Electronically delivered
December 3, 2020

Administrator
Luther Haven
1109 East Highway 7
Montevideo, MN 56265

RE: CCN: 245259
Cycle Start Date: November 16, 2020

Dear Administrator:

On November 16, 2020, a 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.

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

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective January 2, 2021.

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

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective January 2, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 2, 2021.

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.

This Department is also recommending that CMS impose:

- 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.

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.

If you have not achieved substantial compliance by January 2, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Luther Haven will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 2, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.
However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 16, 2021 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

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

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

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

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

Nursing Home Informal Dispute Process
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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

Feel free to contact me if you have questions.

Sincerely,

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 3, 2020

Administrator
Luther Haven
1109 East Highway 7
Montevideo, MN 56265

Re: Event ID: N2XQ11

Dear Administrator:

The above facility survey was completed on November 16, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

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

DIRECTED PLAN OF CORRECTION

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

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.

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.

In accordance with 42 CFR § 488.402(f), the DPOC remedy is effective 15 calendar days from the date of the enforcement letter. The DPOC may be completed before or after that date. A revisit will not be approved prior to receipt of documentation confirming the DPOC was completed. To successfully complete the DPOC, the facility must provide all of the following documentation identified in the chart below.

Documentation must be uploaded as attachments through ePOC to ensure you have completed this remedy.

Imposition of this DPOC does not replace the requirement that the facility must submit a complete POC

for all cited deficiencies (including F880) within 10 days after receipt of the Form CMS 2567.

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

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00062	A. BUILDING: _____ B. WING _____	C 11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER HAVEN	1109 EAST HIGHWAY 7 MONTEVIDEO, MN 56265

(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
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 11/12/20 through 11/16/20, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be IN compliance with the MN State Licensure. The following complaints were found to be SUBSTANTIATED: H5259018C and H5259019C.	2 000		

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

Electronically Signed | 12/11/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00062	A. BUILDING: _____ B. WING _____	C 11/16/2020

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2 000	Continued From page 1 However, NO licensing orders were issued. The following complaints was found to be UNSUBSTANTIATED: H5259020C. 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245259	A. BUILDING _____ B. WING _____	C 11/16/2020

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LUTHER HAVEN	**1109 EAST HIGHWAY 7 MONTEVIDEO, MN 56265**

(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 on 11/12/20 through 11/16/20, at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.73(b)(6). The facility is 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. Although no plan of correction is required, it is required the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 11/12/20 through 11/16/20, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found NOT to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5259018C and H5259019C with a deficiency cited at F689. The following complaints was found to be UNSUBSTANTIATED: H5259020C. Additionally, a COVID-19 Focused Infection Control survey was also conducted at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was determined NOT to be in compliance. The facility's plan of correction (POC) will serve	F 000		

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

Electronically Signed | 12/11/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	Continued From page 1 as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess, monitor, and intervene to prevent the elopement or potential future elopment for 2 of 3 residents (R1 and R2). Findings include: R1's face sheet identified R1 was admission date to facility as 8/4/20, and diagnoses, included dementia without behavioral disturbance, mild	F 689	R-1 was returned to the facility safely and placed on 15-minute checks. A window stop was placed on their window to limit how far the window could crank out. R-2 was returned to the facility safely and placed on 15-minute checks. R-2's primary contact was notified. R-2 was transferred to Meeker County behavioral health on 6/2/2020. Employees received on the spot training following these incidents. All charts were audited for	12/23/20

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LUTHER HAVEN	**1109 EAST HIGHWAY 7 MONTEVIDEO, MN 56265**

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F 689	Continued From page 2 cognitive impairment, hypertension, and Type 2 diabetes. R1's admission Minimum Data Set (MDS) assessment identified he was admitted in August, 2020. R1 had moderate cognitive impairment, adequate vision and hearing, clear speech, understands and was understood. R1 required extensive assistance of one staff for bed mobility, transfers, ambulation and toileting. R1 had no behaviors, no wandering, and no rejection of care during the assessment period. Review of the 11/6/20, State Agency (SA) report filed identified R1's daughter called the facility indicating her brother in-law thought he had seen R1 walking towards a Subway restaurant. Facility staff completed a search and found R1's screen off and his window wide open in R1's room. The social worker was immediately notified who then notified the police. R1 was found with his daughter near McDonalds safe and unharmed. The facility staff, police and family discussed R1 returning to facility. R1 insisted on going to the Running's store and daughter agreed to take R1 there before giving R1 a ride back to facility. Once back at facility R1 was placed on fifteen minute checks as well as window checks. R1's 8/11/20, elopement assessment identified R1 had moderately impaired-decision poor, and required cues and supervision. The section that addressed mobility had been left blank. R1 had been noted to exhibit the following behaviors, such as removing safety devices, his WanderGuard, and tabs alarm. R1 had a recent move to facility with a diagnosis of dementia. Activities were identified as interventions, although specific activities were not listed. R1	F 689	elopement assessment and care plans. All were updated and are current. Residents will be assessed for elopement risk upon admission, quarterly, annually, and as needed. Elopement risk will be addressed on care plan as the risk assessment is completed. This will be completed by the social worker or designee. The Director of Nursing or designee will be responsible for continued monitoring to ensure compliance. Audit of elopement risk assessment and care plan will be completed weekly X4 and monthly thereafter. Results of audit will be reviewed at QAPI meeting. Education will be provided to employees by 12/23/2020.	

