P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

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
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

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

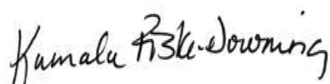
Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, MN 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING ______ B. WING ______	C 09/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VALLEY HEALTH AND REHABILITATION CENTER LLC	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 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) COMPLETION DATE
E 000	Initial Comments A COVID-19 Focused Infection Control survey was conducted 9/21/20 through 9/29/20, at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.73(b)(6). The facility was NOT in compliance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Upon receipt of an acceptable electronic POC, an revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	E 000		
E 024 SS=F	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years (annually for LTC).] At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.	E 024		9/29/20

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

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E 024	Continued From page 1 *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. This REQUIREMENT is not met as evidenced by: Based on interview and policy review, the facility failed to implement its planned strategy to meet the needs of the residents and address surge needs during an emergency. This had the potential to affect all 41 residents residing in the facility. Findings include: Interview on 9/21/20 at 9:36 a.m., with anonymous staff (AS)-B identified they were unlicensed and uncertified to provide cares, but had worked all weekend (9/19/20 through 9/20/20) caring for the residents. They had no training on how to provide direct care and felt "overwhelmed". Interview on 9/21/20 at 12:27 p.m., with administer (A) identified there were no non-certified or non-licensed staff providing direct resident care. All non-certified staff helped with housekeeping, laundry, passed meal trays, and were to be the second staff during a mechanical lift transfer.	E 024	It is the policy of River Valley Health & Rehabilitation to ensure the emergency preparedness policies and procedures include the use of volunteers in an emergency. All residents have the potential to be affected by the alleged deficient practice. The facility has a policy/procedure for the use of Volunteers and Staffing During an Emergency Event. The Volunteers and Staffing During and Emergency Event Policy and Contingency Staffing Plan template have been reviewed and updated, as needed, to reflect outreach to additional resources to secure staff during an emergency staffing crisis to ensure safe staffing levels. Additional staffing resources may include volunteers, outside agency companies and local colleges. These plans are located in the facility's Emergency Preparedness Plan. An in-service will be performed with the leadership team to ensure that the updated policy is understood, and all have	

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	245237	A. BUILDING ______ B. WING ______	C 09/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VALLEY HEALTH AND REHABILITATION CENTER LLC	**200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283**

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E 024	Continued From page 2 Interview on 9/21/20 at 12:38 p.m., with AS-D identified they were not certified or licensed and had no training to provide direct care. AS-D had been told by consultant administrator (C)-A to "step up" and was "expected to work on the floor providing direct care to the residents". AS-D had used a mechanical lift, provided personal cares, worked "alone on the upper west wing. The residents did not get the care they needed. The residents deserve better than this". AS-D was unaware of "what she was doing" or "how to care for the residents" while working on the floor. Corporate had been told staff "need help as residents were not getting cared for. Half of the residents did not get breakfast today. Today had been the best staffing the facility has had for days". 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 several times. There had not been two staff utilized during transfer and running the lift. No documentation was recorded as AS-B was unaware of how to document cares in electronic medical record. AS-B started working on the floor with the residents on 9/18/20, after the consulting administrator-CA-(A) told uncertified staff they had to work the floor. Staff advised the CA-A they did not "feel comfortable or safe" and had been instructed they "had to care for the residents so they did not get an IJ (immediate jeopardy) tag".	E 024	knowledge of this requirement. The Volunteers and Staffing During an Emergency Event Policy and the Contingency Staffing Plan will be reviewed monthly for six months and quarterly thereafter times six months. Re-education on the Volunteers and Staffing During Emergency Event Policy and the Contingency Staffing Plan was reviewed with the leadership team on 09/25/2020. Audit results will be reviewed by QAPI Committee and the scope and frequency of the audits will be adjusted according to the results.	

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E 024	Continued From page 3 Interview on 9/21/20 at 2:58 p.m., AS-C identified they were to be the second person for mechanical lift transfers. They had to assist a couple residents with a gait belt to walk to the bathroom but could not remember who they were or if they were able to be transferred safely in that manner. AS-C assisted residents to eat including last evening on 9/20/20. AS-C had no training in feeding residents or ambulating residents. AS-C worked 9/19/20 and 9/20/20, and would ask others how to "do stuff" to see if it was "something they could do". Staff were told by CA-A they had to "step up and do more" on Friday 9/18/20. AS-C felt "unsafe after helping a resident walk with a gait belt" so they would not do it anymore. "There is not enough staff here to care for the residents. Some residents did not get care, they wait for long times, some are not getting to bed timely. One resident looked like she had not checked before bed at all she as she had crusted bowel dried on her and was incontinent this morning (R4)". AS-C identified they had "no medical background" however, ""this morning R30 had felt warm so she told the nurse who "did not have time" to check R30. AS-C checked R30's temperature and her forehead "seemed okay". When the thermometer was over R30's neck, it registered 102.2. AS-C told the unidentified nurse. AS-C was advised "all residents are warm and that was not a good place to check a temperature". Interview on 9/29/20 at 10:58 a.m., with C-B identified the facility reached out to the MDH telling them we did not have enough staff and we needed help. MDH advised the facility was to staff according to the residents needs. If residents needs were unable to be met, the facility was to transfer residents to a number they could provide	E 024		

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	245237	A. BUILDING ______ B. WING ______	C 09/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VALLEY HEALTH AND REHABILITATION CENTER LLC	**200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283**

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E 024	Continued From page 4 care for. We attempted to get staff into work as soon as possible. The C-B confirmed the contingency staffing plan and emergency staffing plan had not been fully implemented and non-certified staff should not have worked the floor. C-B also confirmed there had been residents who missed breakfast due to short staffing. All residents were to be provided three meals a day with no more than 14 hours between the evening meal and breakfast the next day. He would expect medications to be given and treatments completed as ordered by the physician. He would expect staffing levels to meet the needs of the residents to ensure repositioning of residents at risk for skin breakdown or and repositioning completed. C-B identified the Quality Assurance Performance Improvement (QAPI) committee should have provided oversight to ensure a plan was in place in case of a COVID or other infectious disease outbreak. It was the overall responsibility of the administrator to ensure residents receive the care and services they require. Interview on 9/29/20 at 12:38 p.m., with medical director (MD) identified his expectation would be that the facility had adequate staffing to ensure basic care needs are being met such as personal hygiene, repositioning, meals provided to residents, and residents who require assistance with meals receive that assistance. Further, the MD would expect enough staffing to ensure medications are timely and given. The MD confirmed the facility should not have had non-certified or non-licensed staff providing direct care to the residents. The facility should have followed their contingency staffing plan and staff should not have provided direct care without any training. He was notified about the immediate	E 024		

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RIVER VALLEY HEALTH AND REHABILITATION CENTER LLC	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

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E 024	Continued From page 5 jeopardy situation and care was compromised at the facility, however, was not made aware of any concerns or issues before the immediate jeopardy. The facility was discharging some residents to a sister facility to reduce census to manageable level. The MD expected the facility notify him of the inability to provide care to residents. Review of the undated, Volunteers and Staffing During an Emergency Event policy revealed the written plan for emergency included the use of volunteers who would be checked in and directed by the designee in charge of facility. Non-medical volunteers would assist with non-medical needs. If additional staff are needed off duty staff were to be called in. The designated person in charge may also contact corporate office in order to contact sister facilities for additional staff assistance. Review of the 9/3/20, Emergency Staffing policy identified the facility was to give competent, conscientious, and consistent quality care to each resident 24 hours per day. Nursing, laundry, culinary, and maintenance departments must be adequately staffed and therefore, it may be necessary to stay on duty until replacements could report for duty. If more staff were needed, the designee person in charge of the facility will contact the corporate office to contact sister facilities in the company for staff assistance. Critical staffing shortages during an emergency had the potential to result in staff injury or illness and post-traumatic stress. In order to prepare for potential staffing shortages, licensed and unlicensed personnel and volunteers were to be recruited and trained for emergency assistance. The facility was not to engage in non-credentialed	E 024		

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E 024 Continued From page 6 — E 024

or untrained volunteers for direct resident care.

Review of the 8/26/20, Long-Term Care Contingency Staffing Plan policy identified a training plan to cross-train staff to fulfill different roles in case the primary staff responsible for a given function was not available. In emergency situations, direct care would be performed by facility staff, then the corporate float pool, outside agencies, and lastly via cross-trained staff from other departments. Quality of care was deemed the highest practicable level of care to meet the needs of residents with proactive steps to have been taken before a crisis occurs to minimize the risk of crisis staffing.

F 000 INITIAL COMMENTS — F 000

A COVID-19 Focused Infection Control survey was conducted on 9/21/20 through 9/29/20, at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was determined NOT to be in compliance. Additionally, an abbreviated survey for complaints H5237021C, H5237022C, H5237023C was also conducted. The facility was NOT in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.

The following complaints were found to be SUBSTANTIATED: H5237021C with deficiency cited at F880, H5237022C with deficiency cited at F725 and F885, and H5237023C with deficiency cited at F725.

The survey resulted in two findings of Immediate Jeopardy (IJ) to resident health and safety. An IJ at F880 began on 9/16/20, when the the facility

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F 000	Continued From page 7 failed to have a system for daily cummulative surveillance to identify potential symptoms of COVID-19, implement droplet precautions to mitigate COVID-19 transmission, and wear appropriate (PPE) resulting in 39 of 41 residents testing positive for COVID-19. The administrator and director of nursing (DON) were notified of the IJ on 9/23/20 at 3:30 p.m. The IJ was removed on 9/24/20 at 2:35 p.m. The IJ at F725 began on 9/19/20, when the facility failed to provide sufficient nursing staff to ensure residents' basic care needs were met and ensure scheduled medications and wound dressings were administered or completed for 14 of 41 residents (R3, R6, R8, R14, R29, R15, R13, R33, R24, R20, R27, R12,R15, R18). In addition, the facility failed to provide a breakfast meal for 17 of 41 residents (R31, R30, R5, R33, R32, R38, R28, R11, R17, R40, R7, R12, R8, R21, R25, R9, R23) between the dates of 9/19/20 and 9/23/20 and failed to ensure repositioning was completed to prevent pressure ulcers for 1 of 1 resident (R28). The facility also engaged non-licensed and non-certified staff to perform direct care duties without training and implement their emergency staffing plan to cross-train non-certified staff prior to an emergency of a COVID outbreak. The administrator and DON were notified of the IJ on 9/24/20 at 2:45 p.m.. The IJ was removed on 9/25/20 at 6:36 p.m.. The above findings did NOT constitute substandard quality of care, therefore, an extended survey was NOT performed. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance.	F 000		

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F 000	Continued From page 8 Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 725 SS=L	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides.	F 725		9/29/20

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F 725	Continued From page 9 §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide sufficient nursing staff to ensure residents' safety and overall care and needs were maintained by ensuring scheduled medications to treat pain, blood sugar [insulin], blood thinners, blood pressure, and seizures were administered, and failed to ensure wound dressings were completed for 14 of 41 residents (R3, R6, R8, R14, R29, R15, R13, R33, R24, R20, R27, R12,R15, and R18). The facility also failed to ensure breakfast was provided for 17 of 38 residents (R31, R30, R5, R33, R32, R38, R28, R11, R17, R40, R7, R12, R8, R21, R25, R9, R23) between the dates of 9/19/20 and 9/23/20, and failed to ensure repositioning was completed to prevent pressure ulcers for 1 of 1 resident (R28). The facility failed to implement their emergency staffing plan to cross-train non-certified staff prior to an emergency and before performing direct care duties. This affected all 41 residents who resided in the facility and resulted in an immediate jeopardy (IJ) for all residents. The IJ began on 9/19/20, when the facility failed to ensure sufficient staffing to provide meals, treatment and medication administration, and repositioning. The administrator and director of nursing (DON) were notified of the IJ on 9/24/20 at 2:45 p.m. The IJ was removed on 9/25/20 at 6:36 p.m. however, non-compliance remained at the scope and severity level of G, isolated, actual harm that is not immediate jeopardy.	F 725	R17, R19, and R21 were already admitted to the hospital. R5, R7, R8, R11, R29, R33, R37, and R38 were immediately sent out to Redwood area Carris hospital on 9/24/20 to receive safe care. R18, R23, and R24 were sent out to Redwood area hospital on 9/25 due to change in condition. R25 and R26 were placed at another skilled nursing facility on 9/25/20, leaving total in-house census of 20. Residents, families, providers and Medical Director were all notified and approved transfers. The facility completed a tracking log and documented in the residents medical record, to appropriately track all resident transfers to ensure that that resident whereabouts and status were known, tracked, and appropriately communicated to coordinate care. All remaining in house residents are provided with 24-hour qualified nursing and related services to assure resident safety according to the facility assessment of resident population that is being served. All residents have the potential to be affected by insufficient nursing staff. All non-licensed/uncertified staff will not be allowed to provide direct care to residents unless they have been trained to do so. Tasks non-licensed/uncertified staff can potentially be trained to assist with includes feeding assistants. Emergency Staffing policy, Planning for	

