALTH AND	REHABILITATION CENTER LLC		STREET ADDRESS, CITY, STATE, ZIP C 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283	<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 880	R25's nurses' note reported flu-like sylcontinue to monito progress notes may symptoms were may arantined, and if implemented to proceed to pro	s identified on 8/18/20, R25 mptoms. Staff were to r R25's symptoms. R25's de no further mention R25's onitored, whether R25 was droplet precautions were event potential transmission of September 2020, nurses' notes 8/17/20, to 9/2/20, R26 es stools. R26's progress notes ention R26's symptoms were r R26 was quarantined, and if s were implemented to prevent sion of COVID. s identified on 8/22/20, R28 t of phlegm she was unable to ounds had fine crackles. Ind 9/6/20, R28 continued to (PRN) medications for cough mptoms. R28's August and nurse notes made no mention were monitored or whether R28 olet precautions. On 9/17/20,	F8	80			

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	PROVIDER OR SUPPLIER	REHABILITATION CENTER LLC		200	REET ADDRESS, CITY, STATE, ZIP CODE O SOUTH DEKALB STREET EDWOOD FALLS, MN 56283	1 09//	23/2020
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F 880	9/17/20, R29 tested R30's nurses' notes and 9/16/20, R30's scratchy throat, and 9/11/20, R30 was nright side, had a ter of 99, and was tran evaluation. R30 rediagnoses of kidner weak, and tested properties on the example of the exa	d positive for COVID. sidentified between 8/22/20 shad a runny nose, sore d increased lethargy. On ot feeling well, leaning to the mperature of 100.7, pulse rate sferred to the ED for turned on 9/11/20 with a y infection. R2 continued to be ositive for COVID on 9/16/20. tion R30 was placed on ent spread of COVID. sidentified R31 was admitted local facility that recently made no mention whether ed upon admission. On d positive for COVID. sidentified on 8/21/20 to ermittent loose stools and was e notes made no mention R33 eautions when loose stools R33 tested positive for sidentified on 7/30/20, R34 lity on 7/30/20. Between 0, R34 reported intermittent was no mention R34 was ons upon admission or when on 8/21/20. R34 tested	F8	880			

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F 880	On 9/17/20, R35 te R37's nurses' notes admitted to the faci 2020, nurse notes was placed on precent 9/4/20, R37 comple (SOB). On 9/5/20, degrees F. There we placed on precautic loose stools or SOB R41's July 2020, note 7/16/20, R41 admit facility that closed. R41 was quaranting R44's nurses' notes was admitted from 8/8/20 through 8/9, productive cough. On 9/18/20, R44 te Review of the Sept Electronic Medicati Documentation (El record temperature the MAR and monit shortness of breath sore throat, muscle taste or smell, naus three times daily. A document in the su section of the nurse	aff was to continue to monitor. sted positive for COVID. sidentified on 8/11/20, R37 lity from a hospital. The July made no mention whether R37 cautions upon admission. On ained of shortness of breath R37's temperature was 100.0 vas no mention R37 was ons upon admission or when 3 began. urses' notes identified on ted to the facility from a local The notes made no mention ed upon admission. sidentified on 7/22/20, R44 a local facility that closed. On R44 had increased On 8/21/20, R44 had loose in 8/25/20. There was no quarantined or placed on disprecautions upon admission. sted positive for COVID.	F 8	80		

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F 880	Interview on 9/23/2 identified only infection were included in the Infection document to identify potential done as daily cumular agreed all potential be documented on reviewed on an ong infection outbreaks as soon as possible COVID or any infection control propreventionist was represented in a timely to prevention which is a timely to prevention where the infection control propressible of the covid and hygiene and land RN-C identified no documented and not available as evident ensure staff were used in the covid interview on 9/29/2 medical director identified in the covid interview on 9/29/2 medical director identified in the covid interview on 9/29/2 medical director identified in the covid interview on 9/29/2 medical director identified in the covid interview on 9/29/2 medical director identified in the covid interview on 9/29/2 medical director identified in the covid interview on 9/29/2 medical director identified in the covid interview on 9/29/2 medical director identified interview on 9/29/2 medical director identified in the covid interview on 9/29/2 medical director identified in the covid interview on 9/29/2 medical director identified interview on 9/29/	on at 4:00 p.m., with RN-C ctions treated with antibiotics e infection control line listing. Itation was monitored monthly infection issues and was not plative monitoring. RN-C I symptoms of infection should the line list as the occur and going basis to identify potential and to implement precautions to implement precautions to mitigate transmission of ctions. The infection esponsible to oversee the ogram and provide oversight to the identified and responded to ant transmission. Audits of PPE use were requested. Competencies were of audit documentation was not estaff were monitored to using PPE appropriately. No isson symptoms was sure staff were not working illoutbreak. To at 12:38 p.m., with the centified staff with symptoms were allowed to work. Staff were the presidents for potential ID, implement droplet of the providers to prevent ion. The medical director had the transferred from the closed	F 880			
	a family member w facility, and was tol the closed facility w					

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F 880	do don gowns, glov protections when consuspected and knot perform and hygier before and after do staff screen found the following 1) 9/16/20, licensed identified symptom Nursing assistant (migraine and procession 10:47 p.m., and COVID. The health identified symptom headache and had Proceeded to work later tested positive symptoms of heada 3:28 p.m. to 9:34 p for COVID. 2) 9/17/20, NA-G ich headache, had head proceeded to work p.m., and later testidentified symptom muscle pain, heada	esidents. Staff were expected ves, N-95 masks, and eye aring for residents with wn COVID residents and ne prior to leaving rooms, and inning gloves.	F 8	,		
	new/changed coug NA-C identified syn headache and prod 2:48 p.m. NA-M ide new/changed coug work 3:57 a.m. to 2	dentified symptoms of h, sore throat, and headache. Inptom of sore throat, eeded to work 2:47 a.m. to entified symptom of h, muscle pain, proceeded to 2:55 p.m., and later tested . RN-H identified symptom of				

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F 880	to 11:30 p.m. NA-N pain, headache an into 6:00 a.m. next identified on 9/16/2 to 4:30 p.m., and la HID-D who had syr proceeded to work later tested positive 4) 9/19/20, NA-O won 9/18/20 proceed identified symptom and proceeded to vinto 6:34 a.m. on 9 identified on 9/18/2 to 11:23 a.m. 5) 9/20/20, NA-N w 9/18/20 proceeded a.m NA-E had syr proceeded to work a.m. on 9/20/20. D symptom of chills p 2:58 p.m. Interview on 9/21/2 anonymous staff (Amedical backgrour morning and the nuher. AS-C took her the nurse that R30 seemed okay but wover R30's neck it advised AS-C all renot a good place to reported R30 had and had a COVID the local hospital of	h proceeded to work 6:31 a.m. I identified symptom of muscle d proceeded to work 6:00 p.m. day. NA-F who had symptoms to proceeded to work 1:54 p.m. ater tested positive for COVID. mptoms identified on 9/16/20 8:00 a.m. to 12:30 p.m., and	F 88				

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	PROVIDER OR SUPPLIER ALLEY HEALTH AND	REHABILITATION CENTER LLC		200 9	EET ADDRESS, CITY, STATE, ZIP CODE SOUTH DEKALB STREET DWOOD FALLS, MN 56283	00/1	20/2020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	so she was not isol residents to stay in required. A-C is una symptoms like a ter to isolate. Interview on 9/22/2 identified she is scrarriving for work on body aches that consclerosis (MS) and related to sinus prodraining. She identified working and she would get tested agone has contacted uncertified staff that on the floor. Those cares, feeding. NAweekend and does weekend unless the Interview on 9/22/2 consulting administ have symptoms up of their shift the nur is an allergy or some tested and not to 3:40 p.m., identified staff screening revibelieved COVID may via NA-D who did nand was negative. I good but worked, we positive. C-A believ tomorrow.	did not have an overnight stay ated. They encourage the their rooms but it is not aware if a resident had mperature if they would have 0 at 10:04 a.m., with NA-E eened at the door when 9/19/20, verifying she had uld related to her multiple a sore throat that could be blems as her sinus had been fied it was a "nightmare cried each night, they said we rain this Wednesday" but no her to come in. They had t were "thrown into" working untrained staff did transfers, E verified she worked all not work now until her next	F8	80			

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NAME OF I	PROVIDER OR SUPPLIER	240201		STREET ADDRESS, CITY, STATE, ZIP CODE	09/	29/2020	
RIVER VALLEY HEALTH AND REHABILITATION CENTER LLC			200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283				
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F 880	she reported she si head cold coming of "little worse" but co maybe it was allerg screened. She reportemperature but did and noticed some wand also body ache facility protocol and her having symptom was aware of residhaving temperature no changes being more nown. NA-D worked night into Tuesday, and reported she "saches and a temperature decided to go to the test came back posinotified the facility in there was a new accomposed with Codstaff did not have to staff had to do is chother residents identified staff were information from mathematical transfer of the present by were to be screened staff were not to be nurse was to assess symptoms to see if	age 41 (9/12/20) night during work tarted to feel like she had a on. Sunday (9/13/20) she felt a ntinued to work as she thought jies. On 9/14/20, she was orted she did not have a d have a headache, dry cough wheezing when breathing out, es. LPN-C was unaware of let NA-D work regardless of ms. LPN-C advised NA-D she ents on the upper west wing es between 99.0 and 99.7 with made like isolation to their d the shift Monday (9/14/20). In the morning she left work slept a little". NA-D had body erature of 101.5 degrees F, and e local clinic on 9/15/20. Her sitive on 9/15/20, and she right away. NA-D identified dmission, R11 who was liff. He was in a room alone but o gown to go in the only thing nange their mask. There were ntified with loose stools, and if were notified. No new placed. "It is hard to get anagement about what is staff are overworked". O at 3:40 p.m., with RN-C of to ring the doorbell if staff the entrance door. The staff the entrance door. The staff the staff person with it is "allergies or something". If som that has no explanation	F8	80			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245237	B. WING			09/2	29/ 2020
	PROVIDER OR SUPPLIER ALLEY HEALTH AND	REHABILITATION CENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CO 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283	DE	337-	0, = 0 = 0
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD	BE	(X5) COMPLETION DATE
F 880	(ICP) was responsimonitoring the screhowever, was curre (A)-A was doing that Interview on 9/22/21 administrator (A)-A any screening form in her office. A-A was creening forms but DON's responsibility PPE Observation on 9/22 registered nurse (Repassing medication rooms on the West without wearing a general RN-A exited R34's administer medication a.m., without wearing R23's room and ad R23 was COVID por cough and coughed RN-A was stood neroom while wearing her gloves in the hahand hygiene, RN-A the main entrance, grabbed a gown. Interview with RN-A identified RN-A had this week. She had was needed on the COVID outbreak.	The infection control nurse oble for reviewing and ening logs for staff. The ICP only out ill. The administrator at at this time. O at 4:41 p.m. with identified she does not review showever, she does file them as unsure who reviewed the t believed that would be the	F 8	880			

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		245237	B. WING		_		C 29/2020
	PROVIDER OR SUPPLIER ALLEY HEALTH AND	REHABILITATION CENTER LLC		STREET ADDRESS, CITY, STATE 200 SOUTH DEKALB STREE REDWOOD FALLS, MN 5	ET	, , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED		BE	(X5) COMPLETION DATE
F 880	time. RN-A verified when she entered t gown while adminis West wing. RN-A hecause she forgot regarding PPE and outbreak occurred. Review of the 9/19/ and Doffing COVID was not included or Interview on 9/23/2 identified no docume evidence RN-A receor prior to the start expected to don a gand change PPE and to exiting resident reshould have received working the floor. The undated Coronidentified staff were general infection into ongoing basis as not utilization of PPE, hof adhering to the notation of the purposensure infections we prevented among reprogram included copolicies and proceduallysis, antibiotic smanagement, prevented in the purpose and procedually in the purpose an	ative for COVID at the present I she had not donned a gown he facility, and had not worn a stering medications on the had not donned a gown to do so. RN-A had training hang hygiene at the time the 20, through 9/21/20, Donning training roster identified RN-A	F8	80			