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was identified not to be an elopement risk. The preventative actions taken had been noted as wearing a clothing labeled with identification, and a photograph had been posted. Staff noted they initiated measures on R1's care plan. An additional note was added to indicate R1's family was concerned about possible elopement.

R1's progress notes identified on 8/25/20 at 8:31 a.m., R1 had refused treatments and meals and had made verbal threats he was going home and he "did not care what the doctor said". On 9/4/20, R1 had wandered out into the courtyard by himself, and told staff he was looking for his wife and a "way out of there". Staff was able to redirect R1 back into the facility. On 9/12/20, R1 came to desk and reported he had stuck his head out the window and finally got enough air to wake up.

There was no elopement assessment documented after R1 made attempts or threats of elopement beginning on 8/25/20.

R1's care plan was revised on 11/12/20, following R1's elopement on 11/6/20, to indicate R1 was an elopement risk, related to successful elopement and staff were to distract R1 from wandering by offering pleasant diversions such as an activity, food, conversation, television, or a book. Staff were to redirect R1 as necessary. The window cranks were removed from R1's room but stored in medication room to open if needed. There was no documentation to support R1's prior working care plan had interventions placed as noted in the 8/11/20 elopment assessment or from R1's 8/25/20 elopement attempt, to prevent R1 from eloping prior to the revision.

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Interview on 11/12/20 at 8:43 a.m., with activity director (AD) identified R1 was confused and had dementia. The day he left the building (11/6/20), we found his window screen under his bed and his window wide open. The AD identified R1 previously had a WanderGuard on but he would not leave that on, therefore it was discontinued.

Interview on 11/12/20 at 9:38 with family member (FM)-A identified there was a concern when R1 first moved there as he joked about going out the window with family however, unsure if facility knew he made those comments. FM-A was unaware if any interventions had been implemented prior to R1 leaving the building but after the elopement R1 had been placed on safety checks and his window cranks had been removed.

R2's face sheet identified R2 was admitted in May 2020, with diagnoses of dementia with behavioral disturbance, generalized anxiety, compression fracture of the lower back, hypertension, and weakness.

R2's admission Minimum Data Set (MDS) assessment dated 5/19/20, indicated R2 had moderate cognitive impairment, inattention, disorganized thinking, physical and verbal behaviors, supervision for activities of daily living (ADL's), no wandering noted during assessment period.

R2's 5/12/20, progress note identified on admission, R2 refused to enter facility. The medical doctor assessed with success in getting R2 into the building. Later that day additional note identified R2 was out in hallway, propelling self in wheelchair, wanting to go home, and was

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refusing to stay in her room. R2 had been "screaming she wanted to go home". On 5/13/20, R2 walked out into hallway and was attempting to go home, but staff able to redirect her back to her room. On 5/27/20, R2 exited the north hall door at the west end of facility. The door did not lock down but the alarm had sounded. R2 continued to want to go outside and would ask staff when someone would be coming pick her up. R2 was reported as angry and wanted staff to give her ride to her house.

R2's 5/19/20, elopement assessment identified the assessment lacked a complete assessment. Portions were left blank, including cognitive patterns, mobility status, behaviors, events such as changes in medication, history of leaving facility, recent move to facility, recent room/roommate change, wandering in past 60 days, other diagnoses, and interventions. Staff had identified R2 was accurately assessed and R2 was identified at risk as R2 was only able to make simple decisions. Social services was to continue to provide support as needed and complete assessments quarterly.

Review of the 5/27/20, State Agency (SA) report identified R2 had diagnosis of dementia and had exited the door at end of north hall on station one. R2 does have a roam alert that did not activate the lock down on the door, but the silent alarm on the door did activate on the staff pagers. R2 was easily redirected back into the facility and was safe. R2 was placed on fifteen minute checks and a maintenance slip filled out to check the system. There was no mention how staff determined R1 was safe to be off 15 minute checks, or whether the MD was notified and asked to assist the facility with appropriate interventions.