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F 725	Continued From page 10 Findings include: Interview on 9/21/20 at 9:36 a.m., with anonymous staff (AS)-B identified they were unlicensed and uncertified to provide cares, but had worked all weekend (9/19/20 through 9/20/20) caring for the residents. They had no training on how to provide direct care and felt "overwhelmed". Interview on 9/21/20 at 10:19 a.m., with director of nursing (DON)-B identified the first COVID positive case had been from nursing assistant (NA)-D who reported on 9/15/20 she tested positive. The DON stated the facility had also been notified that a resident (R30) who had been at the emergency room for stroke symptoms and had returned a couple days prior, had been tested and was positive. The DON verified the facility was unaware R30 had been tested while at the hospital for COVID until the hospital had called on 9/15/20 to report the positive results. R30 was immediately isolated to her room following the results. The facility already had planned facility wide testing for 9/16/20, and positive results started coming in on Thursday afternoon 9/17/20. The DON stated positive residents were placed on isolation, positive staff were removed from the facility and everyone pitched in as the results came in. During interview with the administrator (A) on 9/21/20 at 12:27 p.m., A stated there were no non-certified or non-licensed staff providing direct resident care. All non-certified staff helped with housekeeping, laundry, passed meal trays, and were to be the second staff during a mechanical lift transfer.	F 725	Additional Staffing Needs policy, Facility risk assessment, and Contingency Staffing Plan template have been reviewed and updated, as needed, to reflect outreach to additional resources to secure staff during an emergency staffing crisis to ensure safe staffing levels. Additional staffing resources may include outside agency companies and local colleges. Emergency evacuation plan has been reviewed and updated to reflect scenarios when it would be necessary to transfer residents out of facility. The facility determines staffing needs identified through the facility assessment of resident population, which is determined based on evaluation of resident assessments, and plan of care needs. The facility assessment of the resident population will drive staffing decisions and determine the qualifications staff must possess to deliver the necessary care required by the residents being served. The staffing contingency template will be utilized as it pertains to sufficient staffing with any changes to the COVID-19 status at the facility. The Administrator/DON is responsible for ensuring adequate staffing levels to provide safe cares to residents to ensure all basic needs are met. Administrator/DON will review nursing schedule with staffer daily Monday through Friday to ensure staffing levels are sufficient to meet the residents basic needs on all shifts. The Administrator/DON or designee is responsible to complete visual	

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F 725	Continued From page 11 Interview on 9/21/20 at 12:32 p.m., with R26 stated there had been three staff working who "normally do not assist" her or her husband [who is in the same room] helping them. Care service was "slow", but they "thought they did get help". Interview on 9/21/20 at 12:38 p.m., with AS-D identified they were not certified or licensed and had no training to provide direct care. AS-D had been told by consultant administrator (C)-A to "step up" and was "expected to work on the floor providing direct care to the residents". AS-D had used a mechanical lift, provided personal cares, worked "alone on the upper west wing. The residents did not get the care they needed. The residents deserve better than this". AS-D was unaware of "what she was doing" or "how to care for the residents" while working on the floor. Corporate had been told staff "need help as residents were not getting cared for. Half of the residents did not get breakfast today. Today had been the best staffing the facility has had for days". Interview on 9/21/20 at 1:10 p.m., dietary director (DD) identified seventeen residents missed their breakfast this morning. DD provided list of residents who did not get breakfast. Those residents included 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	F 725	observations, record review, and interviews with residents, and staff, to confirm that: Residents are getting cares provided, Medications administered timely, wound treatments completed as indicated, Meals are being provided, and residents needing assistance with meals are provided with assistance. Administrator/DON or designee to conduct audits daily times 7 days, weekly times 4 weeks, then monthly for 2 months. Audit results will be reviewed by QAPI Committee and the scope and frequency of the audits will be adjusted according to the results.	

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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 several times. There had not been two staff utilized during transfer and running the lift. No documentation was recorded as AS-B was unaware of how to document cares in electronic medical record. AS-B started working on the floor with the residents on 9/18/20, after the consulting administrator-CA-(A) told uncertified staff they had to work the floor. Staff advised the CA-A they did not "feel comfortable or safe" and had been instructed they "had to care for the residents so they did not get an IJ (immediate jeopardy) tag".

Interview on 9/21/20 at 2:58 p.m., AS-C identified

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they were to be the second person for mechanical lift transfers. They had to assist a couple residents with a gait belt to walk to the bathroom but could not remember who they were or if they were able to be transferred safely in that manner. AS-C assisted residents to eat including last evening on 9/20/20. AS-C had no training in feeding residents or ambulating residents. AS-C worked 9/19/20 and 9/20/20, and would ask others how to "do stuff" to see if it was "something they could do". Staff were told by CA-A they had to "step up and do more" on Friday 9/18/20. AS-C felt "unsafe after helping a resident walk with a gait belt" so they would not do it anymore. "There is not enough staff here to care for the residents. Some residents did not get care, they wait for long times, some are not getting to bed timely. One resident looked like she had not checked before bed at all she as she had crusted bowel dried on her and was incontinent this morning (R4)". AS-C identified they had "no medical background" however, ""this morning R30 had felt warm so she told the nurse who "did not have time" to check R30. AS-C checked R30's temperature and her forehead "seemed okay". When the thermometer was over R30's neck, it registered 102.2. AS-C told the unidentified nurse. AS-C was advised "all residents are warm and that was not a good place to check a temperature".

R30's progress notes dated 9/21/20 at 19:54 (7:54 p.m.) identified R30 had been lethargic this shift. Temperature 103.6 Tylenol suppository administered and effective temperature decreased to 98.4. There lacked any documentation that a temperature had been checked or monitored during the morning shift.

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F 725	Continued From page 14 Interview on 9/21/20 at 3:58 p.m., with AS-A identified the facility needed "to shut down or send our resident someplace else in order to be cared for". There were residents who "did not eat this morning.... these residents needed assistance to eat and we just do not have enough staff to help with this". The facility had the" activity director and human resources staff working the floor doing everything a nursing assistant would do...use lifts, feed residents and provide cares and we still do not have enough staff to provide appropriate cares. Nurses have had to pass medication for all residents and medications have been given late or not at all". R32 had a low blood sugar (BS) and was given orange juice, but she did not get breakfast. There has been new skin breakdown as R28 has a "new area. We have not had time to update the doctor but did clean and apply a dressing to the wound. They have orders that they have not gotten to that are sitting on the nurses desk". They have several residents with "increased temperatures and no more oxygen's concentrators". Facility staff were using portable tanks but only "have so many of them". AS-A felt A-A and DON-B are trying to help on the floor as staff "literally cannot do it...we cannot care for the residents at this point. I would like to throw in my keys and go...we cannot provide care due to not having enough staff. Today there is no one to relieve us, staff did not show up at 2:00 p.m.. Corporate staff have not notified any of us on the floor that no one is coming in and we are sinking fast". Interview on 9/22/20 at 7:56 a.m., with LPN-B identified there was no one scheduled to relieve her after her twelve hour shift that was finishing up at 10:00 a.m. that day. LPN-B was scheduled to be back in eight hours at 6:00 p.m., for another	F 725		

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twelve hour shift. "The residents are not getting cared for appropriately, no one here is getting showed, rooms are dirty, residents smell, we do not have enough staff. The two day shift girls came in at 4:00 a.m., so they could start to get residents up so they did not miss breakfast for not being up anyway's. There is not enough staff to get everyone up on time to eat and not enough staff to assist the residents who need help to eat. Management just tells us they are working on it and to do the best you can".

Interview on 9/22/20 at 10:00 a.m., with C-A identified there are no competencies for training for the uncertified or unlicensed staff that are working on the floor.

Interview on 9/22/20 at 9:38 a.m., with FM-B identified receiving information via automated system about a positive resident and positive staff. FM-B was told by one of the staff (unknown name), there was 36 residents and 22 staff positive and they did not have enough help. A call was placed to CA-A who reassured things were under control and confirmed that there were several positive cases but they "did not believe the results". FM-B identified he felt the facility was not being "very transparent" and gave him different information daily. FM-B was concerned for his family who was a resident, along with other 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

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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 screened. She reported she did not have a temperature but did have a headache, dry cough and noticed some wheezing when breathing out, and also body aches. LPN-C was unaware of facility protocol and let NA-D work regardless of her having symptoms. LPN-C advised NA-D she was aware of residents on the upper west wing having temperatures between 99.0 and 99.7 with no changes being made like isolation to their room. NA-D worked the shift Monday (9/14/20)

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night into Tuesday. In the morning she left work and reported she "slept a little". NA-D had body aches and a temperature of 101.5 degrees F, and decided to go to the local clinic on 9/15/20. Her test came back positive on 9/15/20, and she notified the facility right away. NA-D identified there was a new admission, R11 who was diagnosed with C-diff. He was in a room alone but staff did not have to gown to go in the only thing staff had to do is change their mask. There were other residents identified with loose stools, and facility nursing staff were notified. No new interventions were placed. "It is hard to get information from management about what is happening and the staff are overworked".

Observation on 9/23/20 at 11:21 p.m., of R28 identified they were laying in bed, had oxygen on, covers off, bed is in lowest position, was awake, coughing and pulling at their oxygen tubing. R28 had not been dressed for the day and was unkempt.

Observation on 9/23/20 at 12:03 p.m., of registered nurse (RN)-E identified they carried a meal tray into R28 room and told R28 it was time to eat. R28 was laying twisted slightly to the left side. RN-B raised head of bed, and attempted to assist with noon meal which R28 was observed to eat poorly. RN-E lowered bed to floor and left room at 12:32 p.m. with R28 remaining in same position. At 12:35 p.m. RN-E walked by R28's room again and shut the door. At no time did RN-E attempt to reposition R28 during the observation. There was no documentation to support R28 had been repositioned in any way that day. Continuous observations identified no staff had entered R28's room by 2:22 p.m. to reposition R28.

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F 725	Continued From page 18 Interview on 9/23/20 at 12:56 p.m., with trained medication aid (TMA)-B identified the nurse usually does the dressing changes and was unaware R28 had any wound dressings. Observation and interview on 9/23/20 at 1:00 p.m., with RN-E while reviewing R15's physician orders for Aspart insulin 10 units subcutaneous before meals. There was no insulin pen in the medication cart. RN-E had not administered R15's insulin yet that day. RN-E went to retrieve R15's insulin from the medication room, and returned with insulin pen for R15. She waited for staff currently in R15's room to finish laying R15 down. RN-E entered the room at 1:44 p.m., to administer R15 their insulin that was due earlier that morning prior to lunch. RN-E confirmed insulin was late and should have been given within thirty minutes of the noon meal. Observation on 9/23/20 at 1:51 p.m., RN-E verified R32 ate noon meal and she is to get 7 units of Novolog for meal coverage. At 1:54 p.m., prior to administration, R32's insulin pen was noted not to have an open or expired date labeled on the pen. RN-E disposed and obtained a new insulin pen. RN-E confirmed R32's insulin was also late. Observation on 9/23/20 at 2:12 p.m., RN-E preparing to give R29 her Lispro 2 units of insulin with meals and sliding scale for blood sugar of 155. The insulin pen did not have an open date or expired date identified RN-E disposed and obtained a new insulin pen. RN-E confirmed insulin was late and should have been given within thirty minutes of the noon meal.	F 725		

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F 725	Continued From page 19 Observation on 9/23/20 at 2:18 p.m., RN-E preparing R14's Humalog 24 units subcutaneous with meals, with no labeled open date identified. RN-E disposed and obtained new insulin. RN-E confirmed R14's insulin was late being administered. Observation and interview on 9/23/20 at 2:26 p.m. with nursing assistant (NA)-C identified she thought RN-E had possibly repositioned R28 at noon but was unsure. R28 was observed to still have head of bed elevated approximately 75 degrees and was still positioned on her back with body slightly twisted to left. TMA-B entered R28's room after being advised by the surveyor R28 had not been repositioned timely. TMA-B assisted R28 to the side to check her for incontinence at that time. R28 was observed to be soiled with bowel. R28 had a bandage in left gluteal fold that was soiled with bowel and had drainage saturated through an area approximately an inch in diameter. TMA-B called for the nurse to come. RN-E entered R28's room and identified R28 had left gluteal unstageable wound that was overall 4.8 centimeters (cm) x 3.5 cm including the dark reddened boarders. The actual open area within measured 1.5 cm x 2.4 cm and also within that was an area was a hardened spot measuring 1 cm x 2 cm. RN-E identified the areas were new pressure ulcers not previously known for R28. RN-E described an open coccyx wound that measured 0.5 cm x 0.9 cm and two open wounds on her right buttocks the proximal measured 0.5 cm x 0.8 cm x 0.1 cm and the distal measured 0.4 cm x 0.6 cm. RN-E cleansed, applied dressing and planned to notify the doctor. R28 was noted to moan during the wound treatment. Staff repositioned R28 on her right side with RN-E instructing staff she should be repositioned	F 725		

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hourly. RN-E identified she would also be updating hospice for an air mattress and notifying the family. RN-E confirmed that resident should have been repositioned when new areas of pressure were identified. Any time skin breakdown was observed direct care staff, they were to notify the nurse to assess, notify doctor, get wound orders, place resident on wound rounds, complete a Braden skin assessment, begin skin assessments, and notify family.

Review of R28's progress notes dated 9/23/20 at 4:11 p.m., identified the R28's primary doctor was left a message that R28 had four pressure ulcers. At 4:21 p.m., R28's son was updated that R28 had four pressure sores on her bottom with family requesting the facility keep her comfortable.

Review of R28's weekly skin inspection dated 8/21/20, identified that R28 had new 3 cm x 1 cm area on her right left gluteus that was slightly open and a chronic problem. Wound care was to evaluate and treat on 8/26/20. There was no drainage noted at that time. R28 would sit in her wheelchair and wheel herself around all day. A skin inspection note dated 8/28/20, identified R28 had a chronic left buttocks wounds, that were not open. A standard barrier cream was to be applied. There was no mention of the new open area in her gluteal fold. Review of R28's assessment records found no pressure wound evaluation from 8/28/20 to 9/23/20.

R28's current, undated care plan identified R28 had potential for skin breakdown related to infrequent self-mobility or repositioning and incontinence. Interventions included having a foam covering on wheelchair frame where foot peddles attach, geri-sleeves to help protect arms

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and hands, monitor red area under left breast every shift, pressure reducing cushion in wheelchair and in recliner, pressure reducing mattress when she chooses to use bed, turn and reposition every 2-3 hours, with weekly skin observations by licensed nurse. There was no mention R28's care plan had ever been updated to identify the need for more frequent repositioning related to her health or history.