,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245237	B. WING				C 29/2020
	PROVIDER OR SUPPLIER ALLEY HEALTH AND	REHABILITATION CENTER LLC		STREET ADDRESS, CITY, STATE, Z 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 5628	83		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		TION SHOULD THE APPROPI	BE	(X5) COMPLETION DATE
F 880	was responsible for control program. S tools to recognize or recording the numb detection of outbread employee infections patterns with infections patterns with infections patterns with infection management was a presence of outbread residents, preventing documenting information reporting to the apparauthorities, education monitoring for recurrence or revised policion fection prevention determine sporadic. The undated Coronic identified staff were promptly detect, trial infectious residents exposures among and visitors at the foresidents daily for posymptoms included breath, new or charmuscle pain, head smell, nausea, vom to document absen in the EMR daily. The listing of reside Residents with symillness or suspicion identified symptoms precautions implementations implementations in the providers, residents residents residents implementations in the providers, residents residents residents in the providers, residents resi	ge 44 y. The infection preventionist oversight of the infection urveillance consisted of using occurrence of infections, frequency, aks and epidemics, monitoring is and detecting unusual on control issues. Outbreak a process of determine the ak, managing affected ag spread to other residents, nation about the outbreak, propriate public healthing staff and the public, frences, and recommending cies for future outbreaks. The aist was to review data to cases from true outbreaks. Lavirus (COVID-19) policy to take reasonable steps to age, and isolate potentially and prevent unnecessary residents, healthcare workers, acility. Staff were to monitor obtential symptoms of COVID. If fever, chills, shortness of age in cough, sore throat, ache, new loss of taste or aiting, or diarrhea. Staff were ce or presence of symptoms the facility was to maintain a ants with respiratory symptoms. Potoms of acute respiratory of COVID according to a were to have droplet tented. Staff were to notify representatives, department director, facility infection.	F8	80			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		245237	B. WING	·····		29/2020
	NAME OF PROVIDER OR SUPPLIER RIVER VALLEY HEALTH AND REHABILITATION CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETION DATE
F 880	temperature, oxyge status, and other seach shift. Staff we before and after all infectious material, of PPE, including georeened for symp and actively screen take their temperate to leave the workpl maintain a line list symptoms. Staff we symptoms of respit their shift, inform the contact their primal with the public as rewho were new addred COVID, and placed separate observation of COVID-19. Recogloves, mask, eye during care of residents and staff of PPE and verified protocols would be addition, the facility	I, and administrator. Resident en saturation, respiratory ymptoms were to be monitored vere to perform hand hygiene I resident contact, contact with and before and after removal gloves. Staff were to be toms prior to reporting to work for COVID symptoms and tures. If staff were ill, they were lace. The facility was to of staff with identified vere to leave the workplace if ratory infection occurred during the infection preventionist, ry provider, and limit contact much as possible. Residents the infection status was be screened for symptoms of d in a single room or in a con area to monitor for evidence to mended PPE (gown, protection) were to be worn dents under observation. Bed on 9/24/20 at 2:35 p.m. the infection surveillance of implemented appropriate used the facility quarantine implemented as required. In a provided staff re-education, rocedures were reviewed and	F 880			
F 885 SS=F	Reporting-Residen	ts,Representatives&Families	F 88	5		9/29/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245237	B. WING		0	C 09/29/2020	
	ROVIDER OR SUPPLIER	REHABILITATION CENTER LLC		STREET ADDRESS, CITY, STATE, ZIP 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283	CODE	0/20/2020	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
	S483.80(g)(3) Information prepresentatives, and acilities by 5 p.m. to the occurrence of enfection of COVID-or staff with new-ondocurring within 72 information must— (i) Not include persection include information must— (ii) Include information must— (iii) Include any cumplemented to prepresentative or by 5 p.m. the new confirmed infection whenever three or information must— (iii) Include any cumple information infection with the end of the prepresentative or by 5 p.m. the new confirmed infection whenever three or infection infection in facilities day following the occupation of the prepresentative residing in facilities day following the occupation of the prepresentative residing in facilities day following the occupation of the prepresentative residing in facilities day following the occupation of the prepresentative residing in facilities day following the occupation of the prepresentative residing in facilities day following the occupation of the prepresentative residing in facilities day following the occupation of the prepresentative residing in facilities day following the occupation of the prepresentative residing in facilities day following the occupation of the prepresentative residing in facilities day following the occupation of the prepresentative residing in facilities day following the occupation of the prepresentative residing in facilities day following the occupation of the prepresentative residing in facilities day following the occupation of the prepresentative residing in facilities day following the occupation of the prepresentative residing in facilities day following the occupation of the prepresentative residing in facilities day following the occupation of the prepresentative residing in facilities day following the occupation of the prepresentative residing in facilities day following the occupation of the prepresentative residing in facilities day following the occupation of the prepresentative residing in facilities day following the occupation of the prepresentative residing in	m residents, their d families of those residing in he next calendar day following ither a single confirmed 19, or three or more residents uset of respiratory symptoms hours of each other. This conally identifiable information; ion on mitigating actions vent or reduce the risk of ding if normal operations of the d; and mulative updates for residents, s, and families at least weekly at calendar day following the ence of either: each time a of COVID-19 is identified, or more residents or staff with atory symptoms occur within	F8	There were no residents a not having appropriately in residents, families, and the representatives of confirm COVID-19. All of the residents could haffected by not having appinformed residents, familie representatives of confirm	formed bir ed or suspecte ave been ropriately s, and their	ed	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	JLTIPLE CONSTRUCTION .DING		(X3) DATE SURVEY COMPLETED	
		245237	B. WING		C 09/29/2020		
	NAME OF PROVIDER OR SUPPLIER RIVER VALLEY HEALTH AND REHABILITATION CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283	1 00/2	.5/2525	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFICE OF THE APPROPROPROFICE OF THE APPROPROFICE OF THE APPROPROPROFICE OF THE APPROPROPROFICE OF THE APPROPROFICE OF THE APPROPROPROFICE OF THE APPROPROPROPROFICE OF THE APPROPROPROFICE OF THE APPROPROPROFICE OF THE APPROPROPROPROFICE OF THE APPROPROPROFICE OF THE APPROPROPROPROPROPROPROPROPROPROPROPROPRO	D BE	(X5) COMPLETION DATE	
F 885	Findings include: Interview on 9/22/2 identified receiving system about a postaff. FM-B was tolename), there was 3 positive and they di	sentatives in the facility with	F 885	The Family Support Program Polic reviewed and updated to reflect th notification of confirmed or suspect (three suspected within 72-hour per COVID-19 cases must be done by 5:00pm the next calendar day and necessary and appropriate regulation information will be sent out in the automated message. An in-service performed with the leadership tear ensure that the updated policy is understood, and all have knowledged.	at cted ceriod) that all cory e will be m to		
	under control and of several positive cast the results". FM-B is not being "very trandifferent information for his family who we residents at the factor of the family who we residents at the factor of the family who we resident at the factor of the family who we resident at the factor of the family and resident representatives received confirmation of the family encouraged for the family in the family encouraged for the family encouraged family encouraged for the family encouraged for the family encouraged	confirmed that there were sees but they "did not believe dentified he felt the facility was asparent" and gave him n daily. FM-B was concerned was a resident, along with other		this requirement. Auditing and monitoring will take p the administrator or designee by tr the timing of the communication to residents and families should a ca that meets the criteria set forth in a policy occur. Audits will be perform the administrator or designee to as the timing of a known positive cas communication with the residents families to alert them of this fact. A will be conducted weekly times for weeks, then monthly times two, ar there is an identified case. Audit re will be reviewed by QAPI Committ the scope and frequency of the au be adjusted according to the resul	lace by racking or se(s) above ned by ssess e and and Audits ur nd when esults ee and dits will		
	3) 9/20/20 at 4:40 p	o.m., an automated notice was the facility provided families					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	COM	E SURVEY MPLETED
		245237	B. WING _			C 29/2020
	PROVIDER OR SUPPLIER	REHABILITATION CENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283	1 00/	23/2020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 885	received confirmati and residents" had COVID-19. They en representatives to of residents. The communication widespread outbread ata. More so, the to support residents to the extent of the home. Interview on 9/29/2 consultant administ corporate had a too residents, families, to update on confirm unaware of the example	s an automated message they on "additional staff members been diagnosed with accouraged families and call for updates on the status an lacked the extent of ak or specific and updated facility had no documentation is had been notified in any way COVID outbreak in their. O at 10:58 a.m., with trator (C)-B identified of for communicating with and resident representatives med COVID cases, he was ct guidance or requirement. O at 12:38 p.m., with medical is expectation would be the current guidelines identified by re and Medicaid Services.	F 88	5		
	No policy on report	ing was provided by the end of				

NAME OF PROVIDER OR SUPPLIER RIVER VALLEY HEALTH AND REHABILITATION CENTER LLC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER RIVER VALLEY HEALTH AND REHABILITATION CENTER LLC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE	C 09/29/2020	
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TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 885 Continued From page 49 the survey. F 885		

PRINTED: 11/06/2020 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ C B. WING 00063 09/29/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH DEKALB STREET RIVER VALLEY HEALTH AND REHABILITATION REDWOOD FALLS, MN 56283 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 000 Initial Comments 2 000 *****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:

A COVID-19 Focused Infection Control survey and abbreviated survey was conducted on 9/21/20 through 9/29/20, at your facility by the Minnesota Department of Health to determine compliance with State Licensure. Your facility was found to be NOT in compliance with the MN State Licensure.

Minnesota Department of Health

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

10/30/20

(X6) DATE

TITLE

Electronically Signed

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
71110 1 27111	or connection	BENTH TOX THOMBET.	A. BUILDING:			
		00063	B. WING		09/2	: !9/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
RIVER V	ALLEY HEALTH AND	BEHARILITATION	H DEKALB D FALLS, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 1	2 000			
	SUBSTANTIATED: cited at S1375, H52	plaints were found to be H5237021C with deficiency 237022C with deficiency cited , and H5237023C with 5800.				
		ed in ePOC and therefore a uired at the bottom of the first				
		f correction is required, it is cility acknowledge receipt of ments.				
2 800	MN Rule 4658.0510 Staffing requiremen	0 Subp. 1 Nursing Personnel; nts	2 800			9/29/20
	home must have or number of qualified registered nurses, I nursing assistants t residents at all nurs in all buildings if mo	requirements. A nursing a duty at all times a sufficient nursing personnel, including icensed practical nurses, and to meet the needs of the ses' stations, on all floors, and ore than one building is udes relief duty, weekends, cements.				
	by: Based on observati review, the facility finursing staff to ens overall care and ne ensuring scheduled blood sugar [insulin pressure, and seizu	ent is not met as evidenced ion, interview and document ailed to provide sufficient ure residents' safety and eds were maintained by a medications to treat pain, blood thinners, blood ures were administered, and und dressings were completed		Corrected.		

Minnesota Department of Health

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		7.1. 20.22			С		
	00063	B. WING		09/	29/2020		
NAME OF PROVIDER OR SUPPLIER RIVER VALLEY HEALTH AND F	REHABILITATION 200 SOUT	DRESS, CITY, S' I'H DEKALB S I'D FALLS, MN	TREET				
PREFIX (EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE		
R15, R13, R33, R24 R18). The facility als was provided for 17 R5, R33, R32, R38, R12, R8, R21, R25, of 9/19/20 and 9/23/ repositioning was co- ulcers for 1 of 1 resi to implement their e cross-train non-certi emergency and beford duties. This affected in the facility and resi jeopardy (IJ) for all r Findings include: Interview on 9/21/20 anonymous staff (AS unlicensed and unce had worked all week 9/20/20) caring for th training on how to pe "overwhelmed". Interview on 9/21/20 of nursing (DON)-B positive case had be (NA)-D who reported positive. The DON s been notified that a at the emergency ro had returned a coup and was positive. Th was unaware R30 h hospital for COVID to 9/15/20 to report the immediately isolated	ts (R3, R6, R8, R14, R29, 4, R20, R27, R12,R15, and so failed to ensure breakfast of 38 residents (R31, R30, R28, R11, R17, R40, R7, R9, R23) between the dates (20, and failed to ensure completed to prevent pressure ident (R28). The facility failed emergency staffing plan to differ staff prior to an ore performing direct care did all 41 residents who resided sulted in an immediate residents.						