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Following elopement on 5/27/20, R2's care plan was revised on 5/28/20, to indicate R2 was an elopement risk related to wandering aimlessly, impaired cognition, and impaired safety awareness. Staff were to check R2's location every shift/hour/thirty minutes/fifteen minutes. Staff were to distract R2 from wondering by offering pleasant diversions such as an activity, food, conversation, television or book. Staff were to redirect R2 if necessary, approach R2 from the front, and speak to R2 in calm, reassuring manner. R2 to wear wander guard to left ankle at all times. There was no documentation to support R2's prior initial care plan had interventions placed as the elopement assessment had been incomplete.

Interview on 11/12/20 at 10:58 a.m., with the licensed practical nurse (LPN)-A identified if a resident had a behavior or would exit the building like into the courtyard now that it is not secured the nurse would call the social worker or email her if she was not in the building. The nurse would also implement intervention to address the concern and complete an event report. LPN-A made no mention of reporting attempted elopements or verbal claims of potential elopement to the director of nursing or other management.

Interview on 11/12/20 at 11:03, with the licensed social worker (LSW) identified when an event is reported to her she would complete a elopement assessment. LSW identified that the facility had previously tried to place a WanderGuard on R1 as family had been worried because R1 did not want to be here but R1 kept getting the WanderGuard off. After the second time, the

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interdisciplinary team (IDT) discussed it and decided since he had not attempted to leave and it had been causing agitation, it would not be placed on his person again. The LSW confirmed there had been no documentation the WanderGuard had been tried, or that R1 had removed more than one time, or that the IDT team had met and discussed the situation again to ensure interventions were appropriate. LSW confirmed the progress notes identified R1 had wandered out into courtyard on 9/4/20. The LSW verified the courtyard had not been enclosed at that time related to the family window visits. LSW identified staff should have notified her or the director of nursing (DON) regarding the incident. The LSW confirmed the intervention put into place on 11/6/20 to keep R1 safe had been fifteen minute checks and removal of R1's window cranks on 11/10/20, stating "I guess we just didn't think of taking them off on Friday", immediately after R1 returned to the facility. LSW confirmed R2's elopement assessment identified a risk for elopement but lacked documented interventions on R2's care plan until after R2's elopement event on 5/27/20. The LSW agreed, following the assessment and identified risk, the care plan should be updated and interventions implemented to prevent elopement.

Interview on 11/12/20 at 12:56 p.m., with the DON identified care plans' should identify residents at risk for elopement upon admission, quarterly, with a significant change or been revised as needed and appropriate interventions implemented. Staff were to notify her and the nurse manager of elopement attempts and an event report should have be completed. The DON would expect if an elopement risk had been identified through an assessment or by a nursing progress note, an

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F 689	Continued From page 8 assessment would be performed and the care plan would be updated to include the risk with interventions identified. Review of the 4/5/16, Elopement Policy, identified the goal to ensure the safety of residents at the facility Staff were to attempt to prevent a resident from leaving if observed, and staff may ask for assistance from another staff, instruct staff to alert the charge nurse. Social services was to complete elopement observation and assessment on all new admissions, then annually, quarterly and with significant changes for residents who are at risk. Upon return of the resident after an elopement, staff are to check for injuries, and report the elopement to the DON, legal representative, and primary MD. Staff were to complete an elopement event, make a notation in medical record, place an electronic roam alert on resident if able, and enter new orders into medical record. The policy failed to mention if a resident reported verbal remarks of potential elopement, a new assessment should occur, and failed to identify a process to ensure the process was audited to ensure appropriate interventions had been placed into residents care plans, with those interventions being implemented.	F 689		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		1/21/21

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F 880	Continued From page 9 §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 (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	F 880		

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F 880	Continued From page 10 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 interview and document review, the facility failed to follow Centers for Disease Control (CDC) guidance for Healthcare Personnel (HCP) to return to work following confirmed or suspected symptoms of COVID-19 for 11 nurse aides (NA-A, NA-B, NA-C, NA-D, NA-E, NA-F, NA-G, NA-H, NA-I, NA-J and NA-K), 4 licensed practical nurse (LPN-B, LPN-C, LPN-D, and LPN-E), 1 registered nurse (RN)-B, and 2 laundry aides (LA-A, LA-B) of 18 total staff reviewed. the facility also failed to implement active daily cumulative surveillance to monitor, track and trend signs and symptoms of suspected or potential COVID-19 or other infections for all 72 residents that currently resided in the facility. Finding include: SCREENING/RETURN TO WORK	F 880	Tracking and trending infection control program The corrective action for the residents affected includes updating surveillance and infection control outbreak policy. All residents in the facility are potentially affected and the facility will conduct rounds, audits, and monitoring to assure compliance is met. Policies/Procedures/System Changes The root cause analysis (RCA) was addressed at the 1/12/21 QAPI meeting. The facility will conduct a RCA once the infection control consultant starts with the facility. A planning meeting with Pathways is scheduled for 1/13/2021 to begin this process. The Covid and Respiratory Illness Policy has been updated to ensure better	