Review of the Medication Administration and Treatment Administration records identified R15, R36, R12, R22, R13, R8, R23, R24, R27, R3, R20, R6, R18, R39, R19, R14, R33, R38, R29 had not received medications timely or at all, on varied dates and times from 9/18/20 through 9/25/20. Of those administration records the following critical medications were not received or administered such as insulin for R14, R29, R15, R13, heart medications were not administered for R20, R3, R27, R13, R12, R15, R6, nutritional supplements R22, R8, R33, R38, seizure medication for R29, pain medication for R33, R8, R24, R3, R6, and blood thinners for R20, R27, R13. There were also multiple other medications that were not administered as ordered during this time frame. Additionally, R18 did not receive a wound dressing change as scheduled.

Interview on 9/29/20 at 10:58 a.m., with C-B identified the facility reached out to the MDH telling them we did not have enough staff and we needed help. MDH advised the facility was to staff according to the residents needs. If residents needs were unable to be met, the facility was to transfer residents to a number they could provide care for. We attempted to get staff into work as soon as possible. The C-B confirmed the contingency staffing plan and emergency staffing

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plan had not been fully implemented and non-certified staff should not have worked the floor. C-B also confirmed there had been residents who missed breakfast due to short staffing. All residents were to be provided three meals a day with no more than 14 hours between the evening meal and breakfast the next day. He would expect medications to be given and treatments completed as ordered by the physician. He would expect staffing levels to meet the needs of the residents to ensure repositioning of residents at risk for skin breakdown or and repositioning completed. C-B identified the Quality Assurance Performance Improvement (QAPI) committee should have provided oversight to ensure a plan was in place in case of a COVID or other infectious disease outbreak. It was the overall responsibility of the administrator to ensure residents receive the care and services they require.

Interview on 9/29/20 at 12:38 p.m., with medical director (MD) identified his expectation would be that the facility had adequate staffing to ensure basic care needs are being met such as personal hygiene, repositioning, meals provided to residents, and residents who require assistance with meals receive that assistance. Further, the MD would expect enough staffing to ensure medications are timely and given. The MD confirmed the facility should not have had non-certified or non-licensed staff providing direct care to the residents. The facility should have followed their contingency staffing plan and staff should not have provided direct care without any training. He was notified about the immediate jeopardy situation and care was compromised at the facility, however, was not made aware of any concerns or issues before the immediate

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jeopardy. The facility was discharging some residents to a sister facility to reduce census to manageable level. The MD expected the facility notify him of the inability to provide care to residents.

Review of the 9/2012, Meal times policy identified the facility was to serve meals no more than 14 hours between the evening meal of one day and the breakfast meal of the next day.

Review of the July 2017, Prevention of Pressure Ulcers/Injuries policy identified assessing the resident for existing pressure ulcer upon admission and for risk factors, repeat the assessment weekly and upon any changes in condition. Reposition residents as indicated on the care plan. Staff were to provide preventative interventions, monitor, evaluate and document potential changes in the skin and review interventions and strategies for effectiveness on an ongoing basis.

Review of the 9/3/20, Emergency Staffing policy identified the facility was to give competent, conscientious, and consistent quality care to each resident 24 hours per day. Nursing, laundry, culinary, and maintenance departments must be adequately staffed and therefore, it may be necessary to stay on duty until replacements could report for duty. If more staff were needed, the designee person in charge of the facility will contact the corporate office to contact sister facilities in the company for staff assistance. Critical staffing shortages during an emergency had the potential to result in staff injury or illness and post-traumatic stress. In order to prepare for potential staffing shortages, licensed and unlicensed personnel and volunteers were to be

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F 725	Continued From page 24 recruited and trained for emergency assistance. The facility was not to engage in non-credentialed or untrained volunteers for direct resident care. Review of the 8/26/20, Long-Term Care Contingency Staffing Plan policy identified a training plan to cross-train staff to fulfill different roles in case the primary staff responsible for a given function was not available. In emergency situations, direct care would be performed by facility staff, then the corporate float pool, outside agencies, and lastly via cross-trained staff from other departments. Quality of care was deemed the highest practicable level of care to meet the needs of residents with proactive steps to have been taken before a crisis occurs to minimize the risk of crisis staffing. The IJ was removed on 9/25/20 at 6:36 p.m.-when it could be verified by observation, interview and document review, the facility took steps to remove the immediacy by discharging 8 residents to the local hospital to receive safe care, with an additional 3 resident discharged to the hospital for a change in condition. The facility then transferred additional residents to other nursing facilities until they were able to a manage a census of 16. Policies and procedures were reviewed and revised. Sufficient staffing levels were verified and audited. Non-certified and non-licensed staff were not allowed to provide direct care unless they had completed training to do so.	F 725		
F 880 SS=L	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an	F 880		9/29/20

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F 880	Continued From page 25 infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and	F 880		

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F 880	Continued From page 26 (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow Centers for Disease Control (CDC) and Centers for Medicare and Medicaid Services (CMS) guidelines for COVID-19 to prevent or minimize the transmission of COVID-19 which resulted in an ongoing facility outbreak when 31 of 41 residents (R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R14, R15, R6, R17, R18, R19, R12, R21, R22, R23, R24, R27, R28, R20, R30, R31, R32, R33, R34, R35, R36, R38, R38, R39, R40, R42, and R42) whom had COVID-19 symptoms. As a result of this, 39 of 41 residents tested positive for COVID-19. The facility's failures	F 880	R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R14, R15, R6, R17, R18, R19, R12, R21, R22, R23, R24, R27, R28, R20, R30, R31, R32, R33, R34, R35, R36, R38, R38, R39, R40, and R42's plans of care and orders were reviewed and updated to reflect appropriate COVID-19 monitoring. Residents are currently being monitored for signs and symptoms of COVID-19 at least daily and treated according to policy and physicians' orders. Signs and symptoms of COVID-19 are assessed in residents daily and documented in the	

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resulted in an immediate jeopardy (IJ) situation for all residents.

The IJ began on 9/16/20, when R30 was identified as positive for COVID-19. The facility failed to have a system for daily cumulative surveillance to identify potential symptoms of COVID-19, implement droplet precautions, quarantined residents, and implement appropriate (PPE) to mitigate COVID-19 transmission which resulted in 39 of 41 residents testing positive for COVID-19. The administrator and director of nursing (DON) were notified of the IJ on 9/23/20 at 3:30 p.m. The IJ was removed on 9/24/20 at 2:35 p.m. Non-compliance remained at the scope and severity of F, widespread- potential for harm that is not immediate jeopardy.

Findings include:

SURVEILLANCE
Interview on 9/21/20 at 9:15 a.m., with NA-B identified none of the 17 residents who admitted from a local nursing home that closed, were quarantined upon admission and staff did not wear gowns when providing care. NA-B was unaware if any residents had symptoms of COVID.

Continued interview on 9/22/20 at 9:50 a.m., with nursing assistant (NA)-B identified a month or so ago, there was one resident whom had C. Diff (severe intestinal infection) was quarantined when they admitted from a local nursing home that closed. No other residents admitted from the facility were placed on quarantine for COVID-19, and staff were not instructed to don a gown in addition to using standard PPE precautions to provide care. NA-B also reported that a month

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resident medical record. If residents are identified as having signs and/or symptoms of COVID-19, a request will be made to the provider to test for COVID-19, resident will be suspected as having COVID-19 until results come back, placed on enhanced respiratory precautions, and vital sign monitoring will be increased to 3 times per day. The facility now has a system for daily cumulative surveillance to identify potential symptoms of COVID-19, has implemented droplet precautions, quarantined residents, and implemented appropriate PPE.

All residents had the potential to be affected, so all residents are currently being monitored for signs and symptoms of COVID-19 at least daily and treated according to policy and physicians' orders. Signs and symptoms of COVID-19 are assessed in residents daily and documented in the resident medical record. If residents are identified as having signs and/or symptoms of COVID-19, a request will be made to the provider to test for COVID-19, resident will be suspected as having COVID-19 until results come back, placed on enhanced respiratory precautions, and vital sign monitoring will be increased to 3 times per day. The facility now has a system for daily cumulative surveillance to identify potential symptoms of COVID-19, has implemented droplet precautions, quarantined residents, and implemented appropriate PPE.
Donning and doffing audits will be

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ago the entire west wing of the facility had diarrhea. There were no precautions implemented during that time. NA-B was unaware if any residents had COVID symptoms in the facility.

Interview on 9/21/20 at 2:00 p.m., with licensed practical nurse (LPN)-A identified none of the 17 residents were placed on precautions/quarantine when they were admitted from a local nursing home that closed and were admitted to their facility. LPN-A was unaware if any residents had symptoms of COVID prior to the facility outbreak on 9/16/20.

Review of July 2020, August 2020, and September 2020, Infection Prevention Surveillance documentation only identified infections treated with antibiotics. There was no documentation of potential COVID-19 symptoms or other symptoms prior to the first identified positive COVID tests on 9/16/20.

CDC defines symptoms of COVID-19 to include but not limited to Fever, either 100.4 or subjective, cough, shortness of breath, headache, new loss of taste or smell, congestion or runny nose, sore throat, diarrhea, myalgia (muscle aches, body aches), tiredness or fatigue

Review of resident's electronic medical records (EMRs) identified the following:
R1's nurse notes identified on 7/9/20, R1 admitted to the facility from the local facility that closed. The notes made no mention R1 was quarantined R1's vital sign report identified on 7/26/20, R1's temperature was 99.0 degrees Fahrenheit (F) and on 8/20/20, R1's temperature was 99.1 (F). Between 8/4/20, and 9/7/20, R1

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conducted on all shifts four times a week for one week, then twice a week until compliance is 100% for use of PPE.
Facility will audit the screening process daily for five days, then weekly for three weeks to ensure compliance.
Facility has created an audit form, and a calendar for audits to include facility leadership to 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.
Facility has established a contract with Pathway Heath for infection control consulting for a duration of at least 2 months. Facility has added this DPOC to QAPI to be reviewed with the IDT team.
Any non-compliance of the screening process will be brought to the DON/NHA attention and will be dealt with accordingly.
COVID-19 screening tool process has been reviewed and educated on when to report irregularities to a nurse to assess:
COVID-19 competency training included screener will notify nurse if any questions are answered “yes” on the COVID-19 screening tool. Employee will not be allowed in the building until nurse assess the employee. Employee will be sent home after nurse assess, and nurse feels they symptomatic. This is to be reviewed daily by Infection Control nurse, or designee.
Daily Stand UP format has been updated to discuss infections and signs and

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F 880	Continued From page 29 also complained of intermittent explosive loose stools for several days. On 9/17/20, R1 tested positive for COVID. R1's July through September 2020, nurse notes made no mention R1 was quarantined upon admission or when potential COVID symptoms occurred. There was no mention R1's provider was notified of potential symptoms of COVID. R2's nurses' notes identified R2 was admitted from a hospital. On 8/28/20, R2 admitted to the hospital and returned to the facility on 9/9/20. R2's vital sign report identified on 9/14/20, R2's temperature was 99.1 degrees F. On 9/17/20, R2 tested positive for COVID. R2's August and September 2020, nurse notes made no mention R2 was placed on isolation upon return from the hospital 14 days to mitigate potential transmission of COVID. R3's 9/2/20, nurses' notes identified R3 had a headache was feeling off, had difficulty standing, and was unresponsive to verbal cues. R3's vital sign report identified on 9/15/20, R3's temperature was 99.1 degrees F. R3's September 2020, progress notes made no mention R3 had potential symptoms of COVID-19 was placed on precautions, or whether R3's provider was notified of potential COVID symptoms. R5's nurses' notes identified on 7/16/20, R5 was admitted from local facility that closed. R5's July 2020, notes made no mention precautions were implemented. R5's vital signs showed R5 had a temperature of 99.7 degrees F on 7/17/20. 99.2 on 9/22/20; and 100.2 F on 9/24/20. On 8/21/20, R5 was having loose stools. On 9/6/20, R5 had an emesis, had wet breath sounds, mumbled	F 880	symptoms of COVID daily with IDT. The Facility Interdisciplinary Team will review screening and surveillance daily in morning stand up meetings. Any unexpected increases in infection will be in communication with the Medical Director, Public Health Department, and the state agency. All incoming residents discharged from hospitals, or other facilities, are to be isolated for 14 days. The facility will document the resident's temperature, oxygen saturation, and the absence or presence of symptoms in the residents' EMR at least daily. The facility will complete and maintain a line listing of residents with respiratory symptoms. Facility has provided residents and their representatives education on the facility's Infection Prevention Control Program and the use of transmission-based precautions as it relates to them and to the degree possible/consistent with the resident's capacity. Infection Control binder and resident infection statistics forms were reviewed and updated to include identification of signs and symptoms of COVID-19. All policies and procedures for COVID-19, emerging infectious diseases and emergency preparedness relating to testing and staffing is implemented according to CDC and MDH guidelines. Staff is being educated on the Coronavirus (COVID-19) policy and procedure. COVID-19 signs and symptoms surveillance has been updated and added to the infection control binder. The Infection Preventionist is out sick at	

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speech, and flaccid limbs. R5 was transported to the emergency department (ED), was admitted to the intensive care unit (ICU) with diagnoses of pneumonia, sepsis, and acute hypoxia and returned on 9/10/20. There was no indication R5 had been tested for COVID in the hospital and was not identified as being placed on precautions when he returned. On 9/12/20, R5 was congested and productive with slight yellow-tinged sputum. On 9/15/20, R5's guardian declined COVID-19 testing. The guardian was informed R5 would then be placed on quarantine and would not be allowed visitors.

R6's progress notes identified on 7/16/20, R6 was admitted from a local facility that closed. R6's vital sign report identified on 8/7/20, R6's temperature was 99.1 degrees F; and 99.3 on 9/14/20. On 9/16/20, R6 intermittently coughed up blood tinged sputum, experienced chest pain, dizziness, had productive cough with yellow sputum, shortness of breath, hoarseness, and diminished wheezy lung sounds. On 9/17/20, R6 tested positive for COVID-19. There was no indication R6 had been placed on any precautions until they were diagnosed with COVID-19.