Minnesota Department of Health

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Minnesota Department of Health

AND BLAN OF CORRECTION TO TRENTIFICATION NUMBERS					SURVEY PLETED	
		00063	B. WING			C 29/2020
	PROVIDER OR SUPPLIER ALLEY HEALTH AND	REHABILITATION 200 SOUT	DRESS, CITY, S TH DEKALB			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 800	wide testing for 9/16 started coming in or The DON stated poon isolation, positive facility and everyon came in. During interview wit 9/21/20 at 12:27 p.r non-certified or non resident care. All not housekeeping, laun were to be the secolifit transfer. Interview on 9/21/20 stated there had be "normally do not as is in the same room was "slow", but they Interview on 9/21/20 identified they were had no training to p been told by consul "step up" and was "providing direct card used a mechanical worked "alone on the residents did not ge residents deserve bunaware of "what si for the residents" were not gresidents were not gresidents did not ge been the best staffindays".	ge 3 6/20, and positive results in Thursday afternoon 9/17/20. sitive residents were placed e staff were removed from the e pitched in as the results the the administrator (A) on m., A stated there were no -licensed staff providing direct on-certified staff helped with dry, passed meal trays, and and staff during a mechanical of at 12:32 p.m., with R26 en three staff working who sist" her or her husband [who may be a provided get help". Of at 12:38 p.m., with AS-D and tertified or licensed and rovide direct care. AS-D had tant administrator (C)-A to expected to work on the floor er to the residents". AS-D had lift, provided personal cares, he upper west wing. The set the care they needed. The petter than this". AS-D was he was doing" or "how to care hile working on the floor. In told staff "need help as getting cared for. Half of the ent breakfast today. Today had not the facility has had for the control of the facility has had for the facility had had facility had facility had facility had facility had facility h	2 800			

Minnesota Department of Health

STATE FORM 6899 TN4F11 If continuation sheet 4 of 37

Minnesota Department of Health

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:	(X3) DATE SURVEY COMPLETED	
A. BOILDING.	С	
00063 B. WING 0	9/29/2020	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
RIVER VALLEY HEALTH AND REHABILITATION 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
2 800 Continued From page 4 (DD) identified seventeen residents missed their breakfast this morning. DD provided list of residents who did not get breakfast. Those residents who luded R31, R30, R5, R33, R32, R38, R28, R11, R17, R40, R7, R12, R8, R21, R25, R9, R23. There is not enough staff to assist these residents who need help to eat". DD identified that there were approximately eight residents who also did not get breakfast Saturday 9/19/20 or Sunday 9/20/20 however, stated she could not recall who they were. Additionally, on 9/23/20, the following residents did not receive their breakfast R5, R33, R32, R38, R11, R40, R7, R25. DD confirmed R7, R25, and R28 who were among the residents who missed their breakfast, are being monitored for identified weight loss. These residents were identified as needing staff assistance to eat. Interview on 9/21/20 at 1:11 p.m., with family member (FM)-A identified there have been long wait times for call light to be answered ½ hour or longer, the facility "does not have enough staff, and staff are overworked". FM-A's parent had been told she is "not the only one here" by staff when she requested help. When the facility started to allow visitors with precautions, FM-A's parent was observed to have sat on the toilet for over one half hour at that time and got a "sore" bottom. Interview on 9/21/20 at 2:48 p.m., with AS-B identified themselves as a non-certified staff with no formal training to provide direct care. AS-B provided personal cares, toileted residents, had to use both hoyer and standing mechanical lifts themselves and reported residents had not been getting bathed. AS-B did have "crash course" on how to run lift one time and then was on their own		

Minnesota Department of Health

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Minnesota Department of Health

AND DIAN OF CODDECTION IN IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		A. BUILDING:		OOWII EETEB			
		00063		B. WING		09/2	29/ 2020
NAME OF I	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
DIV.ED 14	=		200 SOUT	H DEKALB	STREET		
RIVER V	ALLEY HEALTH AND	REHABILITATION	REDWOO	D FALLS, M	N 56283		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
PRÉFIX TAG	(Y MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT	-	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETE DATE
2 800	Continued From pa	ige 5		2 800			
	•		+ No				
		sfer and running the lif s recorded as AS-B wa					
		document cares in ele					
		-B started working on					
		on 9/18/20, after the co					
		A) told uncertified staff					
		or. Staff advised the C					
	did not "feel comfor	rtable or safe" and had	d been				
		d to care for the reside					
	they did not get an	IJ (immediate jeopard	y) tag".				
	Interview on 9/21/2	0 at 2:58 p.m., AS-C i	dentified				
	they were to be the		aominaa				
		sfers. They had to ass	sist a				
		th a gait belt to walk to					
		I not remember who th					
		to be transferred safe					
		sted residents to eat in					
		0/20. AS-C had no tra					
		r ambulating residents d 9/20/20, and would a					
	others how to "do s		15K				
		uld do". Staff were tol	d by				
		step up and do more"					
		C felt "unsafe after he					
		a gait belt" so they wor					
	do it anymore. "The	ere is not enough staff	here to				
		nts. Some residents di					
		ong times, some are r					
		y. One resident looked					
		ed before bed at all sh dried on her and was	e as sne				
		oned on her and was rning (R4)". AS-C ider	ntified				
		al background" howe					
		elt warm so she told th					
		ime" to check R30. As					
		perature and her fore					
		nen the thermometer v					
		tered 102.2. AS-C told					
		AS-C was advised "al					

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Minnesota Department of Health

AND BLAN OF CORRECTION \ \ \ \ IDENTIFICATION NUMBER:		` '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		A. BUILDING:					
		00063		B. WING			C 29/2020
NAME OF I	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
RIVER V	ALLEY HEALTH AND	REHABILITATION		H DEKALB : D FALLS, MI			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY I SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE
2 800	Continued From pa	ige 6		2 800			
	•	and that was not a g	ood				
	(7:54 p.m.) identifies shift. Temperature administered and edecreased to 98.4. documentation that checked or monitor Interview on 9/21/2 identified the facility send our resident's cared for". There we this morning these assistance to eat a staff to help with this director and human floor doing everythidouse lifts, feed rand we still do not lappropriate cares. I medication for all rebeen given late or resugar (BS) and was did not get breakfast breakdown as R28 had time to update apply a dressing to that they have not genurses desk". They "increased temperatoncentrators". Fact tanks but only "have A-A and DON-B are staff "literally cannot residents at this po	es dated 9/21/20 at 19 de R30 had been letha 103.6 Tylenol supposifiective temperature. There lacked any a temperature had beed during the morning of at 3:58 p.m., with Ally needed "to shut downweld to share the sidents needed and we just do not have its." The facility had the resources staff working a nursing assistant esidents and provide have enough staff to provide have enough staff to provide the staff to provide the staff to provide the staff to provide the wound. They have several residents and medication that are sitting that are sitting that are sitting that the staff were using provided the wound. They have several resider at the staff were using the trying to help on the ot do itwe cannot calint. I would like to threat and provide care during the provide care during t	een g shift. S-A yn or er to be d not eat e enough e" activity sing the t would cares provide ass ions have low blood but she ew skin e have not an and re orders ng on the nts with xygen's portable AS-A felt floor as re for the ow in my				

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AND DUAN OF CODDECTION IDENTIFICATION NUMBER.			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
					C	;
		00063	B. WING		09/2	9/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
RIVER V	ALLEY HEALTH AND	REHABILITATION	H DEKALB			
(VA) ID	CLIMMADV CTA	TEMENT OF DEFICIENCIES	D FALLS, M	PROVIDER'S PLAN OF CORRECTION	N.	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 800	Continued From pa	ge 7	2 800			
	Corporate staff hav	not show up at 2:00 p.m e not notified any of us on the coming in and we are sinking				
	for the uncertified of working on the floo Interview on 9/22/2	0 at 9:38 a.m., with FM-B				
	system about a posstaff. FM-B was told name), there was 3 positive and they di was placed to CA-A under control and o several positive cast the results". FM-B i not being "very trandifferent information	information via automated sitive resident and positive d by one of the staff (unknown 6 residents and 22 staff d not have enough help. A call A who reassured things were confirmed that there were sees but they "did not believe dentified he felt the facility was isparent" and gave him in daily. FM-B was concerned was a resident, along with other				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	A. BUILDING:	-
00063	B. WING	— C — 09/29/2020
NAME OF PROVIDER OR SUPPLIER STREET ADD	PRESS, CITY, STATE, ZIP CODE	
DIVED VALLEY HEALTH AND DEHARILITATION	H DEKALB STREET D FALLS, MN 56283	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE TAG CROSS-REFERENCE	NN OF CORRECTION (E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY) (X5) COMPLETE DATE
residents at the facility. On 9/22/20 at 10:49 a.m., C-A reports she had reached out to the corporate pool staff, Minnesota Department of Health, AnnLeo, and Redwood County Emergency Management between the dates of 9/17/20 and 9/22/20, for staffing assistance with no success. C-A stated she hoped to "reach out to the Minnesota Board of Nursing today to see if they are able to assist in any way." Interview on 9/22/20 at 2:19 p.m., with R4 identified she had not been out of her recliner since she had risen for the day. Staff that "normally help her have not helped her". Interview on 9/22/20 at 3:10 p.m., C-A and RN-C identify they are working on finding staff to fill the afternoon shift. One day person had agreed to stay on but they were still working on filling the afternoon shift. Interview on 9/22/20 at 3:14 p.m., with RN-D asked the surveyor, "What can we do to get these residents out of here? They need care". Interview on 9/22/20 at 3:14 p.m., with A-A identified she did not know what the plan for the evening shift was, as they had "no one to work". She stated that C-A was still trying to work on it. Interview on 9/22/20 at 3:55 p.m., with NA-D identified Saturday (9/12/20) night during work she reported she started to feel like she had a head cold coming on. Sunday (9/13/20) she felt a "little worse" but continued to work as she thought maybe it was allergies. On 9/14/20, she was	2 800	CIENCY)

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Minnesota Department of Health

AND DIAN OF CODDECTION INDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00063		B. WING			C 29/2020
NAME OF PROVIDER OR SUPPLIER STREET AD 200 SOUT				DRESS, CITY, S TH DEKALB S D FALLS, M		,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 800	and also body ache facility protocol and her having symptor was aware of reside having temperature no changes being room. NA-D worked night into Tuesday, and reported she "saches and a tempedecided to go to the test came back posnotified the facility rathere was a new aches and at the ending of the facility rathere was a new aches and to do is chother residents ider facility nursing staff interventions were information from manappening and the Observation on 9/2 identified they were covers off, bed is in coughing and pulling had not been dress unkempt. Observation on 9/2 registered nurse (Registered nurse (Registered nurse) (Regist	wheezing when breat is. LPN-C was unaware let NA-D work regarms. LPN-C advised Nents on the upper were shetween 99.0 and made like isolation to did the shift Monday (9.1 In the morning she less lept a little". NA-D has rature of 101.5 degree local clinic on 9/15/20, and ight away. NA-D ider limits on 9/15/20, and ight away. NA-D ider limits on the or ange their mask. The tified with loose stood were notified. No ne placed. "It is hard to ganagement about whis taff are overworked 3/20 at 11:21 p.m., of laying in bed, had on lowest position, was go at their oxygen tubed for the day and where local which R28 mand attention and told R28 it ing twisted slightly to need of bed, and attention and the R28 was observed bed to floor and with R28 remaining in with R28 remaining in with R28 remaining in which R28 remaining in w	are of dless	2 800			

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Minnesota Department of Health

AND DUAN OF CODDECTION INDENTIFICATION NUMBER:				(X3) DATE S COMPL		
					С	
		00063	B. WING	· · · · · · · · · · · · · · · · · · ·	09/29	9/2020
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
RIVER V	ALLEY HEALTH AND	REHABILITATION	TH DEKALB : D FALLS, M			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	COMPLETE DATE
2 800	Continued From pa	ge 10	2 800			
	RN-E attempt to re observation. There support R28 had be that day. Continuous taff had entered R reposition R28. Interview on 9/23/2 medication aid (TM usually does the dreed to be supported by the dreed by the dreed to be supported by the dreed by the	ut the door. At no time did position R28 during the was no documentation to be repositioned in any way as observations identified no 28's room by 2:22 p.m. to 0 at 12:56 p.m., with trained A)-B identified the nurse essing changes and was any wound dressings.				
	Observation and in p.m., with RN-E whorders for Aspart in before meals. Ther medication cart. RN R15's insulin yet the R15's insulin from the returned with insulin staff currently in R1 down. RN-E entere administer R15 the that morning prior the order of the staff currently in R1 down.	terview on 9/23/20 at 1:00 ile reviewing R15's physician sulin 10 units subcutaneous e was no insulin pen in the N-E had not administered at day. RN-E went to retrieve he medication room, and n pen for R15. She waited for 5's room to finish laying R15 d the room at 1:44 p.m., to ir insulin that was due earlier to lunch. RN-E confirmed it should have been given				
	verified R32 ate no- units of Novolog for prior to administrati noted not to have a on the pen. RN-E d insulin pen. RN-E d also late.	3/20 at 1:51 p.m., RN-E on meal and she is to get 7 meal coverage. At 1:54 p.m., on, R32's insulin pen was n open or expired date labeled isposed and obtained a new onfirmed R32's insulin was				
	preparing to give R	3/20 at 2:12 p.m., RN-E 29 her Lispro 2 units of insulin ing scale for blood sugar of				

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AND DIANIOE CORRECTION I DENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
						С	
		00063	B. WING		09/2	29/2020	
	PROVIDER OR SUPPLIER ALLEY HEALTH AND	REHABILITATION 200 SOUT	DRESS, CITY, S TH DEKALB DD FALLS, M				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
2 800	expired date identification obtained a new insulin was late and within thirty minutes. Observation on 9/25 preparing R14's Hu with meals, with no RN-E disposed and confirmed R14's insum administered. Observation and into p.m. with nursing as thought RN-E had proon but was unsul have head of bed edegrees and was sibody slightly twisted room after being ach had not been reposed R28 to the side to contact time. R28 was bowel. R28 had a bow was soiled with bow	n did not have an open date or ied RN-E disposed and ulin pen. RN-E confirmed I should have been given of the noon meal. 3/20 at 2:18 p.m., RN-E malog 24 units subcutaneous labeled open date identified. I obtained new insulin. RN-E					
	RN-E entered R28's left gluteal unstages 4.8 centimeters (cm reddened boarders measured 1.5 cm x	alled for the nurse to come. s room and identified R28 had able wound that was overall n) x 3.5 cm including the dark. The actual open area within 2.4 cm and also within that hardened spot measuring 1					
	cm x 2 cm. RN-E id pressure ulcers not RN-E described an measured 0.5 cm x on her right buttock	lentified the areas were new previously known for R28. open coccyx wound that 0.9 cm and two open wounds the proximal measured 0.5 cm and the distal measured					

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AND DUAN OF CODDECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		00063	B. WING			C 29/2020
	PROVIDER OR SUPPLIER	REHABILITATION 200 SOL	DDRESS, CITY, S JTH DEKALB S OD FALLS, MI	STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 800	0.4 cm x 0.6 cm. RI dressing and plann was noted to moan Staff repositioned FRN-E instructing state hourly. RN-E identifupdating hospice for the family. RN-E cohave been reposition pressure were identified breakdown was obswere to notify the niget wound orders, prounds, complete a begin skin assessm. Review of R28's production of R28's production of R28's production of R28's were a message that At 4:21 p.m., R28's had four pressure strequesting the facility area on her right let open and a chronic evaluate and treat of drainage noted at the wheelchair and whe skin inspection note had a chronic left boron. A standard by applied. There was area in her gluteal fassessment record evaluation from 8/2 R28's current, undagen.	N-E cleansed, applied ed to notify the doctor. R28 during the wound treatment. R28 on her right side with aff she should be repositioned fied she would also be or an air mattress and notifying infirmed that resident should oned when new areas of tified. Any time skin served direct care staff, they curse to assess, notify doctor, place resident on wound Braden skin assessment, ments, and notify family. Digress notes dated 9/23/20 at the R28's primary doctor was R28 had four pressure ulcers son was updated that R28 fores on her bottom with famility keep her comfortable. Dekly skin inspection dated that R28 had new 3 cm x 1 cm ft gluteus that was slightly problem. Wound care was to be no 8/26/20. There was no nat time. R28 would sit in her sel herself around all day. A et dated 8/28/20, identified R28 uttocks wounds, that were no arrier cream was to be no mention of the new open old. Review of R28's s found no pressure wound	9 3 5 5 5 7			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			. ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
				A. BUILDING.			,
		00063		B. WING			29/2020
NAME OF PR	OVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
RIVER VALUEY HEALTH AND REHABILITATION				H DEKALB : D FALLS, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
ir in figure of the page of th	ncontinence. Intervious commovering on wooddles attach, gerand hands, monitor every shift, pressure wheelchair and in reposition every 2-3 observations by lice mention R28's care to identify the need epositioning related epositioning eritical meadministered such and eposition for R29, R3, R27, R13, redication for R29, R3, R6, and kappelements R22, I hat were not admirring frame. Addition eposition deceded help. MDH eccording to the respect	illity or repositioning a ventions included have vheelchair frame whe i-sleeves to help pro- red area under left the reducing cushion in ecliner, pressure red chooses to use bed, 8 hours, with weekly sensed nurse. There we plan had ever been	ring a ere foot tect arms breast of ucing a turn and skin was no updated tory. In and fied R15, 7, R3, 8, R29 at all, on ough sthe ecceived or 29, R15, istered for tional re R33, R8, 0, R27, dications during this beive a C-B MDH exas to staff dents y was to	2 800			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` '	E CONSTRUCTION	(X3) DATE	SURVEY PLETED	
				A. BUILDING:			0
		00063		B. WING			C 29/2020
NAME OF	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
RIVER \	/ALLEY HEALTH AND	REHARII II A I I () N		H DEKALB : D FALLS, M			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FI SC IDENTIFYING INFORMATI	-	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 800	care for. We attem soon as possible. It contingency staffing plan had not been non-certified staff staffor. C-B also contresidents who miss staffing. All resident meals a day with not the evening meal at would expect mediate treatments comple physician. He would the needs of the residents at risk repositioning compountity Assurance (QAPI) committees to ensure a plan was or other infectious overall responsibilitiensure residents rethey require. Interview on 9/29/2 director (MD) ident that the facility had basic care needs a hygiene, reposition residents, and residents, and residents, and residents, and residents are tin confirmed the facility non-certified or nor care to the resident followed their continuous nor training. He was not the resident followed their continuous nor the resident followed the resident followed their continuous nor the resident followed the resident followed their continuous nor the resident followed th	pted to get staff into worker C-B confirmed the g plan and emergency fully implemented and should not have worked firmed there had been sed breakfast due to shots were to be provided to more than 14 hours to and breakfast the next of cations to be given and ted as ordered by the despect staffing levels sidents to ensure reported. C-B identified the Performance Improver should have provided to as in place in case of a disease outbreak. It was to get the care and service the staffing to early and given. The Mitter assistance. Further that assistance is that assistance. Further that assistance is the first provided to dents who require assistance is that assistance is the first provided to dents who require assistance is that assistance is the first provided to dents who require assistance is the first provided to dents who require assistance is the first provided to dents who require assistance is the first provided to dents who require assistance is the first provided to dents who require assistance is the first provided to dents who require assistance is the first provided to dents who require assistance is the first provided to dents who require assistance is the first provided to dents who require assistance is the first provided to dents who require assis	staffing d the nort three between day. He d s to meet sitioning and e ment oversight c COVID as the to rvices nedical ould be nsure bersonal stance er, the ire of d g direct nave nd staff out any diate	2 800			

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
			,			;
		00063	B. WING			9/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
RIVER V	ALLEY HEALTH AND	REHABILITATION	H DEKALB			
		REDWOO	D FALLS, M		_	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 800	Continued From pa	ge 15	2 800			
	concerns or issues jeopardy. The facili residents to a sister manageable level. notify him of the inaresidents.	r, was not made aware of any before the immediate ty was discharging some r facility to reduce census to The MD expected the facility ability to provide care to				
	the facility was to s	erve meals no more than 14 evening meal of one day and				
	Ulcers/Injuries police resident for existing admission and for reassessment weekly condition. Reposition the care plan. Staff interventions, monipotential changes in	2017, Prevention of Pressure by identified assessing the gressure ulcer upon risk factors, repeat the rand upon any changes in on residents as indicated on were to provide preventative tor, evaluate and document on the skin and review trategies for effectiveness on				
	identified the facility conscientious, and resident 24 hours p culinary, and maint adequately staffed necessary to stay o could report for dut the designee perso contact the corpora facilities in the com Critical staffing sho had the potential to and post-traumatic	O, Emergency Staffing policy was to give competent, consistent quality care to each per day. Nursing, laundry, enance departments must be and therefore, it may be and therefore, it may be an duty until replacements y. If more staff were needed, n in charge of the facility will the office to contact sister pany for staff assistance. It ages during an emergency result in staff injury or illness stress. In order to prepare for nortages, licensed and				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			,
		00063	B. WING			9/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
RIVER V	ALLEY HEALTH AND	REHABILITATION	H DEKALB			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	D FALLS, M	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	COMPLETE DATE
2 800	Continued From pa	ge 16	2 800			
	recruited and traine The facility was not	nel and volunteers were to be ad for emergency assistance. to engage in non-credentialed eers for direct resident care.				
	Contingency Staffin training plan to cross roles in case the pregiven function was situations, direct castacility staff, then the agencies, and lastly other departments. The highest practication needs of residents	20, Long-Term Care ag Plan policy identified a ass-train staff to fulfill different imary staff responsible for a not available. In emergency are would be performed by e corporate float pool, outside a via cross-trained staff from Quality of care was deemed able level of care to meet the with proactive steps to have a crisis occurs to minimize the g.				
	administrator, DON adequate policy and sufficient staffing be population to staffin received safe, adec with toileting, bathir ulcer care, and eati COVID-19 outbreak disease. The facility these policies and period to ensure residents services with adequality assurance per (QAPI) committee featermine compliar monitoring.	HOD OF CORRECTION: The or designee should ensure d programs are developed for ased on the resident ag availability so residents quate and timely assistance ag, repositioning, pressure as or like emerging infectious or like emerging infectious of should educate staff on perform audits of resident care are receiving care and that staffing. The facility andings of these audits to the performance improvement for further recommendations to accord the need for further				