R7's vital sign record identified R7's temperature was 99.4 degrees F on 9/8/20; 99.1 on 9/13/20 through 9/15/20; 100.6 on 9/17/20; 99.5 on 9/18/20; 99.1 on 9/20/20; and 100.6 on 9/17/20 There was no indication R12 had been placed on any precautions until they were diagnosed with COVID-19.
R8's nurses' notes identified on 7/24/20, R8 admitted from a local closed facility. Between 8/21/20 through 9/9/20, R8 intermittently had symptoms of loose stools and a cough. R8's vital sign record identified between 8/11/20, and

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this time and will be re-educated prior to returning to work. DON or designee will be reviewing and tracking infections daily.
All staff were inserviced prior to their next scheduled shift on change of condition, COVID-19 Screening Tool, proper hand hygiene, 14-day admission/readmission transmission-based precautions, appropriate donning and doffing of PPE while providing cares to residents who are suspected and/or confirmed as having COVID-19. Training of all staff began on 9/23/2020. Infection Control nurse, DON, or designee will continue providing training. Mass communication alert sent to staff to inform them that training must be completed prior to the start of their next scheduled shift. Signs are posted at the time clock and on the employee/visitor Screening Tool clipboard to alert staff of this requirement.
Facility has re-implemented an infection sign and symptom tracking tool to monitor all residents for communicable, respiratory infection that is the responsibility of the Infection Preventionist. All nursing leaders will be educated on how to use the tool.
All staff have received education to include the Root Cause Analysis results from the facility QAPI Committee regarding the deficient practices, including proper use of PPE donning/doffing. Any staff who fail the post- test (competency) will repeat the training until the testing is successful.
Infection Preventionist has reviewed the Monarch Healthcare Management COVID19 Policy.

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F 880	Continued From page 31 9/14/20, R8 had intermittent elevated temperatures. On 9/20/20, R8 tested positive for COVID-19. There was no indication R7 had been placed on any precautions until they were diagnosed with COVID-19. R9's nurses' notes identified on 7/23/20, R9 admitted from a local facility that closed. There was mention R8 was placed on transmission based precautions upon admission. R11's nurses' notes identified they were admitted to the facility from a local facility that closed with diagnosis of Clostridium difficile (a contagious intestinal infections) and was placed on IC precautions. On 8/27/20, R11's precautions were discontinued and were not renewed when R11 had a temp on 9/9/20, of 99.5 degrees F. On 9/15/20, it was 99.1 degrees F. On 9/17/20, R11 tested positive for COVID-19. There was no indication R11 had been placed on any precautions until they were diagnosed with COVID-19 R12's nurses' notes identified on 7/29/20, R12 was admitted to the facility from another local facility that closed. R12's temperature was 99.5 degrees F on 9/8/20; 100.3 degrees F on 9/13/20. R5's temperatures ranged from 99.1 degrees F 102.3 degrees F on 9/14/20. On 9/15/20 R12's 101.0. R12's progress notes identified between 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	F 880	Infection Preventionist has reviewed Monarch Healthcare Management COVID19 Policy specific to standard and transmission-based precautions. Facility has provided education on transmission-based precautions, appropriate PPE use, and donning and doffing of PPE for all staff providing direct care to residents, and all staff entering resident’s rooms. Corrective action will be accomplished by providing education for all staff on the requirements to be screened in by another competent staff member. Competency training was initiated to ensure those screening have proven to be competent in the screening process. Infection Preventionist /Director of Nursing has developed, and initiated education based on our corporate screening process, as well as our site-specific screening process to ensure an active screening process. IP/DON has initiated education to ensure screeners are competent in the screening process and how to use a thermometer. All staff have received education to include the Root Cause Analysis results from the facility QAPI Committee regarding the deficient practices, including proper use of PPE donning/doffing. The facility will document the resident’s temperature, oxygen saturation, and the absence or presence of symptoms in the residents’ EMR at least daily. The facility will complete and maintain a line listing of residents with respiratory symptoms. Facility will be auditing the resident screening process on different shifts/days	

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admitted from the hospital. On 8/21/20, 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 precautions were implemented to prevent potential transmission of COVID, and no mention R15's provider was contacted regarding potential COVID-19 symptoms. On 9/17/20, R15 tested positive for COVID-19.

R16's nurses' notes identified on 7/13/20, R16 was admitted from from a locally closed facility. R16's note made no mention R16 was quarantined to prevent potential transmission of COVID-19. On 9/17/20, R16 tested positive for COVID-19.

R17's nurses' notes identified between 8/25/29 and 9/1/20, R17 had intermittent increased confusion, lethargy, and decreased appetite. On 9/13/20, R17 was hospitalized for increased confusion and was found to be dehydrated. R17 returned to the facility on 9/14/20. R17's notes made no mention R17 was quarantined upon identifying symptoms or when they returned from the hospital. On 9/17/20, R17 tested positive for COVID-19.

to ensure compliance. Facility has added this DPOC to QAPI to be reviewed with the IDT team.
Any staff who fail the post- test (competency) will repeat the training until the testing is successful.
The facility has provided training for the Infection Preventionist, the Director of Nursing, nursing leadership/management, and facility administration. The training covered standard infection control practices, active surveillance, tracking and trending for a comprehensive infection control program. The facility used 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.
Audits will continue to be conducted monthly times one year. Audit results will be reviewed by QAPI Committee and the scope and frequency of the audits will be adjusted according to the results.

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R19's nurses' notes identified on 9/11/20, R19 had a temperature of 100.8 degrees F. On 9/12/20 through 9/14/20, R19 complained of upset stomach, not feeling well, poor appetite, and wanted to see her provider. R19's notes made no mention R19 was quarantined and COVID precautions were implemented when symptoms were identified. On 9/17/20 R19 tested positive for COVID.

R22's nurses' notes identified between 8/19/20 and 9/16 20, R22 had symptoms of cough and vomiting. On 9/22/20, R20 tested positive for COVID. R22's notes made no mention he was placed on quarantine or that droplet precautions were implemented when potential COVID symptoms were identified.

R23's nurses' notes identified on 7/9/20, R23 admitted from a local facility that was closed. R23's notes made no mention R23 was quarantined at the time of admission to prevent potential transmission of COVID. Between 8/24/20, and 9/15 /20, and 9/15/20, R23 had loose stools, a red, goopy eye, allergy symptoms, cough, and elevated temperature, and crackles in her lungs. On 9/17/20, R23 tested positive for COVID. R23's notes made no mention R23 was quarantined and droplet precautions implemented to prevent potential transmission of COVID at the time potential COVID symptoms were identified.

R24's nurses' notes identified on 9/2/20, R24 admitted to the hospital with a diagnoses of pneumonia. R24 was negative for COVID. R24 continued to have a productive cough. R24's notes made no mention R24 was quarantined upon admission to prevent potential transmission

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of COVID. On 9/21/20, R24 tested positive for COVID.

R25's nurses' notes identified on 8/18/20, R25 reported flu-like symptoms. Staff were to continue to monitor R25's symptoms. R25's progress notes made no further mention R25's symptoms were monitored, whether R25 was quarantined, and if droplet precautions were implemented to prevent potential transmission of COVID.

R26's August and September 2020, nurses' notes identified between 8/17/20, to 9/2/20, R26 complained of loose stools. R26's progress notes made no further mention R26's symptoms were monitored, whether R26 was quarantined, and if droplet precautions were implemented to prevent potential transmission of COVID.

R28's nurses' notes identified on 8/22/20, R28 had a large amount of phlegm she was unable to clear. R28's lung sounds had fine crackles. Between 8/22/20 and 9/6/20, R28 continued to receive as needed (PRN) medications for cough and congestion symptoms. R28's August and September, 2020, nurse notes made no mention R28's symptoms were monitored or whether R28 was placed on droplet precautions. On 9/17/20, R28 tested positive for COVID.

R29's nurses' notes identified R29 was admitted from the hospital on 8/25/20. R29 was hospitalized for seizure activity on 8/31/20, and for a second time and returned on 9/10/20. The August and September, 2020, nurse notes made no mention R29 was quarantined to prevent potential COVID Transmission upon admission to the facility or after the second hospitalization. On

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9/17/20, R29 tested positive for COVID.

R30's nurses' notes identified between 8/22/20 and 9/16/20, R30's had a runny nose, sore scratchy throat, and increased lethargy. On 9/11/20, R30 was not feeling well, leaning to the right side, had a temperature of 100.7, pulse rate of 99, and was transferred to the ED for evaluation. R30 returned on 9/11/20 with a diagnoses of kidney infection. R2 continued to be weak, and tested positive for COVID on 9/16/20. There was no mention R30 was placed on precautions to prevent spread of COVID.

R31's nurses' notes identified R31 was admitted on 7/17/20, from a local facility that recently closed.. The notes made no mention whether R31 was quarantined upon admission. On 9/17/20, R31 tested positive for COVID.

R33's nurses' notes identified on 8/21/20 to 9/7/20, R33 had intermittent loose stools and was not feeling well. The notes made no mention R33 was placed on precautions when loose stools began. On 9/17/20, R33 tested positive for COVID.

R34's nurses' notes identified on 7/30/20, R34 admitted to the facility on 7/30/20. Between 8/21/20 and 8/27/20, R34 reported intermittent loose stools. There was no mention R34 was placed on precautions upon admission or when loose stools began on 8/21/20. R34 tested positive for COVID.

R35's nurses' notes identified on 7/30/20, R35 was admitted from a locally closed facility. On 8/26/20 R35 had loose stools. On 9/16/20, R35 had a productive cough, clammy skin, and was

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F 880	Continued From page 36 not feeling well. Staff was to continue to monitor. On 9/17/20, R35 tested positive for COVID. R37's nurses' notes identified on 8/11/20, R37 admitted to the facility from a hospital. The July 2020, nurse notes made no mention whether R37 was placed on precautions upon admission. On 9/4/20, R37 complained of shortness of breath (SOB). On 9/5/20, R37's temperature was 100.0 degrees F. There was no mention R37 was placed on precautions upon admission or when loose stools or SOB began. R41's July 2020, nurses' notes identified on 7/16/20, R41 admitted to the facility from a local facility that closed. The notes made no mention R41 was quarantined upon admission. R44's nurses' notes identified on 7/22/20, R44 was admitted from a local facility that closed. On 8/8/20 through 8/9, R44 had increased productive cough. On 8/21/20, R44 had loose stools and again on 8/25/20. There was no mention R44 was quarantined or placed on transmission based precautions upon admission. On 9/18/20, R44 tested positive for COVID. Review of the September 2020, residents' Electronic Medication Administration Documentation (EMAR)s identified staff were to record temperature, and oxygen saturations on the MAR and monitor residents for fever, chills, shortness of breath, new or a change in cough, sore throat, muscle pain, headache, new loss of taste or smell, nausea, vomiting, and diarrhea three times daily. Additionally, staff were to document in the supplementary documentation section of the nurse notes when any of COVID symptoms were identified and update the clinical	F 880		

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F 880	Continued From page 37 leadership, provider, and initiate droplet precautions. Interview on 9/23/20 at 4:00 p.m., with RN-C identified only infections treated with antibiotics were included in the infection control line listing. Infection documentation was monitored monthly to identify potential infection issues and was not done as daily cumulative monitoring. RN-C agreed all potential symptoms of infection should be documented on the line list as the occur and reviewed on an ongoing basis to identify potential infection outbreaks and to implement precautions as soon as possible to mitigate transmission of COVID or any infections. The infection preventionist was responsible to oversee the infection control program and provide oversight to ensure infection were identified and responded to in a timely to prevent transmission. Audits of hand hygiene and PPE use were requested. RN-C identified no competencies were documented and no audit documentation was available as evidence staff were monitored to ensure staff were using PPE appropriately. No line list of staff illness or symptoms was implemented to ensure staff were not working ill prior to the COVID outbreak. Interview on 9/29/20 at 12:38 p.m., with the medical director identified staff with symptoms should not have been allowed to work. Staff were expected to monitor residents for potential symptoms of COVID, implement droplet precautions, and notify their providers to prevent potential transmission. The medical director had a family member who transferred from the closed facility, and was told residents transferring from the closed facility were to be quarantined and staff to wear appropriative PPE during quarantine	F 880		

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RIVER VALLEY HEALTH AND REHABILITATION CENTER LLC	**200 SOUTH DEKALB STREET REDWOOD FALLS, MN 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) COMPLETION DATE
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of newly admitted residents. Staff were expected do don gowns, gloves, N-95 masks, and eye protections when caring for residents with suspected and known COVID residents and perform and hygiene prior to leaving rooms, and before and after donning gloves.

STAFF
Review of staff screening forms and time sheets found the following on:
1) 9/16/20, licensed practical nurse (LPN)-D identified symptoms of muscle pain, headache. Nursing assistant (NA)-F identified symptoms of migraine and proceeded to work from 1:56 p.m. to 10:47 p.m., and later tested positive for COVID. The health information director (HID)-D identified symptoms of chills, muscle pain, headache and had been sick the day prior. Proceeded to work 7:32 a.m. to 8:25 a.m. ,and later tested positive for COVID. NA-G identified symptoms of headache and proceeded to work 3:28 p.m. to 9:34 p.m., and later tested positive for COVID.
2) 9/17/20, NA-G identified symptom of headache, had headache day prior also proceeded to work another shift 6:00 a.m. to 1:30 p.m., and later tested positive for COVID. NA-H identified symptoms of new/changed in cough, muscle pain, headache proceeded to work 11:07 a.m. to 2:19 p.m., and later tested positive for COVID.
3) 9/18/20, NA-O identified symptoms of new/changed cough, sore throat, and headache. NA-C identified symptom of sore throat, headache and proceeded to work 2:47 a.m. to 2:48 p.m. NA-M identified symptom of new/changed cough, muscle pain, proceeded to work 3:57 a.m. to 2:55 p.m., and later tested positive for COVID. RN-H identified symptom of

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new/changed cough proceeded to work 6:31 a.m. to 11:30 p.m. NA-N identified symptom of muscle pain, headache and proceeded to work 6:00 p.m. into 6:00 a.m. next day. NA-F who had symptoms identified on 9/16/20 proceeded to work 1:54 p.m. to 4:30 p.m., and later tested positive for COVID. HID-D who had symptoms identified on 9/16/20 proceeded to work 8:00 a.m. to 12:30 p.m., and later tested positive for COVID.
4) 9/19/20, NA-O who had symptoms identified on 9/18/20 proceeded to work the morning and night shift unspecified number of hours. NA-E identified symptom of sore throat, muscle pain and proceeded to work from 9/18/20 at 9:00 p.m. into 6:34 a.m. on 9/19/20. RN-H had symptoms identified on 9/18/20 proceeded to work 9:53 a.m. to 11:23 a.m.
5) 9/20/20, NA-N who had symptoms identified on 9/18/20 proceeded to work 3:45 p.m. to 12:02 a.m.. NA-E had symptoms identified on 9/19/20 proceeded to work 9/19/20 8:17 p.m. into 6:44 a.m. on 9/20/20. Dietary Aide (DA)-A identified symptom of chills proceeded to work 5:28 a.m. to 2:58 p.m.