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Minnesota Department of Health
STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
7.1.12 . 27.11	o. oo20		A. BUILDING:			
		00063	B. WING		09/2	; 9/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
RIVER V	ALLEY HEALTH AND	REHABILITATION	TH DEKALB D FALLS, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 800	Continued From pa	ge 17	2 800			
	(21) days.					
21375	MN Rule 4658.0800 Program	0 Subp. 1 Infection Control;	21375			9/29/20
	home must establis	on control program. A nursing sh and maintain an infection signed to provide a safe and nt.				
	by: Based on observatireview, the facility for Disease Control (C) and Medicaid Servit COVID-19 to prevestransmission of CO ongoing facility outly (R1, R2, R3, R4, R12, R13, R14, R1 R21, R22, R23, R2 R32, R33, R34, R3 R42, and R42) who As a result of this, 3 positive for COVID-	ent is not met as evidenced ion, interview and document ailed to follow Centers for DC) and Centers for Medicare ces (CMS) guidelines for nt or minimize the VID-19 which resulted in an oreak when 31 of 41 residents 5, R6, R7, R8, R9, R10, R11, 5, R6, R17, R18, R19, R12, 4, R27, R28, R20, R30, R31, 5, R36, R38, R38, R39, R40, or had COVID-19 symptoms. 39 of 41 residents tested 19. The facility's failures ediate jeopardy (IJ) situation		Corrected.		
	identified none of the from a local nursing quarantined upon a wear gowns when p	0 at 9:15 a.m., with NA-B ne 17 residents who admitted g home that closed, were admission and staff did not providing care. NA-B was dents had symptoms of				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					3) DATE SURVEY COMPLETED	
	00063	B. WING			C 29/2020	
NAME OF PROVIDER OR SUPPLIER RIVER VALLEY HEALTH AND RE	HARILITATION 200 SOUT	DRESS, CITY, S TH DEKALB S D FALLS, MN		·		
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES JST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
nursing assistant (NA) ago, there was one results (severe intestinal infective when they admitted from that closed. No other infacility were placed on and staff were not instructed addition to using stand provide care. NA-B also ago the entire west wire diarrhea. There were mimplemented during the if any residents had Confacility. Interview on 9/21/20 at practical nurse (LPN)-residents were placed when they were admitted home that closed and facility. LPN-A was una symptoms of COVID pon 9/16/20. Review of July 2020, And September 2020, Infections treated with documentation of pote or other symptoms price positive COVID tests of CDC defines symptoms but not limited to Fever subjective, cough, sho	n 9/22/20 at 9:50 a.m., with a-B identified a month or so sident whom had C. Diff ction) was quarantined om a local nursing home residents admitted from the quarantine for COVID-19, ructed to don a gown in dard PPE precautions to so reported that a monthing of the facility had no precautions at time. NA-B was unaware OVID symptoms in the at 2:00 p.m., with licensed A identified none of the 17 on precautions/quarantine ted from a local nursing were admitted to their aware if any residents had brior to the facility outbreak august 2020, and ction Prevention tation only identified antibiotics. There was no ential COVID-19 symptoms or to the first identified on 9/16/20.					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00063	B. WING		C 09/20	9/2020
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 03/23	72020
RIVER V	ALLEY HEALTH AND	REHABILITATION	TH DEKALB			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID FALLS, IVI	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETE DATE
21375	Continued From pa	ge 19	21375			
	(muscle aches, bod	ly aches), tiredness or fatigue				
	(EMRs) identified the R1's nurse notes identified to the facilic closed. The notes in quarantined R1's vir 7/26/20, R1's temporal fahrenheit (F) and was 99.1 (F). Betwee also complained of stools for several day positive for COVID. 2020, nurse notes in quarantined upon a COVID symptoms of	entified on 7/9/20, R1 lity from the local facility that made no mention R1 was tal sign report identified on erature was 99.0 degrees on 8/20/20, R1's temperature een 8/4/20, and 9/7/20, R1 intermittent explosive loose ays. On 9/17/20, R1 tested R1's July through September made no mention R1 was dmission or when potential occurred. There was no der was notified of potential				
	from a hospital. On hospital and returned R2's vital sign report temperature was 98 tested positive for C September 2020, nr R2 was placed on is hospital 14 days to of COVID. R3's 9/2/20, nurses headache was feeliand was unresponsing report identified temperature was 98 September 2020, pt	9.1 degrees F. R3's rogress notes made no				
	was placed on prec	tential symptoms of COVID-19 autions, or whether R3's d of potential COVID				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00063	B. WING		09/2) 19/2020
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 09/2	.9/2020
		200 SOUT	'H DEKALB			
RIVER V	ALLEY HEALTH AND	REHARII ITATION	D FALLS, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21375	Continued From pa	ge 20	21375			
	symptoms.					
	admitted from local 2020, notes made r implemented. R5's temperature of 99.7 on 9/22/20; and 100 R5 was having loos an emesis, had wel speech, and flaccid the emergency dep the intensive care upneumonia, sepsis, returned on 9/10/20 had been tested for was not identified a when he returned. On 9/15/20, R5's gutesting. The guardia	identified on 7/16/20, R5 was facility that closed. R5's July no mention precautions were vital signs showed R5 had a 7 degrees F on 7/17/20. 99.2 0.2 F on 9/24/20. On 8/21/20, se stools. On 9/6/20, R5 had a breath sounds, mumbled limbs. R5 was transported to artment (ED), was admitted to artment (ED), was admitted to anit (ICU) with diagnoses of and acute hypoxia and 0. There was no indication R5 of COVID in the hospital and se being placed on precautions on 9/12/20, R5 was congested slight yellow-tinged sputum. Juardian declined COVID-19 and was informed R5 would quarantine and would not be				
	admitted from a loc sign report identified was 99.1 degrees F 9/16/20, R6 intermitinged sputum, exp had productive courshortness of breath wheezy lung sound positive for COVID- R6 had been placed were diagnosed with	s identified on 7/16/20, R6 was al facility that closed. R6's vital d on 8/7/20, R6's temperature; and 99.3 on 9/14/20. On ttently coughed up blood erienced chest pain, dizziness, gh with yellow sputum, hoarseness, and diminished s. On 9/17/20, R6 tested 19. There was no indication d on any precautions until they h COVID-19.				
	was 99.4 degrees F	on 9/8/20; 99.1 on 9/13/20 0.6 on 9/17/20; 99.5 on				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
					C	
		00063	B. WING	·····	09/2	9/2020
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
RIVER V	ALLEY HEALTH AND	REHARII ITATION	'H DEKALB : D FALLS, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21375	Continued From pa	ge 21	21375			
	9/18/20; 99.1 on 9/2 There was no indicany precautions uncovID-19. R8's nurses' notes admitted from a loc 8/21/20 through 9/9 symptoms of loose sign record identifice 9/14/20, R8 had intemperatures. On 9 COVID-19. There we placed on any preciding nosed with COR9's nurses' notes admitted from a loc There was mention	20/20; and 100.6 on 9/17/20 ation R12 had been placed on til they were diagnosed with identified on 7/24/20, R8 al closed facility. Between 1/20, R8 intermittently had stools and a cough. R8's vital to between 8/11/20, and termittent elevated 1/20/20, R8 tested positive for was no indication R7 had been autions until they were VID-19.				
	to the facility from a diagnosis of Clostri intestinal infections precautions. On 8/2 discontinued and w had a temp on 9/9/2 9/15/20, it was 99.1 tested positive for Cindication R11 had precautions until the COVID-19 R12's nurses' notes was admitted to the facility that closed. degrees F on 9/8/2 R5's temperatures 102.3 degrees F or	s identified they were admitted a local facility that closed with dium difficile (a contagious) and was placed on IC 27/20, R11's precautions were ere not renewed when R11 20, of 99.5 degrees F. On degrees F. On 9/17/20, R11 COVID-19. There was no been placed on any ey were diagnosed with s identified on 7/29/20, R12 a facility from another local R12's temperature was 99.5 c; 100.3 degrees F on 9/13/20. Tranged from 99.1 degrees F on 9/14/20. On 9/15/20 R12's less notes identified between				

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00063 B. WING 09	C 29/2020
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG	(X5) COMPLETE DATE
21375 Continued From page 22 9/13/20 and 9/15/20, R12 also had symptoms of being flushed and was weak. On 9/16/20, R12's temperature was 99.4. R12 was diagnosed with COVID-19 on 9/18/20. There was no indication R12 had been placed on any precautions until they were diagnosed with COVID-19. R13's nurses' notes identified on 7/2/20, R13 admitted from the hospital. On 8/2/1/20, R13 had loose stools, staff requested a stool culture and Imodium for diarrhea. The notes made no mention R13 was placed on precautions at that time. R13 tested positive for COVID on 9/17/20. R14's nurses' notes identified on 9/13/20, R14 complained of getting a chest cold. R14's temperature on 9/13/20 was 99.1 degrees F and 99.2 degrees on 9/15/20. R14 tested positive for COVID on 9/17/20. There was no mention isolation precautions were implemented until they were diagnosed with COVID-19. R15's nurses' notes identified between 9/9/20 and 9/13/20, R15 had loose stools. R15's notes made no mention R15's provider was contacted regarding potential COVID-19 symptoms. On 9/17/20, R15 tested positive for COVID, R16's nurses' notes identified between 9/9/20 and 9/13/20, R15 tested positive for COVID-19. R16's nurses' notes identified of 7/13/20, R16 was admitted from from a locally closed facility. R16's note made no mention R16 was quaramtined to prevent potential transmission of COVID-19. R16's nurses' notes identified between 8/25/29 and 9/1/20, R17 had intermittent increased confusion, lethargy, and decreased appetite. On	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00063	B. WING		09/2) 19/2020
	PROVIDER OR SUPPLIER	STREET AD STREET AD 200 SOUT	DRESS, CITY, S TH DEKALB : D FALLS, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21375	9/13/20, R17 was hor confusion and was returned to the facil made no mention Fidentifying symptom the hospital. On 9/1 COVID-19. R19's nurses' notes had a temperature 9/12/20 through 9/1 upset stomach, not and wanted to see made no mention FCOVID precautions symptoms were ide tested positive for CR22's nurses' notes and 9/16 20, R22 hor vomiting. On 9/22/2 COVID. R22's note placed on quarantim were implemented symptoms were ide R23's nurses' notes admitted from a loc R23's notes made in quarantined at the totential transmissi 8/24/20, and 9/15 /2 loose stools, a red, cough, and elevate her lungs. On 9/17/COVID. R23's note quarantined and drot prevent potential	ospitalized for increased found to be dehydrated. R17 ity on 9/14/20. R17's notes R17 was quarantined upon as or when they returned from 7/20, R17 tested positive for sidentified on 9/11/20, R19 of 100.8 degrees F. On 4/20, R19 complained of feeling well, poor appetite, her provider. R19's notes R19 was quarantined and were implemented when entified. On 9/17/20 R19 COVID.	21375			

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00063	B. WING		09/2) 9/2020
	PROVIDER OR SUPPLIER	REHABILITATION 200 SOUT	DRESS, CITY, S TH DEKALB : D FALLS, M			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
21375	R24's nurses' notes admitted to the hos pneumonia. R24 w continued to have a notes made no merupon admission to of COVID. On 9/21 COVID. R25's nurses' notes reported flu-like syr continue to monitor progress notes may symptoms were more quarantined, and if implemented to pre COVID. R26's August and Sidentified between Side	s identified on 9/2/20, R24 spital with a diagnoses of vas negative for COVID. R24 a productive cough. R24's ntion R24 was quarantined prevent potential transmission 1/20, R24 tested positive for sidentified on 8/18/20, R25 mptoms. Staff were to R25's symptoms. R25's de no further mention R25's onitored, whether R25 was droplet precautions were event potential transmission of September 2020, nurses' notes 8/17/20, to 9/2/20, R26 e stools. R26's progress notes ention R26's symptoms were R26 was quarantined, and if swere implemented to prevent ion of COVID. sidentified on 8/22/20, R28 t of phlegm she was unable to bunds had fine crackles. and 9/6/20, R28 continued to (PRN) medications for cough mptoms. R28's August and nurse notes made no mention ere monitored or whether R28 blet precautions. On 9/17/20,	21375			
	from the hospital o	s identified H29 was admitted in 8/25/20. R29 was zure activity on 8/31/20, and				