Interview on 9/21/20 at 2:58 p.m., with anonymous staff (AS)-C identified they had no medical background however, R30 felt warm this morning and the nurse did not have time to check her. AS-C took her temperature and reported to the nurse that R30's temperature on her forehead seemed okay but when she held the thermometer over R30's neck it registered 102.2. The nurse advised AS-C all residents are warm and that was not a good place to check a temperature. AS-C reported R30 had been in the hospital on 9/11/20, and had a COVID test. The facility was called by the local hospital on 9/16/20, identifying R30 was positive for COVID. She had only been at hospital

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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.

Interview on 9/22/20 at 3:55 p.m., with NA-D

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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 screened. She reported she did not have a temperature but did have a headache, dry cough and noticed some wheezing when breathing out, and also body aches. LPN-C was unaware of facility protocol and let NA-D work regardless of her having symptoms. LPN-C advised NA-D she was aware of residents on the upper west wing having temperatures between 99.0 and 99.7 with no changes being made like isolation to their room. NA-D worked the shift Monday (9/14/20) night into Tuesday. In the morning she left work and reported she "slept a little". NA-D had body aches and a temperature of 101.5 degrees F, and decided to go to the local clinic on 9/15/20. Her test came back positive on 9/15/20, and she notified the facility right away. NA-D identified there was a new admission, R11 who was diagnosed with C-diff. He was in a room alone but staff did not have to gown to go in the only thing staff had to do is change their mask. There were other residents identified with loose stools, and facility nursing staff were notified. No new interventions were placed. "It is hard to get information from management about what is happening and the staff are overworked".

Interview on 9/22/20 at 3:40 p.m., with RN-C identified staff were to ring the doorbell if staff was not present by the entrance door. The staff were to be screened. If symptoms were present, staff were not to be allowed to enter the facility. A nurse was to assess the staff person with symptoms to see if it is "allergies or something". If a staff had a symptom that has no explanation

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F 880	Continued From page 42 they are sent home. The infection control nurse (ICP) was responsible for reviewing and monitoring the screening logs for staff. The ICP however, was currently out ill. The administrator (A)-A was doing that at this time. Interview on 9/22/20 at 4:41 p.m. with administrator (A)-A identified she does not review any screening forms however, she does file them in her office. A-A was unsure who reviewed the screening forms but believed that would be the DON's responsibility. PPE Observation on 9/23/23 at 8:45 a.m., identified registered nurse (RN)-A was in the hallway passing medications. RN-A entered resident rooms on the West wing to administer medication without wearing a gown. Without wearing a gown RN-A entered R34's room to assist with care. RN-A exited R34's room and continued to administer medications in the West wing. At 9:05 a.m., without wearing a gown, RN-A entered R23's room and administered R23's medication. R23 was COVID positive. R23's had a coarse cough and coughed with her mouth open while RN-A was stood next to her. RN-A exited the room while wearing her gloves. RN-A removed her gloves in the hallway, without performing hand hygiene, RN-A walked to a PPE cart in at the main entrance, opened the drawer and grabbed a gown. Interview with RN-A on 9/23/20 at 9:15 a.m., identified RN-A had started working at the facility this week. She had not had training yet, as she was needed on the floor immediately due to the COVID outbreak. Staff were supposed to wear a gown at all times in the facility. Only two	F 880		

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residents were negative for COVID at the present time. RN-A verified she had not donned a gown when she entered the facility, and had not worn a gown while administering medications on the West wing. RN-A had not donned a gown because she forgot to do so. RN-A had training regarding PPE and hang hygiene at the time the outbreak occurred.

Review of the 9/19/20, through 9/21/20, Donning and Doffing COVID training roster identified RN-A was not included on the roster.

Interview on 9/23/20 at 3:30 p.m., with RN-C identified no documentation was found as evidence RN-A received PPE training on 9/21/20, or prior to the start of her first shift. RN-A was expected to don a gown at the start of the shift and change PPE and perform hand hygiene prior to exiting resident rooms. RN-C agreed RN-A should have received training for PPE use prior to working the floor.

The undated Corona Virus (COVID-19) policy identified staff were to be trained regarding general infection information upon hire and on an ongoing basis as needed. Training included utilization of PPE, hand hygiene, and importance of adhering to the necessary requirements.

The Infection Prevention and Control Program identified the purpose of the program was to ensure infections were detected, addressed, and prevented among residents and staff. The program included coordination and oversight, policies and procedures, surveillance, data analysis, antibiotic stewardship, outbreak management, prevention of infection and employee health. All staff were to be trained upon

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F 880	Continued From page 44 hire and periodically. The infection preventionist was responsible for oversight of the infection control program. Surveillance consisted of using tools to recognize occurrence of infections, recording the number of infections, frequency, detection of outbreaks and epidemics, monitoring employee infections and detecting unusual patterns with infection control issues. Outbreak management was a process of determine the presence of outbreak, managing affected residents, preventing spread to other residents, documenting information about the outbreak, reporting to the appropriate public health authorities, educating staff and the public, monitoring for recurrences, and recommending new or revised policies for future outbreaks. The infection preventionist was to review data to determine sporadic cases from true outbreaks. The undated Coronavirus (COVID-19) policy identified staff were to take reasonable steps to promptly detect, triage, and isolate potentially infectious residents and prevent unnecessary exposures among residents, healthcare workers, and visitors at the facility. Staff were to monitor residents daily for potential symptoms of COVID. Symptoms included fever, chills, shortness of breath, new or change in cough, sore throat, muscle pain, headache, new loss of taste or smell, nausea, vomiting, or diarrhea. Staff were to document absence or presence of symptoms in the EMR daily. The facility was to maintain a line listing of residents with respiratory symptoms. Residents with symptoms of acute respiratory illness or suspicion of COVID according to identified symptoms were to have droplet precautions implemented. Staff were to notify providers, resident representatives, department of health, medical director, facility infection	F 880		

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F 880	Continued From page 45 preventionist, DON, and administrator. Resident temperature, oxygen saturation, respiratory status, and other symptoms were to be monitored each shift. Staff were to perform hand hygiene before and after all resident contact, contact with infectious material, and before and after removal of PPE, including gloves. Staff were to be screened for symptoms prior to reporting to work and actively screen for COVID symptoms and take their temperatures. If staff were ill, they were to leave the workplace. The facility was to maintain a line list of staff with identified symptoms. Staff were to leave the workplace if symptoms of respiratory infection occurred during their shift, inform the infection preventionist, contact their primary provider, and limit contact with the public as much as possible. Residents who were new admissions, had suspected COVID symptoms, or whose infection status was unknown, were to be screened for symptoms of COVID, and placed in a single room or in a separate observation area to monitor for evidence of COVID-19. Recommended PPE (gown, gloves, mask, eye protection) were to be worn during care of residents under observation. The IJ was removed on 9/24/20 at 2:35 p.m. when it could be verified by observation, interview and document review, that the facility took steps to remove the immediacy by implementing daily cumulative infection control surveillance of residents and staff, implemented appropriate use of PPE and verified the facility quarantine protocols would be implemented as required. In addition, the facility provided staff re-education, and policies and procedures were reviewed and revised.	F 880		
F 885 SS=F	Reporting-Residents,Representatives&Families	F 885		9/29/20

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F 885	Continued From page 46 CFR(s): 483.80(g)(3)(i)-(iii) §483.80(g) COVID-19 reporting. The facility must— §483.80(g)(3) Inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. This information must— (i) Not include personally identifiable information; (ii) Include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered; and (iii) Include any cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to appropriately inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of a single confirmed infection or 3 or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other prior to and during facility's COVID-19 outbreak. That had the potential to affect the 41 residents, their families,	F 885	There were no residents affected due to not having appropriately informed residents, families, and their representatives of confirmed or suspected COVID-19. All of the residents could have been affected by not having appropriately informed residents, families, and their representatives of confirmed or suspected COVID-19.	

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F 885	Continued From page 47 and resident representatives in the facility with their right to be informed. Findings include: Interview on 9/22/20 at 9:38 a.m., with FM-B identified receiving information via automated system about a positive resident and positive staff. FM-B was told by one of the staff (unknown name), there was 36 residents and 22 staff positive and they did not have enough help. A call was placed to CA-A who reassured things were under control and confirmed that there were several positive cases but they "did not believe the results". FM-B identified he felt the facility was not being "very transparent" and gave him different information daily. FM-B was concerned for his family who was a resident, along with other residents at the facility. Review of notification documentation to families and resident representatives identified the following on: 1) 9/17/20 at 1:56 p.m. an automated notice was initiated identifying the facility provided families and representatives an automated message they received confirmation a staff member and a resident had been diagnosed with COVID-19. They encouraged families and representatives to call for updates on the status of residents. 2) 9/18/20 at 3:03 p.m., an automated notice was initiated identifying the facility provided families and representatives an automated message they received confirmation a staff member and a resident had been diagnosed with COVID-19. They encouraged families and representatives to call for updates on the status of residents. 3) 9/20/20 at 4:40 p.m., an automated notice was initiated identifying the facility provided families	F 885	The Family Support Program Policy was reviewed and updated to reflect that notification of confirmed or suspected (three suspected within 72-hour period) COVID-19 cases must be done by 5:00pm the next calendar day and that all necessary and appropriate regulatory information will be sent out in the automated message. An in-service will be performed with the leadership team to ensure that the updated policy is understood, and all have knowledge of this requirement. Auditing and monitoring will take place by the administrator or designee by tracking the timing of the communication to residents and families should a case(s) that meets the criteria set forth in above policy occur. Audits will be performed by the administrator or designee to assess the timing of a known positive case and communication with the residents and families to alert them of this fact. Audits will be conducted weekly times four weeks, then monthly times two, and when there is an identified case. Audit results will be reviewed by QAPI Committee and the scope and frequency of the audits will be adjusted according to the results.	

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and representatives an automated message they received confirmation "additional staff members and residents" had been diagnosed with COVID-19. They encouraged families and representatives to call for updates on the status of residents.
The communication lacked the extent of widespread outbreak or specific and updated data. More so, the facility had no documentation to support residents had been notified in any way to the extent of the COVID outbreak in their home.

Interview on 9/29/20 at 10:58 a.m., with consultant administrator (C)-B identified corporate had a tool for communicating with residents, families, and resident representatives to update on confirmed COVID cases, he was unaware of the exact guidance or requirement was for reporting.

Interview on 9/29/20 at 12:38 p.m., with medical director identified his expectation would be the facility followed the current guidelines identified by Centers for Medicare and Medicaid Services (CMS) to inform all residents, their representatives and families by 5:00 p.m., the next day following a single confirmed COVID-19 case and identify mitigating actions taken by the facility to prevent transmission including any alterations in normal facility operations. The facility should provide cumulative updates for residents, their representatives, and families at least weekly or by 5:00 p.m., the next calendar day following the subsequent occurrence of each time a confirmed infection of COVID-19 is identified.

No policy on reporting was provided by the end of

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: 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.	2 000		

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RIVER VALLEY HEALTH AND REHABILITATION	**200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283**

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2 000	Continued From page 1 The following complaints were found to be SUBSTANTIATED: H5237021C with deficiency cited at S1375, H5237022C with deficiency cited at S1375 and S800, and H5237023C with deficiency cited at S800. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		
2 800	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide sufficient nursing staff to ensure residents' safety and overall care and needs were maintained by ensuring scheduled medications to treat pain, blood sugar [insulin], blood thinners, blood pressure, and seizures were administered, and failed to ensure wound dressings were completed	2 800	Corrected.	9/29/20

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for 14 of 41 residents (R3, R6, R8, R14, R29, R15, R13, R33, R24, R20, R27, R12,R15, and R18). The facility also failed to ensure breakfast was provided for 17 of 38 residents (R31, R30, R5, R33, R32, R38, R28, R11, R17, R40, R7, R12, R8, R21, R25, R9, R23) between the dates of 9/19/20 and 9/23/20, and failed to ensure repositioning was completed to prevent pressure ulcers for 1 of 1 resident (R28). The facility failed to implement their emergency staffing plan to cross-train non-certified staff prior to an emergency and before performing direct care duties. This affected all 41 residents who resided in the facility and resulted in an immediate jeopardy (IJ) for all residents.

Findings include:

Interview on 9/21/20 at 9:36 a.m., with anonymous staff (AS)-B identified they were unlicensed and uncertified to provide cares, but had worked all weekend (9/19/20 through 9/20/20) caring for the residents. They had no training on how to provide direct care and felt "overwhelmed".

Interview on 9/21/20 at 10:19 a.m., with director of nursing (DON)-B identified the first COVID positive case had been from nursing assistant (NA)-D who reported on 9/15/20 she tested positive. The DON stated the facility had also been notified that a resident (R30) who had been at the emergency room for stroke symptoms and had returned a couple days prior, had been tested and was positive. The DON verified the facility was unaware R30 had been tested while at the hospital for COVID until the hospital had called on 9/15/20 to report the positive results. R30 was immediately isolated to her room following the results. The facility already had planned facility

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wide testing for 9/16/20, and positive results started coming in on Thursday afternoon 9/17/20. The DON stated positive residents were placed on isolation, positive staff were removed from the facility and everyone pitched in as the results came in.

During interview with the administrator (A) on 9/21/20 at 12:27 p.m., A stated there were no non-certified or non-licensed staff providing direct resident care. All non-certified staff helped with housekeeping, laundry, passed meal trays, and were to be the second staff during a mechanical lift transfer.

Interview on 9/21/20 at 12:32 p.m., with R26 stated there had been three staff working who "normally do not assist" her or her husband [who is in the same room] helping them. Care service was "slow", but they "thought they did get help".

Interview on 9/21/20 at 12:38 p.m., with AS-D identified they were not certified or licensed and had no training to provide direct care. AS-D had been told by consultant administrator (C)-A to "step up" and was "expected to work on the floor providing direct care to the residents". AS-D had used a mechanical lift, provided personal cares, worked "alone on the upper west wing. The residents did not get the care they needed. The residents deserve better than this". AS-D was unaware of "what she was doing" or "how to care for the residents" while working on the floor. Corporate had been told staff "need help as residents were not getting cared for. Half of the residents did not get breakfast today. Today had been the best staffing the facility has had for days".

Interview on 9/21/20 at 1:10 p.m., dietary director

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(DD) identified seventeen residents missed their breakfast this morning. DD provided list of residents who did not get breakfast. Those residents included 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 several times. There had not been two staff

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utilized during transfer and running the lift. No documentation was recorded as AS-B was unaware of how to document cares in electronic medical record. AS-B started working on the floor with the residents on 9/18/20, after the consulting administrator-CA-(A) told uncertified staff they had to work the floor. Staff advised the CA-A they did not "feel comfortable or safe" and had been instructed they "had to care for the residents so they did not get an IJ (immediate jeopardy) tag".

Interview on 9/21/20 at 2:58 p.m., AS-C identified they were to be the second person for mechanical lift transfers. They had to assist a couple residents with a gait belt to walk to the bathroom but could not remember who they were or if they were able to be transferred safely in that manner. AS-C assisted residents to eat including last evening on 9/20/20. AS-C had no training in feeding residents or ambulating residents. AS-C worked 9/19/20 and 9/20/20, and would ask others how to "do stuff" to see if it was "something they could do". Staff were told by CA-A they had to "step up and do more" on Friday 9/18/20. AS-C felt "unsafe after helping a resident walk with a gait belt" so they would not do it anymore. "There is not enough staff here to care for the residents. Some residents did not get care, they wait for long times, some are not getting to bed timely. One resident looked like she had not checked before bed at all she as she had crusted bowel dried on her and was incontinent this morning (R4)". AS-C identified they had "no medical background" however, ""this morning R30 had felt warm so she told the nurse who "did not have time" to check R30. AS-C checked R30's temperature and her forehead "seemed okay". When the thermometer was over R30's neck, it registered 102.2. AS-C told the unidentified nurse. AS-C was advised "all

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residents are warm and that was not a good place to check a temperature".

R30's progress notes dated 9/21/20 at 19:54 (7:54 p.m.) identified R30 had been lethargic this shift. Temperature 103.6 Tylenol suppository administered and effective temperature decreased to 98.4. There lacked any documentation that a temperature had been checked or monitored during the morning shift.

Interview on 9/21/20 at 3:58 p.m., with AS-A identified the facility needed "to shut down or send our resident someplace else in order to be cared for". There were residents who "did not eat this morning.... these residents needed assistance to eat and we just do not have enough staff to help with this". The facility had the" activity director and human resources staff working the floor doing everything a nursing assistant would do...use lifts, feed residents and provide cares and we still do not have enough staff to provide appropriate cares. Nurses have had to pass medication for all residents and medications have been given late or not at all". R32 had a low blood sugar (BS) and was given orange juice, but she did not get breakfast. There has been new skin breakdown as R28 has a "new area. We have not had time to update the doctor but did clean and apply a dressing to the wound. They have orders that they have not gotten to that are sitting on the nurses desk". They have several residents with "increased temperatures and no more oxygen's concentrators". Facility staff were using portable tanks but only "have so many of them". AS-A felt A-A and DON-B are trying to help on the floor as staff "literally cannot do it...we cannot care for the residents at this point. I would like to throw in my keys and go...we cannot provide care due to not having enough staff. Today there is no one to

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relieve us, staff did not show up at 2:00 p.m.. Corporate staff have not notified any of us on the floor that no one is coming in and we are sinking fast".

Interview on 9/22/20 at 7:56 a.m., with LPN-B identified there was no one scheduled to relieve her after her twelve hour shift that was finishing up at 10:00 a.m. that day. LPN-B was scheduled to be back in eight hours at 6:00 p.m., for another twelve hour shift. "The residents are not getting cared for appropriately, no one here is getting showed, rooms are dirty, residents smell, we do not have enough staff. The two day shift girls came in at 4:00 a.m., so they could start to get residents up so they did not miss breakfast for not being up anyway's. There is not enough staff to get everyone up on time to eat and not enough staff to assist the residents who need help to eat. Management just tells us they are working on it and to do the best you can".

Interview on 9/22/20 at 10:00 a.m., with C-A identified there are no competencies for training for the uncertified or unlicensed staff that are working on the floor.

Interview on 9/22/20 at 9:38 a.m., with FM-B identified receiving information via automated system about a positive resident and positive staff. FM-B was told by one of the staff (unknown name), there was 36 residents and 22 staff positive and they did not have enough help. A call was placed to CA-A who reassured things were under control and confirmed that there were several positive cases but they "did not believe the results". FM-B identified he felt the facility was not being "very transparent" and gave him different information daily. FM-B was concerned for his family who was a resident, along with other

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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 screened. She reported she did not have a temperature but did have a headache, dry cough

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and noticed some wheezing when breathing out, and also body aches. LPN-C was unaware of facility protocol and let NA-D work regardless of her having symptoms. LPN-C advised NA-D she was aware of residents on the upper west wing having temperatures between 99.0 and 99.7 with no changes being made like isolation to their room. NA-D worked the shift Monday (9/14/20) night into Tuesday. In the morning she left work and reported she "slept a little". NA-D had body aches and a temperature of 101.5 degrees F, and decided to go to the local clinic on 9/15/20. Her test came back positive on 9/15/20, and she notified the facility right away. NA-D identified there was a new admission, R11 who was diagnosed with C-diff. He was in a room alone but staff did not have to gown to go in the only thing staff had to do is change their mask. There were other residents identified with loose stools, and facility nursing staff were notified. No new interventions were placed. "It is hard to get information from management about what is happening and the staff are overworked".

Observation on 9/23/20 at 11:21 p.m., of R28 identified they were laying in bed, had oxygen on, covers off, bed is in lowest position, was awake, coughing and pulling at their oxygen tubing. R28 had not been dressed for the day and was unkempt.

Observation on 9/23/20 at 12:03 p.m., of registered nurse (RN)-E identified they carried a meal tray into R28 room and told R28 it was time to eat. R28 was laying twisted slightly to the left side. RN-B raised head of bed, and attempted to assist with noon meal which R28 was observed to eat poorly. RN-E lowered bed to floor and left room at 12:32 p.m. with R28 remaining in same position. At 12:35 p.m. RN-E walked by R28's

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room again and shut the door. At no time did RN-E attempt to reposition R28 during the observation. There was no documentation to support R28 had been repositioned in any way that day. Continuous observations identified no staff had entered R28's room by 2:22 p.m. to reposition R28.

Interview on 9/23/20 at 12:56 p.m., with trained medication aid (TMA)-B identified the nurse usually does the dressing changes and was unaware R28 had any wound dressings.

Observation and interview on 9/23/20 at 1:00 p.m., with RN-E while reviewing R15's physician orders for Aspart insulin 10 units subcutaneous before meals. There was no insulin pen in the medication cart. RN-E had not administered R15's insulin yet that day. RN-E went to retrieve R15's insulin from the medication room, and returned with insulin pen for R15. She waited for staff currently in R15's room to finish laying R15 down. RN-E entered the room at 1:44 p.m., to administer R15 their insulin that was due earlier that morning prior to lunch. RN-E confirmed insulin was late and should have been given within thirty minutes of the noon meal.

Observation on 9/23/20 at 1:51 p.m., RN-E verified R32 ate noon meal and she is to get 7 units of Novolog for meal coverage. At 1:54 p.m., prior to administration, R32's insulin pen was noted not to have an open or expired date labeled on the pen. RN-E disposed and obtained a new insulin pen. RN-E confirmed R32's insulin was also late.

Observation on 9/23/20 at 2:12 p.m., RN-E preparing to give R29 her Lispro 2 units of insulin with meals and sliding scale for blood sugar of

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2 800	Continued From page 11 155. The insulin pen did not have an open date or expired date identified RN-E disposed and obtained a new insulin pen. RN-E confirmed insulin was late and should have been given within thirty minutes of the noon meal. Observation on 9/23/20 at 2:18 p.m., RN-E preparing R14's Humalog 24 units subcutaneous with meals, with no labeled open date identified. RN-E disposed and obtained new insulin. RN-E confirmed R14's insulin was late being administered. Observation and interview on 9/23/20 at 2:26 p.m. with nursing assistant (NA)-C identified she thought RN-E had possibly repositioned R28 at noon but was unsure. R28 was observed to still have head of bed elevated approximately 75 degrees and was still positioned on her back with body slightly twisted to left. TMA-B entered R28's room after being advised by the surveyor R28 had not been repositioned timely. TMA-B assisted R28 to the side to check her for incontinence at that time. R28 was observed to be soiled with bowel. R28 had a bandage in left gluteal fold that was soiled with bowel and had drainage saturated through an area approximately an inch in diameter. TMA-B called for the nurse to come. RN-E entered R28's room and identified R28 had left gluteal unstageable wound that was overall 4.8 centimeters (cm) x 3.5 cm including the dark reddened boarders. The actual open area within measured 1.5 cm x 2.4 cm and also within that was an area was a hardened spot measuring 1 cm x 2 cm. RN-E identified the areas were new pressure ulcers not previously known for R28. RN-E described an open coccyx wound that measured 0.5 cm x 0.9 cm and two open wounds on her right buttocks the proximal measured 0.5 cm x 0.8 cm x 0.1 cm and the distal measured	2 800		

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0.4 cm x 0.6 cm. RN-E cleansed, applied dressing and planned to notify the doctor. R28 was noted to moan during the wound treatment. Staff repositioned R28 on her right side with RN-E instructing staff she should be repositioned hourly. RN-E identified she would also be updating hospice for an air mattress and notifying the family. RN-E confirmed that resident should have been repositioned when new areas of pressure were identified. Any time skin breakdown was observed direct care staff, they were to notify the nurse to assess, notify doctor, get wound orders, place resident on wound rounds, complete a Braden skin assessment, begin skin assessments, and notify family.

Review of R28's progress notes dated 9/23/20 at 4:11 p.m., identified the R28's primary doctor was left a message that R28 had four pressure ulcers. At 4:21 p.m., R28's son was updated that R28 had four pressure sores on her bottom with family requesting the facility keep her comfortable.

Review of R28's weekly skin inspection dated 8/21/20, identified that R28 had new 3 cm x 1 cm area on her right left gluteus that was slightly open and a chronic problem. Wound care was to evaluate and treat on 8/26/20. There was no drainage noted at that time. R28 would sit in her wheelchair and wheel herself around all day. A skin inspection note dated 8/28/20, identified R28 had a chronic left buttocks wounds, that were not open. A standard barrier cream was to be applied. There was no mention of the new open area in her gluteal fold. Review of R28's assessment records found no pressure wound evaluation from 8/28/20 to 9/23/20.

R28's current, undated care plan identified R28 had potential for skin breakdown related to

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2 800	Continued From page 13 infrequent self-mobility or repositioning and incontinence. Interventions included having a foam covering on wheelchair frame where foot peddles attach, geri-sleeves to help protect arms and hands, monitor red area under left breast every shift, pressure reducing cushion in wheelchair and in recliner, pressure reducing mattress when she chooses to use bed, turn and reposition every 2-3 hours, with weekly skin observations by licensed nurse. There was no mention R28's care plan had ever been updated to identify the need for more frequent repositioning related to her health or history. Review of the Medication Administration and Treatment Administration records identified R15, R36, R12, R22, R13, R8, R23, R24, R27, R3, R20, R6, R18, R39, R19, R14, R33, R38, R29 had not received medications timely or at all, on varied dates and times from 9/18/20 through 9/25/20. Of those administration records the following critical medications were not received or administered such as insulin for R14, R29, R15, R13, heart medications were not administered for R20, R3, R27, R13, R12, R15, R6, nutritional supplements R22, R8, R33, R38, seizure medication for R29, pain medication for R33, R8, R24, R3, R6, and blood thinners for R20, R27, R13. There were also multiple other medications that were not administered as ordered during this time frame. Additionally, R18 did not receive a wound dressing change as scheduled. Interview on 9/29/20 at 10:58 a.m., with C-B identified the facility reached out to the MDH telling them we did not have enough staff and we needed help. MDH advised the facility was to staff according to the residents needs. If residents needs were unable to be met, the facility was to transfer residents to a number they could provide	2 800		

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care for. We attempted to get staff into work as soon as possible. The C-B confirmed the contingency staffing plan and emergency staffing plan had not been fully implemented and non-certified staff should not have worked the floor. C-B also confirmed there had been residents who missed breakfast due to short staffing. All residents were to be provided three meals a day with no more than 14 hours between the evening meal and breakfast the next day. He would expect medications to be given and treatments completed as ordered by the physician. He would expect staffing levels to meet the needs of the residents to ensure repositioning of residents at risk for skin breakdown or and repositioning completed. C-B identified the Quality Assurance Performance Improvement (QAPI) committee should have provided oversight to ensure a plan was in place in case of a COVID or other infectious disease outbreak. It was the overall responsibility of the administrator to ensure residents receive the care and services they require.