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-	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					DATE SURVEY COMPLETED	
		00063	B. WING			C 29/2020	
	PROVIDER OR SUPPLIER	REHABILITATION 200 SOU	DDRESS, CITY, S TH DEKALB S DD FALLS, M				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE	
21375	for a second time a August and Septem no mention R29 wa potential COVID Trathe facility or after the facility of the facil	nd returned on 9/10/20. The ober, 2020, nurse notes made is quarantined to prevent ansmission upon admission to the second hospitalization. On a positive for COVID. Is identified between 8/22/20 and a runny nose, sore a increased lethargy. On the other feeling well, leaning to the inperature of 100.7, pulse rate is ferred to the ED for for feeling well, leaning to the inperature of 100.7, pulse rate is ferred to the ED for for for COVID on 9/16/20. In R30 was placed on the entire for COVID on 9/16/20. It is identified R31 was admitted focal facility that recently made no mention whether the dupon admission. On a positive for COVID. Is identified on 8/21/20 to the ermittent loose stools and was the notes made no mention R33 autions when loose stools R33 tested positive for covidentified on 7/30/20, R34 lity on 7/30/20. Between the on 8/21/20. R34 reported intermittent was no mention R34 was ons upon admission or when on 8/21/20. R34 tested					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,			(X3) DATE SURVEY COMPLETED	
7.1.12 . 2.1.1	0. 0020		A. BUILDING:			
		00063	B. WING		09/2	; 9/ 2020
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
RIVER V	ALLEY HEALTH AND	REHABILITATION	TH DEKALB OD FALLS, M			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21375	Continued From pa	age 26	21375			
	was admitted from 8/26/20 R35 had lo had a productive conot feeling well. St On 9/17/20, R35 te R37's nurses' notes admitted to the faci 2020, nurse notes was placed on prec 9/4/20, R37 compla (SOB). On 9/5/20, I degrees F. There w	s identified on 7/30/20, R35 a locally closed facility. On pose stools. On 9/16/20, R35 ough, clammy skin, and was raff was to continue to monitor. ested positive for COVID. s identified on 8/11/20, R37 illity from a hospital. The July made no mention whether R37 cautions upon admission. On ained of shortness of breath R37's temperature was 100.0 was no mention R37 was ons upon admission or when B began.				
	7/16/20, R41 admit facility that closed.	urses' notes identified on tted to the facility from a local The notes made no mention ed upon admission.				
	was admitted from 8/8/20 through 8/9, productive cough. 0 stools and again or mention R44 was 0 transmission based	s identified on 7/22/20, R44 a local facility that closed. On R44 had increased On 8/21/20, R44 had loose n 8/25/20. There was no quarantined or placed on d precautions upon admission. ested positive for COVID.				
	Electronic Medicati Documentation (El record temperature the MAR and monit shortness of breath sore throat, muscle	tember 2020, residents' ion Administration MAR)s identified staff were to e, and oxygen saturations on tor residents for fever, chills, n, new or a change in cough, e pain, headache, new loss of sea, vomiting, and diarrhea				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					OMPLETED	
		00063	B. WING			C 29/2020
	PROVIDER OR SUPPLIER	REHABILITATION 200 SOUT	DRESS, CITY, S ITH DEKALB S DD FALLS, MI			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21375	three times daily. A document in the su section of the nurse symptoms were ide leadership, provided precautions. Interview on 9/23/20 identified only infection document to identify potential done as daily cumula agreed all potential be documented on reviewed on an ongoinfection outbreaks as soon as possible COVID or any infection control preventionist was reinfection control preventionist was reinfection control preventionist was reinfection wein a timely to prevention documented and not available as evidence and hygiene and FRN-C identified not documented and not available as evidencensure staff were uline list of staff illnest implemented to ensprior to the COVID Interview on 9/29/20 medical director ides should not have been expected to monito symptoms of COVI precautions, and no potential transmissi	dditionally, staff were to pplementary documentation a notes when any of COVID ntified and update the clinical r, and initiate droplet O at 4:00 p.m., with RN-C tions treated with antibiotics infection control line listing, ation was monitored monthly infection issues and was not lative monitoring. RN-C symptoms of infection should the line list as the occur and poing basis to identify potential and to implement precautions at to mitigate transmission of tions. The infection esponsible to oversee the orgam and provide oversight to re identified and responded to the transmission. Audits of PPE use were requested. Competencies were a audit documentation was see staff were monitored to sing PPE appropriately. No as or symptoms was sure staff were not working ill	21375			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
				C	
	00063	B. WING		09/2	9/2020
NAME OF PROVIDER OR SUPPLIER			STATE, ZIP CODE		
RIVER VALLEY HEALTH AND	REHARILLIALION	TH DEKALB : D FALLS, M			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
the closed facility we staff to wear approportion of newly admitted redo don gowns, glow protections when casuspected and know perform and hygiend before and after dor STAFF Review of staff scree found the following of the following of the following assistant (Normigraine and procedule to 10:47 p.m., and lacedule to 10:47 p.m., and lacedule to 10:47 p.m., and lacedule to 10:47 p.m. and later tested positive symptoms of headad the symptoms of headad 3:28 p.m. to 9:34 p.m. for COVID. 2) 9/17/20, NA-G identified symptoms muscle pain, headad a.m. to 2:19 p.m., and covidentified symptoms muscle pain, headad a.m. to 2:19 p.m., and covidentified symptoms muscle pain, headad a.m. to 2:19 p.m., and covidentified symptoms muscle pain, headad a.m. to 2:19 p.m., and covidentified symptoms muscle pain, headad a.m. to 2:19 p.m., and covidentified symptoms muscle pain, headad a.m. to 2:19 p.m., and covidentified symptoms muscle pain, headad a.m. to 2:19 p.m., and covidentified symptoms muscle pain, headad a.m. to 2:19 p.m., and covidentified symptoms muscle pain, headad a.m. to 2:19 p.m., and covidentified symptoms muscle pain, headad a.m. to 2:19 p.m., and covidentified symptoms muscle pain, headad a.m. to 2:19 p.m., and covidentified symptoms muscle pain, headad a.m. to 2:19 p.m., and covidentified symptoms muscle pain, headad a.m. to 2:19 p.m., and covidentified symptoms muscle pain, headad a.m. to 2:19 p.m., and covidentified symptoms muscle pain, headad a.m. to 2:19 p.m., and covidentified symptoms muscle pain, headad a.m. to 2:19 p.m., and covidentified symptoms muscle pain, headad a.m. to 2:19 p.m., and covidentified symptoms muscle pain, headad a.m. to 2:19 p.m., and covidentified symptoms muscle pain, headad a.m. to 2:19 p.m., and covidentified symptoms muscle pain, headad a.m. to 2:19 p.m., and covidentified symptoms muscle pain, headad a.m. to 2:19 p.m., and covidentified symptoms muscle pain, headad a.m. to 2:19 p.m., and covidentified symptoms muscle pain, headad a.m. to 2:19 p.m., and covidentified symptoms mus	d residents transferring from ere to be quarantined and priative PPE during quarantine esidents. Staff were expected es, N-95 masks, and eye aring for residents with wn COVID residents and e prior to leaving rooms, and nning gloves. The ening forms and time sheets on: I practical nurse (LPN)-D of muscle pain, headache. In practical nurse (LPN)-D o	21375			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
				A. BUILDING:			^	
		00063		B. WING			C 29/2020	
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
RIVER V	ALLEY HEALTH AND	REHABILITATION		TH DEKALB : D FALLS, M				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY I SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
21375	work 3:57 a.m. to 2 positive for COVID. new/changed coug to 11:30 p.m. NA-N pain, headache and into 6:00 a.m. next identified on 9/16/2 to 4:30 p.m., and la HID-D who had syr proceeded to work later tested positive 4) 9/19/20, NA-O won 9/18/20 proceed night shift unspecifidentified symptom and proceeded to vinto 6:34 a.m. on 9/identified on 9/18/2 to 11:23 a.m. 5) 9/20/20, NA-N w 9/18/20 proceeded a.m NA-E had syr proceeded to work a.m. on 9/20/20. Disymptom of chills p 2:58 p.m. Interview on 9/21/2 anonymous staff (Amedical backgroun morning and the nuher. AS-C took her the nurse that R30' seemed okay but wover R30's neck it radvised AS-C all renot a good place to reported R30 had band had a COVID to	2:55 p.m., and later test. RN-H identified symphomod proceeded to work of day. NA-F who had so proceeded to work atter tested positive for mptoms identified on Second a.m. to 12:30 p.m. of for COVID. Who had symptoms ided to work the mornified number of hours. of sore throat, muscle work from 9/18/20 at 9/19/20. RN-H had symptoms ided to work 3:45 p.m. to mptoms identified on Second a.m. to 12:30 p.m. into the control of sore throat, muscle work from 9/18/20 at 9/19/20. RN-H had symptoms identified on Second a.m. to 12:30 p.m. into the control of sore throat, muscle to work 3:45 p.m. to 12:30 p.m. into 13:40 p.m. into 15:40 p.m. i	ptom of 6:31 a.m. of muscle 6:00 p.m. ymptoms 1:54 p.m. COVID. 9/16/20 m., and entified ng and NA-E e pain 9:00 p.m. nptoms 9:53 a.m. entified on 12:02 9/19/20 to 6:44 ntified 28 a.m. to and no warm this e to check orted to forehead rmometer nurse d that was e. AS-C in 9/11/20, called by estimate the context of the cont					

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING:

00063

(X3) DATE SURVEY COMPLETED

B. WING _____

C **09/29/2020**

	200 SOUT	DRESS, CITY, S	STATE, ZIP CODE STREET	
KIVEK V	ALLEY HEALTH AND REHABILITATION REDWOO	D FALLS, M	N 56283	
(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) COMPLETE DATE
21375	Continued From page 30	21375		
	positive for COVID. She had only been at hospital during the day and did not have an overnight stay so she was not isolated. They encourage the residents to stay in their rooms but it is not required. A-C is unaware if a resident had symptoms like a temperature if they would have to isolate.			
	Interview on 9/22/20 at 10:04 a.m., with NA-E identified she is screened at the door when arriving for work on 9/19/20, verifying she had body aches that could related to her multiple sclerosis (MS) and a sore throat that could be related to sinus problems as her sinus had been draining. She identified it was a "nightmare working" and she "cried each night, they said we would get tested again this Wednesday" but no one has contacted her to come in. They had uncertified staff that were "thrown into" working on the floor. Those untrained staff did transfers, cares, feeding. NA-E verified she worked all weekend and does not work now until her next weekend unless they call her in.			
	Interview on 9/22/20 at 10:43 a.m., with consulting administrator (C)-A identified if staff have symptoms upon screening at the beginning of their shift the nurse should assesses to see if it is an allergy or something. If not they are sent to be tested and not to work. Additional interview at 3:40 p.m., identified she was unaware of what staff screening reviews had been done, but believed COVID may have "come in the building" via NA-D who did not feel well who was tested and was negative. NA-D continued to not to feel good but worked, was tested again and was positive. C-A believes NA-D was returning to work tomorrow.			
Minnesota D	Interview on 9/22/20 at 3:55 p.m., with NA-D epartment of Health			

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Minnesota Department of Health

winneso	ita Department of He	eaith				
STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	<u> </u>	COMP	LETED
					_	
		00000	B. WING		00/0	
		00063	B. WING		09/2	9/2020
NAME OF I	PROVIDER OR SUPPLIER	STREE	TADDRESS, CITY,	STATE, ZIP CODE		
		200 S	OUTH DEKALB	STREET		
RIVER V	ALLEY HEALTH AND	REHARII ITATION	OOD FALLS, N			
			OOD FALLS, IV			T
(X4) ID		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION SHOULD	-	(X5) COMPLETE
PREFIX TAG	`	SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		DATE
iAd			IAG	DEFICIENCY)		
21375	Continued From pa	ige 31	21375			
	identified Saturday	(9/12/20) night during work				
		tarted to feel like she had a				
		on. Sunday (9/13/20) she fel	t a			
		ntinued to work as she thou				
		ies. On 9/14/20, she was	grit			
	, ,	orted she did not have a				
		d have a headache, dry cou	nh.			
	•	wheezing when breathing ou				
		es. LPN-C was unaware of	ıt,			
		let NA-D work regardless o	f			
		ns. LPN-C advised NA-D sh				
	was aware of regide	ents on the upper west wing	ie			
		es between 99.0 and 99.7 w	ui			
		nade like isolation to their				
		d the shift Monday (9/14/20)				
		In the morning she left worl				
		slept a little". NA-D had body				
		rature of 101.5 degrees F, a				
		e local clinic on 9/15/20. Her				
		sitive on 9/15/20, and she				
		ight away. NA-D identified				
		Imission, R11 who was				
		iff. He was in a room alone				
		gown to go in the only thin				
		nange their mask. There we				
		ntified with loose stools, and				
		were notified. No new				
		placed. "It is hard to get				
		anagement about what is				
	happening and the	staff are overworked".				
		0 at 3:40 p.m., with RN-C				
		to ring the doorbell if staff				
		the entrance door. The staf				
		 d. If symptoms were preser 				
		allowed to enter the facility	Α			
		s the staff person with				
		it is "allergies or something	'. If			
		om that has no explanation				
		. The infection control nurse	•			

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00063	B. WING			C 29/2020
	PROVIDER OR SUPPLIER	REHABILITATION 200 SOU	DDRESS, CITY, S TH DEKALB : DD FALLS, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
21375	(ICP) was responsi monitoring the scre however, was curre (A)-A was doing that Interview on 9/22/2 administrator (A)-A any screening form in her office. A-A was screening forms but DON's responsibility PPE Observation on 9/2 registered nurse (Repassing medication rooms on the West without wearing a grandle RN-A exited R34's administer medicat a.m., without wearing R23's room and ad R23 was COVID pocough and coughed RN-A was stood neroom while wearing her gloves in the hand hygiene, RN-A the main entrance, grabbed a gown. Interview with RN-A identified RN-A had this week. She had was needed on the COVID outbreak. Sigown at all times in residents were neg	ble for reviewing and ening logs for staff. The ICP ently out ill. The administrator at at this time. O at 4:41 p.m. with identified she does not review s however, she does file them as unsure who reviewed the t believed that would be the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
7.1.12 . 2.11.	0. 0020	.5	A. BUILDING:			
		00063	B. WING		C 09/29/2020	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
RIVER V	ALLEY HEALTH AND	REHARII ITATION	TH DEKALB : DD FALLS, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21375	Continued From pa	ige 33	21375			
	when she entered t gown while adminis West wing. RN-A h because she forgot	the facility, and had not worn a stering medications on the had not donned a gown to do so. RN-A had training hang hygiene at the time the				
		(20, through 9/21/20, Donning training roster identified RN-An the roster.				
	identified no docume vidence RN-A recorder to the start expected to don a gand change PPE are to exiting resident r	0 at 3:30 p.m., with RN-C nentation was found as eived PPE training on 9/21/20, of her first shift. RN-A was gown at the start of the shift and perform hand hygiene prior ooms. RN-C agreed RN-A ed training for PPE use prior to				
	identified staff were general infection in ongoing basis as no utilization of PPE, h	na Virus (COVID-19) policy to be trained regarding formation upon hire and on an eeded. Training included nand hygiene, and importance necessary requirements.				
	identified the purpo ensure infections w prevented among re program included of policies and proced analysis, antibiotic s management, preve employee health. A hire and periodically was responsible for	ention and Control Program se of the program was to vere detected, addressed, and esidents and staff. The coordination and oversight, dures, surveillance, data stewardship, outbreak ention of infection and all staff were to be trained upon y. The infection preventionist oversight of the infection curveillance consisted of using				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			X3) DATE SURVEY COMPLETED	
		00063	B. WING			C 29/2020
	PROVIDER OR SUPPLIER	REHABILITATION 200 SOU	DDRESS, CITY, S TH DEKALB ! DD FALLS, MI			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
21375	tools to recognize of recording the numb detection of outbread employee infections patterns with infection management was a presence of outbread residents, preventing documenting information reporting to the appauthorities, education monitoring for recurrence or revised policinfection prevention determine sporadic. The undated Coronidentified staff were promptly detect, triainfectious residents exposures among rand visitors at the faresidents daily for posymptoms included breath, new or charmuscle pain, head a smell, nausea, vom to document absen in the EMR daily. The listing of reside Residents with symillness or suspicion identified symptoms precautions implement providers, resident of health, medical content of health, medical content of health, medical content of health, and other systatus, and other systatus, and other systatus.	ge 34 ccurrence of infections, er of infections, frequency, aks and epidemics, monitoring and detecting unusual on control issues. Outbreak a process of determine the ak, managing affected ag spread to other residents, nation about the outbreak, propriate public healthing staff and the public, rences, and recommending cies for future outbreaks. The aist was to review data to cases from true outbreaks. avirus (COVID-19) policy to take reasonable steps to age, and isolate potentially and prevent unnecessary esidents, healthcare workers, acility. Staff were to monitor otential symptoms of COVID. If fever, chills, shortness of age in cough, sore throat, uche, new loss of taste or iting, or diarrhea. Staff were ce or presence of symptoms of acute respiratory of COVID according to swere to have droplet tented. Staff were to notify representatives, department lirector, facility infection, and administrator. Resident in saturation, respiratory reproms were to be monitored are to perform hand hygiene				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
							С
		00063		B. WING		09/:	29/2020
	PROVIDER OR SUPPLIER	REHABILITATION	200 SOUT	H DEKALB			
	1			D FALLS, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
21375	Continued From pa	ge 35		21375			
	before and after all infectious material, of PPE, including g screened for sympt and actively screen take their temperative leave the workplamaintain a line list of symptoms. Staff w symptoms of respiritheir shift, inform the contact their primar with the public as myhowere new admictory covided their primar with the public as myhowere new admictory. COVID, and placed separate observation of COVID-19. Recogloves, mask, eye puring care of residuring of all illnes implementation of covided the covided t	resident contact, comand before and after loves. Staff were to be oms prior to reporting for COVID symptoms ures. If staff were ill, thace. The facility was of staff with identified ere to leave the work, atory infection occurre infection prevention by provider, and limit on uch as possible. Resissions, had suspected or whose infection states or whose infection states are to monitor for mended PPE (gow or otection) were to be dents under observation. THOD OF CORRECT ursing) or designees by policies to ensure the ents of an infection condaily cumulative track ses in the facility, immorphism of an ensure the ents of an infection stop in the facility, immorphism of an ensure the ents of an infection to daily cumulative track ses in the facility, immorphism of an ensure the ents of an infection to daily cumulative track ses in the facility, immorphism of an ensure the ents of an infection and ensure the ents of an infection and appropriately and time could educate all social should be taken to the ents of the entsure that the entsu	removal e i to work s and hey were to clace if ed during iist, contact sidents ed atus was coms of n a evidence n, worn on. ION: The hould hey ontrol king and hediate mitigate om d cares mely. staff on audits to The o Quality ommittee				

6899

Minnesota Department of Health STATE FORM

PRINTED: 11/06/2020 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _____ С B. WING _ 00063 09/29/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **200 SOUTH DEKALB STREET** RIVER VALLEY HEALTH AND REHABILITATION **REDWOOD FALLS, MN 56283** SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 21375 21375 Continued From page 36 Time Period for Correction: Twenty-one (21) days.

Minnesota Department of Health



Protecting, Maintaining and Improving the Health of All Minnesotans

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:

- In order to assist with identifying appropriate corrective actions and implementing systemic changes, the facility must contract with an infection control consultant to provide consultation and oversight for infection prevention and control within the facility.
- The consultant shall exercise independent judgement in the performance of all duties under the consultant contract. The consultant shall meet the independent judgement requirement if the consultant is not presently and has not within a five (5) year period immediately preceding June 1, 2020 directly or indirectly affiliated with the facility, facility's owner(s), agent(s), or employee(s).
- The consultant shall have completed infection prevention and control training from a recognized source, such as the Centers for Disease Control and Prevention or American Health Care Association.
- The consultant will be contracted to work with the facility for a minimum of two (2) months.
- The consult will assist the facility in completing the CMS infection control self-assessment. If this assessment was completed prior to the June 4, 2020 survey, the assessment should be reviewed to determine if it is an accurate reflection of the facility's infection control program. The self-assessment can be found in the CMS publication QSO-20-20-All: Prioritization of Survey Activity: https://www.cms.gov/files/document/qso-20-20-all.pdf,

Infection control consultant responsibilities must include, but are not limited to, the following:

- Work with the facility to conduct a Root Cause Analysis (RCA) to identify and address the reasons for noncompliance identified in the CMS-2567.
- The facility's Infection Preventionist, Quality Assurance and Performance Improvement (QAPI) committee, must participate in the completion of the RCA. Information regarding RCAs can be found in the CMS publication Guidance for Performing Root Cause Analysis (RCA) with Performance Improvement Projects (PIPs):

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

• Take immediate action to implement an infection prevention plan consistent with the requirements at 42 CFR § 483.80 for the affected residents impacted by the noncompliance identified in the CMS-2567 to include identification of other residents that may have been impacted by the noncompliant practices. This plan must include but is not limited to implementation of procedures to ensure:

ACTIVELY SCREENING RESIDENTS

- 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:

- Conduct active health screening and surveillance of residents upon admission and twice daily for fever (>100.0oF or subjective) and symptoms of COVID-19 (shortness of breath, new or change in cough, chills, sore throat, muscle aches).
- Develop and implement an infection sign and symptom tracking tool to monitor all residents for communicable, respiratory infection. All nursing leaders will be educated on how to use the tool.
- Group residents, or "cohorting," should be done when possible to separate residents with an infectious disease (positive residents) from residents who are not affected. Plans to cohort should be carefully established in advance and should be centered on implementation of infection control practices.
- Isolate and restrict incoming residents discharged from hospitals, or other facilities, to their room for 14 days.
- Assess newly admitted residents with respiratory symptoms that include cough, fever or shortness of breath for known exposure to a person with COVID-19 in the 14 days prior to illness onset, or recent admission to facilities with COVID-19 cases. Ask discharging facility whether diagnostic testing has been conducted for COVID-19.

TRAINING/EDUCATION:

- Guidance on the use of pulse oximetry is available from MDH: Pulse Oximetry and COVID-19: https://www.health.state.mn.us/diseases/coronavirus/hcp/pulseoximetry.pdf
- Remind residents to practice social distancing and perform frequent hand hygiene.
- Educate and assist the resident to utilize an appropriate mask to reduce droplet spread.

CDC RESOURCES:

Infection Control Guidance: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html CDC: Isolation Precautions Guideline:

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

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

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

Healthcare Infection Prevention and Control FAQs for COVID-19:

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

MDH RESOURCES:

Personal Protective Equipment (PPE) for Infection Control:

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

MDH Contingency Standards of Care for COVID-19: Personal Protective Equipment for Congregate Care

Settings (PDF): https://www.health.state.mn.us/communities/ep/surge/crisis/ppegrid.pdf

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

https://www.health.state.mn.us/diseases/coronavirus/hcp/maskssource.pdf

Interim Guidance on Alternative Facemasks (PDF):

https://www.health.state.mn.us/diseases/coronavirus/hcp/masksalt.pdf

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

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

Droplet Precautions:

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

Airborne Precautions:

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

MONITORING/AUDITING:

- Chart all clinical measurements and symptoms daily for each resident.
- Use cumulative data to conduct active surveillance. Record daily the number of residents that have been transferred to acute care, even for non-respiratory disease, by using a sheet like that in Appendix E. In some LTC facilities, an increasing number of transferred residents has preceded confirmation of COVID-19 in the facility.
- All residents positive for fever or symptoms should be isolated, placed under transmission-based precautions, and tested for COVID-19. Clinicians are encouraged to test for other causes of respiratory illness in addition to COVID-19.
- Conduct a RCA (root cause analysis) which will be done with assistance from the Infection Preventionist, Quality Assurance and Performance Improvement (QAPI) committee and Governing Body. The RCA should be incorporated into the intervention plan. Information regarding RCAs is available in the Guidance for Performing Root Cause Analysis (RCA) with Performance Improvement Projects (PIPs).