Interview on 9/29/20 at 12:38 p.m., with medical director (MD) identified his expectation would be that the facility had adequate staffing to ensure basic care needs are being met such as personal hygiene, repositioning, meals provided to residents, and residents who require assistance with meals receive that assistance. Further, the MD would expect enough staffing to ensure medications are timely and given. The MD confirmed the facility should not have had non-certified or non-licensed staff providing direct care to the residents. The facility should have followed their contingency staffing plan and staff should not have provided direct care without any training. He was notified about the immediate jeopardy situation and care was compromised at

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the facility, however, was not made aware of any concerns or issues before the immediate jeopardy. The facility was discharging some residents to a sister facility to reduce census to manageable level. The MD expected the facility notify him of the inability to provide care to residents.

Review of the 9/2012, Meal times policy identified the facility was to serve meals no more than 14 hours between the evening meal of one day and the breakfast meal of the next day.

Review of the July 2017, Prevention of Pressure Ulcers/Injuries policy identified assessing the resident for existing pressure ulcer upon admission and for risk factors, repeat the assessment weekly and upon any changes in condition. Reposition residents as indicated on the care plan. Staff were to provide preventative interventions, monitor, evaluate and document potential changes in the skin and review interventions and strategies for effectiveness on an ongoing basis.

Review of the 9/3/20, Emergency Staffing policy identified the facility was to give competent, conscientious, and consistent quality care to each resident 24 hours per day. Nursing, laundry, culinary, and maintenance departments must be adequately staffed and therefore, it may be necessary to stay on duty until replacements could report for duty. If more staff were needed, the designee person in charge of the facility will contact the corporate office to contact sister facilities in the company for staff assistance. Critical staffing shortages during an emergency had the potential to result in staff injury or illness and post-traumatic stress. In order to prepare for potential staffing shortages, licensed and

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2 800	Continued From page 16 unlicensed personnel and volunteers were to be recruited and trained for emergency assistance. The facility was not to engage in non-credentialed or untrained volunteers for direct resident care. Review of the 8/26/20, Long-Term Care Contingency Staffing Plan policy identified a training plan to cross-train staff to fulfill different roles in case the primary staff responsible for a given function was not available. In emergency situations, direct care would be performed by facility staff, then the corporate float pool, outside agencies, and lastly via cross-trained staff from other departments. Quality of care was deemed the highest practicable level of care to meet the needs of residents with proactive steps to have been taken before a crisis occurs to minimize the risk of crisis staffing. SUGGESTED METHOD OF CORRECTION: The administrator, DON or designee should ensure adequate policy and programs are developed for sufficient staffing based on the resident population to staffing availability so residents received safe, adequate and timely assistance with toileting, bathing, repositioning, pressure ulcer care, and eating assistance during a COVID-19 outbreak or like emerging infectious disease. The facility should educate staff on these policies and perform audits of resident care to ensure residents are receiving care and services with adequate staffing. The facility should report the findings of these audits to the quality assurance performance improvement (QAPI) committee for further recommendations to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one	2 800		

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2 800	Continued From page 17 (21) days.	2 800		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow Centers for Disease Control (CDC) and Centers for Medicare and Medicaid Services (CMS) guidelines for COVID-19 to prevent or minimize the transmission of COVID-19 which resulted in an ongoing facility outbreak when 31 of 41 residents (R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R14, R15, R6, R17, R18, R19, R12, R21, R22, R23, R24, R27, R28, R20, R30, R31, R32, R33, R34, R35, R36, R38, R38, R39, R40, R42, and R42) whom had COVID-19 symptoms. As a result of this, 39 of 41 residents tested positive for COVID-19. The facility's failures resulted in an immediate jeopardy (IJ) situation for all residents. Findings include: SURVEILLANCE Interview on 9/21/20 at 9:15 a.m., with NA-B identified none of the 17 residents who admitted from a local nursing home that closed, were quarantined upon admission and staff did not wear gowns when providing care. NA-B was unaware if any residents had symptoms of	21375	Corrected.	9/29/20

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COVID.

Continued interview on 9/22/20 at 9:50 a.m., with nursing assistant (NA)-B identified a month or so ago, there was one resident whom had C. Diff (severe intestinal infection) was quarantined when they admitted from a local nursing home that closed. No other residents admitted from the facility were placed on quarantine for COVID-19, and staff were not instructed to don a gown in addition to using standard PPE precautions to provide care. NA-B also reported that a month ago the entire west wing of the facility had diarrhea. There were no precautions implemented during that time. NA-B was unaware if any residents had COVID symptoms in the facility.

Interview on 9/21/20 at 2:00 p.m., with licensed practical nurse (LPN)-A identified none of the 17 residents were placed on precautions/quarantine when they were admitted from a local nursing home that closed and were admitted to their facility. LPN-A was unaware if any residents had symptoms of COVID prior to the facility outbreak on 9/16/20.

Review of July 2020, August 2020, and September 2020, Infection Prevention Surveillance documentation only identified infections treated with antibiotics. There was no documentation of potential COVID-19 symptoms or other symptoms prior to the first identified positive COVID tests on 9/16/20.

CDC defines symptoms of COVID-19 to include but not limited to Fever, either 100.4 or subjective, cough, shortness of breath, headache, new loss of taste or smell, congestion or runny nose, sore throat, diarrhea, myalgia

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21375	Continued From page 19 (muscle aches, body aches), tiredness or fatigue Review of resident's electronic medical records (EMRs) identified the following: R1's nurse notes identified on 7/9/20, R1 admitted to the facility from the local facility that closed. The notes made no mention R1 was quarantined R1's vital sign report identified on 7/26/20, R1's temperature was 99.0 degrees Fahrenheit (F) and on 8/20/20, R1's temperature was 99.1 (F). Between 8/4/20, and 9/7/20, R1 also complained of intermittent explosive loose stools for several days. On 9/17/20, R1 tested positive for COVID. R1's July through September 2020, nurse notes made no mention R1 was quarantined upon admission or when potential COVID symptoms occurred. There was no mention R1's provider was notified of potential symptoms of COVID. R2's nurses' notes identified R2 was admitted from a hospital. On 8/28/20, R2 admitted to the hospital and returned to the facility on 9/9/20. R2's vital sign report identified on 9/14/20, R2's temperature was 99.1 degrees F. On 9/17/20, R2 tested positive for COVID. R2's August and September 2020, nurse notes made no mention R2 was placed on isolation upon return from the hospital 14 days to mitigate potential transmission of COVID. R3's 9/2/20, nurses' notes identified R3 had a headache was feeling off, had difficulty standing, and was unresponsive to verbal cues. R3's vital sign report identified on 9/15/20, R3's temperature was 99.1 degrees F. R3's September 2020, progress notes made no mention R3 had potential symptoms of COVID-19 was placed on precautions, or whether R3's provider was notified of potential COVID	21375		

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symptoms.

R5's nurses' notes identified on 7/16/20, R5 was admitted from local facility that closed. R5's July 2020, notes made no mention precautions were implemented. R5's vital signs showed R5 had a temperature of 99.7 degrees F on 7/17/20. 99.2 on 9/22/20; and 100.2 F on 9/24/20. On 8/21/20, R5 was having loose stools. On 9/6/20, R5 had an emesis, had wet breath sounds, mumbled speech, and flaccid limbs. R5 was transported to the emergency department (ED), was admitted to the intensive care unit (ICU) with diagnoses of pneumonia, sepsis, and acute hypoxia and returned on 9/10/20. There was no indication R5 had been tested for COVID in the hospital and was not identified as being placed on precautions when he returned. On 9/12/20, R5 was congested and productive with slight yellow-tinged sputum. On 9/15/20, R5's guardian declined COVID-19 testing. The guardian was informed R5 would then be placed on quarantine and would not be allowed visitors.

R6's progress notes identified on 7/16/20, R6 was admitted from a local facility that closed. R6's vital sign report identified on 8/7/20, R6's temperature was 99.1 degrees F; and 99.3 on 9/14/20. On 9/16/20, R6 intermittently coughed up blood tinged sputum, experienced chest pain, dizziness, had productive cough with yellow sputum, shortness of breath, hoarseness, and diminished wheezy lung sounds. On 9/17/20, R6 tested positive for COVID-19. There was no indication R6 had been placed on any precautions until they were diagnosed with COVID-19.

R7's vital sign record identified R7's temperature was 99.4 degrees F on 9/8/20; 99.1 on 9/13/20 through 9/15/20; 100.6 on 9/17/20; 99.5 on

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21375	Continued From page 21 9/18/20; 99.1 on 9/20/20; and 100.6 on 9/17/20 There was no indication R12 had been placed on any precautions until they were diagnosed with COVID-19. R8's nurses' notes identified on 7/24/20, R8 admitted from a local closed facility. Between 8/21/20 through 9/9/20, R8 intermittently had symptoms of loose stools and a cough. R8's vital sign record identified between 8/11/20, and 9/14/20, R8 had intermittent elevated temperatures. On 9/20/20, R8 tested positive for COVID-19. There was no indication R7 had been placed on any precautions until they were diagnosed with COVID-19. R9's nurses' notes identified on 7/23/20, R9 admitted from a local facility that closed. There was mention R8 was placed on transmission based precautions upon admission. R11's nurses' notes identified they were admitted to the facility from a local facility that closed with diagnosis of Clostridium difficile (a contagious intestinal infections) and was placed on IC precautions. On 8/27/20, R11's precautions were discontinued and were not renewed when R11 had a temp on 9/9/20, of 99.5 degrees F. On 9/15/20, it was 99.1 degrees F. On 9/17/20, R11 tested positive for COVID-19. There was no indication R11 had been placed on any precautions until they were diagnosed with COVID-19 R12's nurses' notes identified on 7/29/20, R12 was admitted to the facility from another local facility that closed. R12's temperature was 99.5 degrees F on 9/8/20; 100.3 degrees F on 9/13/20. R5's temperatures ranged from 99.1 degrees F 102.3 degrees F on 9/14/20. On 9/15/20 R12's 101.0. R12's progress notes identified between	21375		

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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 8/21/20, 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 precautions were implemented to prevent potential transmission of COVID, and no mention R15's provider was contacted regarding potential COVID-19 symptoms. On 9/17/20, R15 tested positive for COVID-19.

R16's nurses' notes identified on 7/13/20, R16 was admitted from from a locally closed facility. R16's note made no mention R16 was quarantined to prevent potential transmission of COVID-19. On 9/17/20, R16 tested positive for COVID-19.

R17'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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9/13/20, R17 was hospitalized for increased confusion and was found to be dehydrated. R17 returned to the facility on 9/14/20. R17's notes made no mention R17 was quarantined upon identifying symptoms or when they returned from the hospital. On 9/17/20, R17 tested positive for COVID-19.

R19's nurses' notes identified on 9/11/20, R19 had a temperature of 100.8 degrees F. On 9/12/20 through 9/14/20, R19 complained of upset stomach, not feeling well, poor appetite, and wanted to see her provider. R19's notes made no mention R19 was quarantined and COVID precautions were implemented when symptoms were identified. On 9/17/20 R19 tested positive for COVID.

R22's nurses' notes identified between 8/19/20 and 9/16 20, R22 had symptoms of cough and vomiting. On 9/22/20, R20 tested positive for COVID. R22's notes made no mention he was placed on quarantine or that droplet precautions were implemented when potential COVID symptoms were identified.

R23's nurses' notes identified on 7/9/20, R23 admitted from a local facility that was closed. R23's notes made no mention R23 was quarantined at the time of admission to prevent potential transmission of COVID. Between 8/24/20, and 9/15 /20, and 9/15/20, R23 had loose stools, a red, goopy eye, allergy symptoms, cough, and elevated temperature, and crackles in her lungs. On 9/17/20, R23 tested positive for COVID. R23's notes made no mention R23 was quarantined and droplet precautions implemented to prevent potential transmission of COVID at the time potential COVID symptoms were identified.

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21375	Continued From page 24 R24's nurses' notes identified on 9/2/20, R24 admitted to the hospital with a diagnoses of pneumonia. R24 was negative for COVID. R24 continued to have a productive cough. R24's notes made no mention R24 was quarantined upon admission to prevent potential transmission of COVID. On 9/21/20, R24 tested positive for COVID. R25's nurses' notes identified on 8/18/20, R25 reported flu-like symptoms. Staff were to continue to monitor R25's symptoms. R25's progress notes made no further mention R25's symptoms were monitored, whether R25 was quarantined, and if droplet precautions were implemented to prevent potential transmission of COVID. R26's August and September 2020, nurses' notes identified between 8/17/20, to 9/2/20, R26 complained of loose stools. R26's progress notes made no further mention R26's symptoms were monitored, whether R26 was quarantined, and if droplet precautions were implemented to prevent potential transmission of COVID. R28's nurses' notes identified on 8/22/20, R28 had a large amount of phlegm she was unable to clear. R28's lung sounds had fine crackles. Between 8/22/20 and 9/6/20, R28 continued to receive as needed (PRN) medications for cough and congestion symptoms. R28's August and September, 2020, nurse notes made no mention R28's symptoms were monitored or whether R28 was placed on droplet precautions. On 9/17/20, R28 tested positive for COVID. R29's nurses' notes identified R29 was admitted from the hospital on 8/25/20. R29 was hospitalized for seizure activity on 8/31/20, and	21375		

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21375	Continued From page 25 for a second time and returned on 9/10/20. The August and September, 2020, nurse notes made no mention R29 was quarantined to prevent potential COVID Transmission upon admission to the facility or after the second hospitalization. On 9/17/20, R29 tested positive for COVID. R30's nurses' notes identified between 8/22/20 and 9/16/20, R30's had a runny nose, sore scratchy throat, and increased lethargy. On 9/11/20, R30 was not feeling well, leaning to the right side, had a temperature of 100.7, pulse rate of 99, and was transferred to the ED for evaluation. R30 returned on 9/11/20 with a diagnoses of kidney infection. R2 continued to be weak, and tested positive for COVID on 9/16/20. There was no mention R30 was placed on precautions to prevent spread of COVID. R30 tested positive for COVID on 9/26/20. R31's nurses' notes identified R31 was admitted on 7/17/20, from a local facility that recently closed.. The notes made no mention whether R31 was quarantined upon admission. On 9/17/20, R31 tested positive for COVID. R33's nurses' notes identified on 8/21/20 to 9/7/20, R33 had intermittent loose stools and was not feeling well. The notes made no mention R33 was placed on precautions when loose stools began. On 9/17/20, R33 tested positive for COVID. R34's nurses' notes identified on 7/30/20, R34 admitted to the facility on 7/30/20. Between 8/21/20 and 8/27/20, R34 reported intermittent loose stools. There was no mention R34 was placed on precautions upon admission or when loose stools began on 8/21/20. R34 tested positive for COVID.	21375		

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R35's nurses' notes identified on 7/30/20, R35 was admitted from a locally closed facility. On 8/26/20 R35 had loose stools. On 9/16/20, R35 had a productive cough, clammy skin, and was not feeling well. Staff was to continue to monitor. On 9/17/20, R35 tested positive for COVID.