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

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 for TBD and 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/maskssource.pdf

Interim Guidance on Alternative Facemasks (PDF):

https://www.health.state.mn.us/diseases/coronavirus/hcp/masksalt.pdf

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

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

Droplet Precautions:

https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html Airborne Precautions:

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

MONITORING/AUDITING:

- The Director of Nursing, the Infection Preventionist, and other facility leadership will 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 us.
- The Director of Nursing, Infection Preventionist, or designee will review the results of audits and monitoring with the Quality Assurance Program Improvement (QAPI) program.

TRACKING AND TRENDING INFECTION CONTROL PROGRAM

- 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 and revise policies for infection surveillance as needed.
- Develop and implement an infection control program sign and symptom tracking tool to monitor all residents and staff for communicable, respiratory infection, according to the CDC guidelines.
- Ensure that the charge nurse for each shift documents all resident and employee infections on the facility's shared infection tracking log. Compliance and review of the infection control log will be completed by the Infection Preventionist daily. The data will be analyzed for possible trends/outbreaks. The Infection Preventionist will investigate any potential outbreaks and follow up as appropriate.
- Conduct rounds throughout the facility to ensure staff is exercising appropriate use of personal protective equipment and to ensure infection control procedures are followed on each unit. Ad hoc education will be provided to persons who are not correctly utilizing infection provention (control practices. Such monitoring will).

equipment and/or infection prevention/control practices. Such monitoring will continue until the facility has been infection free for at least four weeks.

Review infection prevention tracking and trending. Any unexpected increases in infection must

be reported to the Medical Director, Public Health Department, and the state survey agency in order to obtain further assistance to control infection.

TRAINING/EDUCATION:

- As a part of corrective action plan, the facility must provide training for the Infection
 Preventionist, the Director of Nursing, nursing leadership/management, and facility
 administration. The training must cover standard infection control practices, active surveillance,
 tracking and trending for a comprehensive infection control program. The facility may use
 training resources made available by the Centers for Disease Control and Prevention or a
 program developed by well-established centers of geriatric health services education, such as
 schools of medicine or nursing, centers for aging, and area health education centers with
 established programs in geriatrics.
- Include documentation of the training completed with a timeline for completion.
- The training may be provided by the Director of Nursing, Infection Preventionist, or Medical Director with an attestation statement of completion.
- Tier three or four concerns (harm or IJ) training must be provided by a contracted outside infection prevention consultant.
- Online infection prevention training courses may be utilized. The CDC and MDH websites have several infection control training modules and materials.

CDC RESOURCES:

- Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic. https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html
- Infection Control Guidance for Healthcare Professionals about Coronavirus (COVID-19) https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html

CMS RESOURCES:

• CMS & CDC Offer a specialized, online Infection Prevention and Control Training For Nursing Home Staff in the Long-Term Care Setting

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

MDH RESOURCES:

- Infection Prevention and Control Guidelines https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/guidelines.html
- Infection Control Precautions https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/index.html
- National Healthcare Safety Network (NHSN) https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/nhsn.html
- COVID-19 Toolkit: Information for Long-term Care Facilities (PDF) https://www.health.state.mn.us/diseases/coronavirus/hcp/ltctoolkit.pdf
- Responding to and Monitoring COVID-19 Exposures in Health Care Settings (PDF) https://www.health.state.mn.us/diseases/coronavirus/hcp/response.pdf
- COVID-19 Infection Prevention and Control and Cohorting in Long-term Care (PDF)

https://www.health.state.mn.us/diseases/coronavirus/hcp/ltcipchohort.pdf

MONITORING/AUDITING:

Monitoring of approaches to ensure infections are controlled will include:

- The Infection Preventionist and Director of Nursing, each day and more often as necessary, will
 review infection prevention tracking and trending logs and data analysis. Any unexpected
 increases in infection will result in communication with the Medical Director, Public Health
 Department and the state survey agency in order to obtain further assistance to control
 infection.
- The Director of Nursing, Infection Preventionist, or designee will review the results of audits and monitoring with the Quality Assurance Program Improvement (QAPI) program.

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 hand hygiene policies and procedures to ensure they meet CDC guidance, 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 and adequately caring for and disinfecting shared medical equipment. Findings of the RCA should also be incorporated into staff training.
- The Infection Preventionist, Director of Nursing and Clinical Education Coordinator must implement competency assessments for staff on proper hand hygiene and develop a system to ensure all staff have received the training and are competency
- Online infection prevention training courses may be utilized. The CDC and MDH websites have several infection control training modules and materials.

https://www.health.state.mn.us/people/handhygiene/ (MDH)

Hand Hygiene (MDH) https://www.health.state.mn.us/people/handhygiene/index.html

Hand Hygiene for Health Professionals (MDH)

https://www.health.state.mn.us/people/handhygiene/index.html

Cleaning Hands with Hand Sanitizer (MDH)

https://www.health.state.mn.us/people/handhygiene/clean/index.html

CDC: Guideline for Hand Hygiene in Health-Care Settings (CDC)

https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5116a1.htm

WHO Guidelines on Hand Hygiene in Health Care (WHO)

https://apps.who.int/iris/bitstream/handle/10665/44102/9789241597906_eng.pdf;jsessionid=A770590E49844880F6F3E1D8F22F0841?sequence=1

Hand Hygiene in Outpatient and Home-based Care and Long-term Care Facilities (WHO) https://www.who.int/gpsc/5may/hh guide.pdf

CDC RESOURCES:

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

CDC: Isolation Precautions Guideline:

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

CDC: Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare

Settings (2007): https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html

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

Healthcare Infection Prevention and Control FAQs for COVID-19:

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

MDH RESOURCES:

Personal Protective Equipment (PPE) for Infection Control:

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

MDH Contingency Standards of Care for COVID-19: Personal Protective Equipment for Congregate Care

Settings (PDF): https://www.health.state.mn.us/communities/ep/surge/crisis/ppegrid.pdf

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

https://www.health.state.mn.us/diseases/coronavirus/hcp/maskssource.pdf

Interim Guidance on Alternative Facemasks (PDF):

https://www.health.state.mn.us/diseases/coronavirus/hcp/masksalt.pdf

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

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

Droplet Precautions:

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

Airborne Precautions:

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

MONITORING/AUDITING:

- The Director of Nursing, the Infection Preventionist and other facility leadership will conduct audits on all shifts, every day for one week, then may decrease the frequency based upon compliance. Audits should continue until 100% compliance is met.
- The Director of Nursing, Infection Preventionist or designee will review the results of audits and monitoring with the Quality Assurance Program Improvement (QAPI) program.

ACTIVE SCREENING

• 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:

• Develop and implement procedures, policies, and forms regarding active screening for temperature and signs and symptoms of COVID-19, in accordance with CDC guidelines to be conducted at the point of entry for every person who enters the facility. The procedures and policy must restrict entrance to anyone who does not meet the criteria as outlined by the CDC. This procedure must include actively measuring and recording staff temperature and assessment of shortness of breath, new or changed cough, and sore throat. The results must be documented. The MDH COVID-19

<u>Toolkithttps://www.health.state.mn.us/diseases/coronavirus/hcp/ltctoolkit.pdf</u> has examples of forms to utilize for staff screening.

TRAINING/EDUCATION:

As part of a corrective action plan, the facility must provide training for Infection Preventionist and all other staff who enter the facility, as well as staff responsible for the screening. The training must cover the need for active screening. The CDC has training videos available for COVID-19 which may be utilized, Training for Healthcare Professionals;

https://www.cdc.gov/coronavirus/2019-ncov/hcp/training.html and the MDH COVID-19 Toolkit may be utilized.

- Include documentation of the completed training with a timeline for completion.
- The training may be provided by the Director of Nursing, Infection Preventionist, or Medical Director with an attestation statement of completion.

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.cd c.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control-faq.html

MDH RESOURCES:

Personal Protective Equipment (PPE) for Infection Control:

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

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

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

https://www.health.state.mn.us/diseases/coronavirus/hcp/maskssource.pdf

Interim Guidance on Alternative Facemasks (PDF):

https://www.health.state.mn.us/diseases/coronavirus/hcp/masksalt.pdf

Aerosol-Generating Procedures and Patients with Suspected or Confirmed COVID-19

(PDF):https://www.health.state.mn.us/diseases/coronavirus/hcp/aerosol.pdf

Droplet Precautions:

https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html Airborne Precautions:

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

MONITORING/AUDITING:

• The Director of Nursing, the Infection Preventionist, and other facility leadership will conduct audits on all shifts, four times a week for one week, twice weekly for one week and biweekly thereafter, until 100% compliance is achieved to ensure active screening is being completed at the point of entry for all persons who enter the facility.

The Director of Nursing, Infection Preventionist or designee will review the results of audits and monitoring with the Quality Assurance Program Improvement (QAPI) program.

COHORTING RESIDENTS/TRANSMISSION BASED PRECAUTION "ISOLATION"

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

POLICIES/PROCEDURES/SYSTEM CHANGES:

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

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

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

• Provide dedicated equipment for areas, as able.

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

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

TRAINING/EDUCATION:

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

CDC RESOURCES:

Infection Control Guidance: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html CDC: Isolation Precautions Guideline:

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

CDC: Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare

Settings (2007): https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html

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

Healthcare Infection Prevention and Control FAQs for COVID-19:

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

MDH RESOURCES:

Personal Protective Equipment (PPE) for Infection Control:

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

MDH Contingency Standards of Care for COVID-19: Personal Protective Equipment for Congregate Care

Settings (PDF): https://www.health.state.mn.us/communities/ep/surge/crisis/ppegrid.pdf Interim Guidance on Facemasks as a Source Control Measure (PDF):

https://www.health.state.mn.us/diseases/coronavirus/hcp/maskssource.pdf

Interim Guidance on Alternative Facemasks (PDF):

https://www.health.state.mn.us/diseases/coronavirus/hcp/masksalt.pdf

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

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

Droplet Precautions:

https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html Airborne Precautions:

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

MONITORING/AUDITING:

- The Director of Nursing, the Infection Preventionist and other facility leadership will verify the placement of each new admission and location and audit for transmission based precautions are being appropriately implemented.
- Conduct a Root Cause Analysis (RCA) which will be done with assistance from the Infection Preventionist, Quality Assurance and Performance Improvement (QAPI) committee and Governing Body. The RCA should be incorporated into the intervention plan. Information regarding RCAs can be found in the document: Guidance for Performing Root Cause Analysis (RCA) with Performance Improvement Projects (PIPs)

 $\underline{\text{https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/GuidanceforR}} \\ \text{CA.pdf}$

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 on or after that date. The effective date is not a deadline for completion of the DPOC. However, a revisit will not be approved prior to receipt of documentation confirming the DPOC was completed. To demonstrate that the facility successfully completed the DPOC, the facility must provide all of the following documentation. 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	Consultant name and credentials meeting the criteria outlined above				
2	Executed contract with the consultant				
3	Documentation demonstrating that the RCA was completed as described above				
4	List of facility policies and procedures reviewed by the consultant.				
5	Infection control self-assessment				
6	Summary of all changes as a result of the RCA and consultant review – to include a				

	summary of how staff were notified and trained on the changes
7	Content of the trainings provided to staff to include a Syllabus, outline, or agenda as
	well as any training materials used and provided to staff during the training
8	Names and positions of all staff to be trained
9	Staff training sign-in sheets
10	Summary of staff training post-test results, to include facility actions in response to any failed post-tests
11	Summary of follow-up employee supervision and work performance appraisal to
	include when employees were observed, what actions were observed, and an
	evaluation of the effectiveness of any new policies and procedures.

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