R37's nurses' notes identified on 8/11/20, R37 admitted to the facility from a hospital. The July 2020, nurse notes made no mention whether R37 was placed on precautions upon admission. On 9/4/20, R37 complained of shortness of breath (SOB). On 9/5/20, R37's temperature was 100.0 degrees F. There was no mention R37 was placed on precautions upon admission or when loose stools or SOB began.

R41's July 2020, nurses' notes identified on 7/16/20, R41 admitted to the facility from a local facility that closed. The notes made no mention R41 was quarantined upon admission.

R44's nurses' notes identified on 7/22/20, R44 was admitted from a local facility that closed. On 8/8/20 through 8/9, R44 had increased productive cough. On 8/21/20, R44 had loose stools and again on 8/25/20. There was no mention R44 was quarantined or placed on transmission based precautions upon admission. On 9/18/20, R44 tested positive for COVID.

Review of the September 2020, residents' Electronic Medication Administration Documentation (EMAR)s identified staff were to record temperature, and oxygen saturations on the MAR and monitor residents for fever, chills, shortness of breath, new or a change in cough, sore throat, muscle pain, headache, new loss of taste or smell, nausea, vomiting, and diarrhea

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21375	Continued From page 27 three times daily. Additionally, staff were to document in the supplementary documentation section of the nurse notes when any of COVID symptoms were identified and update the clinical leadership, provider, and initiate droplet precautions. Interview on 9/23/20 at 4:00 p.m., with RN-C identified only infections treated with antibiotics were included in the infection control line listing. Infection documentation was monitored monthly to identify potential infection issues and was not done as daily cumulative monitoring. RN-C agreed all potential symptoms of infection should be documented on the line list as the occur and reviewed on an ongoing basis to identify potential infection outbreaks and to implement precautions as soon as possible to mitigate transmission of COVID or any infections. The infection preventionist was responsible to oversee the infection control program and provide oversight to ensure infection were identified and responded to in a timely to prevent transmission. Audits of hand hygiene and PPE use were requested. RN-C identified no competencies were documented and no audit documentation was available as evidence staff were monitored to ensure staff were using PPE appropriately. No line list of staff illness or symptoms was implemented to ensure staff were not working ill prior to the COVID outbreak. Interview on 9/29/20 at 12:38 p.m., with the medical director identified staff with symptoms should not have been allowed to work. Staff were expected to monitor residents for potential symptoms of COVID, implement droplet precautions, and notify their providers to prevent potential transmission. The medical director had a family member who transferred from the closed	21375		

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facility, and was told residents transferring from the closed facility were to be quarantined and staff to wear appropriative PPE during quarantine of newly admitted residents. Staff were expected do don gowns, gloves, N-95 masks, and eye protections when caring for residents with suspected and known COVID residents and perform and hygiene prior to leaving rooms, and before and after donning gloves.

STAFF
Review of staff screening forms and time sheets found the following on:
1) 9/16/20, licensed practical nurse (LPN)-D identified symptoms of muscle pain, headache. Nursing assistant (NA)-F identified symptoms of migraine and proceeded to work from 1:56 p.m. to 10:47 p.m., and later tested positive for COVID. The health information director (HID)-D identified symptoms of chills, muscle pain, headache and had been sick the day prior. Proceeded to work 7:32 a.m. to 8:25 a.m. ,and later tested positive for COVID. NA-G identified symptoms of headache and proceeded to work 3:28 p.m. to 9:34 p.m., and later tested positive for COVID.
2) 9/17/20, NA-G identified symptom of headache, had headache day prior also proceeded to work another shift 6:00 a.m. to 1:30 p.m., and later tested positive for COVID. NA-H identified symptoms of new/changed in cough, muscle pain, headache proceeded to work 11:07 a.m. to 2:19 p.m., and later tested positive for COVID.
3) 9/18/20, NA-O identified symptoms of new/changed cough, sore throat, and headache. NA-C identified symptom of sore throat, headache and proceeded to work 2:47 a.m. to 2:48 p.m. NA-M identified symptom of new/changed cough, muscle pain, proceeded to

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work 3:57 a.m. to 2:55 p.m., and later tested positive for COVID. RN-H identified symptom of new/changed cough proceeded to work 6:31 a.m. to 11:30 p.m. NA-N identified symptom of muscle pain, headache and proceeded to work 6:00 p.m. into 6:00 a.m. next day. NA-F who had symptoms identified on 9/16/20 proceeded to work 1:54 p.m. to 4:30 p.m., and later tested positive for COVID. HID-D who had symptoms identified on 9/16/20 proceeded to work 8:00 a.m. to 12:30 p.m., and later tested positive for COVID.
4) 9/19/20, NA-O who had symptoms identified on 9/18/20 proceeded to work the morning and night shift unspecified number of hours. NA-E identified symptom of sore throat, muscle pain and proceeded to work from 9/18/20 at 9:00 p.m. into 6:34 a.m. on 9/19/20. RN-H had symptoms identified on 9/18/20 proceeded to work 9:53 a.m. to 11:23 a.m.
5) 9/20/20, NA-N who had symptoms identified on 9/18/20 proceeded to work 3:45 p.m. to 12:02 a.m.. NA-E had symptoms identified on 9/19/20 proceeded to work 9/19/20 8:17 p.m. into 6:44 a.m. on 9/20/20. Dietary Aide (DA)-A identified symptom of chills proceeded to work 5:28 a.m. to 2:58 p.m.

Interview on 9/21/20 at 2:58 p.m., with anonymous staff (AS)-C identified they had no medical background however, R30 felt warm this morning and the nurse did not have time to check her. AS-C took her temperature and reported to the nurse that R30's temperature on her forehead seemed okay but when she held the thermometer over R30's neck it registered 102.2. The nurse advised AS-C all residents are warm and that was not a good place to check a temperature. AS-C reported R30 had been in the hospital on 9/11/20, and had a COVID test. The facility was called by the local hospital on 9/16/20, identifying R30 was

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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.

Interview on 9/22/20 at 3:55 p.m., with NA-D

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21375	Continued From page 31 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 screened. She reported she did not have a temperature but did have a headache, dry cough and noticed some wheezing when breathing out, and also body aches. LPN-C was unaware of facility protocol and let NA-D work regardless of her having symptoms. LPN-C advised NA-D she was aware of residents on the upper west wing having temperatures between 99.0 and 99.7 with no changes being made like isolation to their room. NA-D worked the shift Monday (9/14/20) night into Tuesday. In the morning she left work and reported she "slept a little". NA-D had body aches and a temperature of 101.5 degrees F, and decided to go to the local clinic on 9/15/20. Her test came back positive on 9/15/20, and she notified the facility right away. NA-D identified there was a new admission, R11 who was diagnosed with C-diff. He was in a room alone but staff did not have to gown to go in the only thing staff had to do is change their mask. There were other residents identified with loose stools, and facility nursing staff were notified. No new interventions were placed. "It is hard to get information from management about what is happening and the staff are overworked". Interview on 9/22/20 at 3:40 p.m., with RN-C identified staff were to ring the doorbell if staff was not present by the entrance door. The staff were to be screened. If symptoms were present, staff were not to be allowed to enter the facility. A nurse was to assess the staff person with symptoms to see if it is "allergies or something". If a staff had a symptom that has no explanation they are sent home. The infection control nurse	21375		

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21375	Continued From page 32 (ICP) was responsible for reviewing and monitoring the screening logs for staff. The ICP however, was currently out ill. The administrator (A)-A was doing that at this time. Interview on 9/22/20 at 4:41 p.m. with administrator (A)-A identified she does not review any screening forms however, she does file them in her office. A-A was unsure who reviewed the screening forms but believed that would be the DON's responsibility. PPE Observation on 9/23/23 at 8:45 a.m., identified registered nurse (RN)-A was in the hallway passing medications. RN-A entered resident rooms on the West wing to administer medication without wearing a gown. Without wearing a gown RN-A entered R34's room to assist with care. RN-A exited R34's room and continued to administer medications in the West wing. At 9:05 a.m., without wearing a gown, RN-A entered R23's room and administered R23's medication. R23 was COVID positive. R23's had a coarse cough and coughed with her mouth open while RN-A was stood next to her. RN-A exited the room while wearing her gloves. RN-A removed her gloves in the hallway, without performing hand hygiene, RN-A walked to a PPE cart in at the main entrance, opened the drawer and grabbed a gown. Interview with RN-A on 9/23/20 at 9:15 a.m., identified RN-A had started working at the facility this week. She had not had training yet, as she was needed on the floor immediately due to the COVID outbreak. Staff were supposed to wear a gown at all times in the facility. Only two residents were negative for COVID at the present time. RN-A verified she had not donned a gown	21375		

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when she entered the facility, and had not worn a gown while administering medications on the West wing. RN-A had not donned a gown because she forgot to do so. RN-A had training regarding PPE and hang hygiene at the time the outbreak occurred.

Review of the 9/19/20, through 9/21/20, Donning and Doffing COVID training roster identified RN-A was not included on the roster.

Interview on 9/23/20 at 3:30 p.m., with RN-C identified no documentation was found as evidence RN-A received PPE training on 9/21/20, or prior to the start of her first shift. RN-A was expected to don a gown at the start of the shift and change PPE and perform hand hygiene prior to exiting resident rooms. RN-C agreed RN-A should have received training for PPE use prior to working the floor.

The undated Corona Virus (COVID-19) policy identified staff were to be trained regarding general infection information upon hire and on an ongoing basis as needed. Training included utilization of PPE, hand hygiene, and importance of adhering to the necessary requirements.

The Infection Prevention and Control Program identified the purpose of the program was to ensure infections were detected, addressed, and prevented among residents and staff. The program included coordination and oversight, policies and procedures, surveillance, data analysis, antibiotic stewardship, outbreak management, prevention of infection and employee health. All staff were to be trained upon hire and periodically. The infection preventionist was responsible for oversight of the infection control program. Surveillance consisted of using

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tools to recognize occurrence of infections, recording the number of infections, frequency, detection of outbreaks and epidemics, monitoring employee infections and detecting unusual patterns with infection control issues. Outbreak management was a process of determine the presence of outbreak, managing affected residents, preventing spread to other residents, documenting information about the outbreak, reporting to the appropriate public health authorities, educating staff and the public, monitoring for recurrences, and recommending new or revised policies for future outbreaks. The infection preventionist was to review data to determine sporadic cases from true outbreaks.

The undated Coronavirus (COVID-19) policy identified staff were to take reasonable steps to promptly detect, triage, and isolate potentially infectious residents and prevent unnecessary exposures among residents, healthcare workers, and visitors at the facility. Staff were to monitor residents daily for potential symptoms of COVID. Symptoms included fever, chills, shortness of breath, new or change in cough, sore throat, muscle pain, headache, new loss of taste or smell, nausea, vomiting, or diarrhea. Staff were to document absence or presence of symptoms in the EMR daily. The facility was to maintain a line listing of residents with respiratory symptoms. Residents with symptoms of acute respiratory illness or suspicion of COVID according to identified symptoms were to have droplet precautions implemented. Staff were to notify providers, resident representatives, department of health, medical director, facility infection preventionist, DON, and administrator. Resident temperature, oxygen saturation, respiratory status, and other symptoms were to be monitored each shift. Staff were to perform hand hygiene

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21375	Continued From page 35 before and after all resident contact, contact with infectious material, and before and after removal of PPE, including gloves. Staff were to be screened for symptoms prior to reporting to work and actively screen for COVID symptoms and take their temperatures. If staff were ill, they were to leave the workplace. The facility was to maintain a line list of staff with identified symptoms. Staff were to leave the workplace if symptoms of respiratory infection occurred during their shift, inform the infection preventionist, contact their primary provider, and limit contact with the public as much as possible. Residents who were new admissions, had suspected COVID symptoms, or whose infection status was unknown, were to be screened for symptoms of COVID, and placed in a single room or in a separate observation area to monitor for evidence of COVID-19. Recommended PPE (gown, gloves, mask, eye protection) were to be worn during care of residents under observation. SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee should review/revise facility policies to ensure they contain all components of an infection control program, including daily cumulative tracking and trending of all illnesses in the facility, immediate implementation of droplet precautions to mitigate COVID-19 transmission, and ensure the appropriate use of PPE and prevented from working with symptoms of COVID-19 and cares are being performed appropriately and timely. The DON or designee could educate all staff on existing or revised policies and perform audits to ensure the policies are being followed. The results of those audits should be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring.	21375		

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(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 36 Time Period for Correction: Twenty-one (21) days.	21375		

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/GuidanceforRCA.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/GuidanceforRCA.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 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/GuidanceforRCA.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.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 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 Toolkithttps://www.health.state.mn.us/diseases/coronavirus/hcp/ltctoolkit.pdf 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.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 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)
https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/GuidanceforRCA.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.