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F 880	Continued From page 11 Review of the current CDC guidance on health care personnel (HCP) returning to work, https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html, identified HCP with symptoms of COVID-19 should be prioritized for viral testing with approved nucleic acid or antigen detection assays. For HCP who were suspected of having COVID-19 and had it ruled out, either with at least one negative test or a clinical decision that COVID-19 is not suspected and testing is not indicated, then return to work decisions should be based on their other suspected or confirmed diagnoses. Symptom-based strategy for determining when HCP can return to work. HCP with mild to moderate illness who are not severely Immunocompromised may return to work at least 10 days have passed since symptoms first appeared and at least 24 hours have passed since last fever without the use of fever-reducing medications and symptoms (e.g., cough, shortness of breath) have improved. HCP who are not severely Immunocompromised and were asymptomatic throughout their infection may return to work when at least 10 days have passed since the date of their first positive viral diagnostic test Review of monthly staff Calloff Reports that identified employee illness for August 2020 through November 2020 identified in: August 2020 1. NA-J had called into work with potential symptoms of COVID-19 reporting diarrhea on 8/16/20. NA-J then returned to work on 8/20/20, 4 days later. 2. NA-A had called into work with potential symptoms of COVID-19 reporting vomiting, nausea, and diarrhea on 8/30/20. NA-A then returned to work on 9/4/20, 5 days later.	F 880	surveillance. The employee illness tracking form has been updated and initiated. The resident illness tracking form has been updated. The Infection Preventionist or designee will review these forms daily to ensure they are being completed and analyzed for trends/outbreaks. The facility will conduct facility rounds to ensure employees are using PPE appropriately and to ensure infection control practices are being followed appropriately. Monitoring will continue until the criteria established by the IP Consultant is met. Any unexpected increase in infections will be reported to the Medical Director, Public Health, and MDH. Updating will occur per current guidelines. Facility rounds will be initiated by 1/21/2021. The IP, DON or Designee will conduct daily rounds starting by 1/21/2021 and will make changes based upon recommendations from the Infection Control Consultant. Training and Education The facility will provide training for the Infection Preventionist, Director of Nursing, Nurse Managers and the Administrator. The training will be the CDC training as outlined in the DPOC. Training will be provided to the Infection Preventionist and all employees regarding active screening. The training that will be utilized will be the CDC training found in the DPOC. The training will be completed by 1/21/2021.	

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F 880	Continued From page 12 September 2020 1. NA-B had called into work with potential symptom of COVID-19 no details documented on 9/11/20. NA-B then returned to work on 9/18/20 7 days later. 2. NA-C had called into work with potential symptoms of COVID-19 reporting diarrhea on 9/23/20 and 9/24/20. NA-C then returned to work on 9/26/20 2 days later. 3. LPN-B had called into work with potential symptoms of COVID-19 reporting cough and shortness of breath on 9/25/20. LPN-B then returned to work on 9/28/20 3 days later. 4. NA-E had called into work with potential symptoms of COVID-19 reporting headache, sore throat on 9/29/20. NA-E then returned to work on 10/2/20 three days later. 5. LPN-C had called into work with potential symptoms of COVID-19 reporting headache and diarrhea on 9/30/20. LPN-C then returned to work on 9/24/20 one day later. October 2020: 1. NA-C had called into work with potential symptom of COVID-19 reporting diarrhea, nausea, sore throat, and coughing on 10/2/20. NA-C then returned to work 10/5/20 three days later. 2. LPN-D had called into work with potential symptoms of COVID-19 reporting cough and headache on 10/8/20. LPN-D then returned to work 10/13/20 five days later. 3. LPN-E had called into work with potential symptom of COVID-19 reporting body aches and sore throat on 10/16/20. LPN-E then returned to work on 10/19/20 three days later. 4. NA-F had called into work with potential symptom of COVID-19 reporting extremely sore throat on 10/19/20. NA-F then returned to work on 10/20/20 the next day.	F 880	Monitor and Auditing The Infection Preventionist, DON, or designee will conduct audits of the tracking/trending logs to analyze the data and communicate any unexpected increases in infection. The results of these audits will be reviewed at QAPI by the Infection Preventionist, DON, or designee. The Infection Preventionist, DON, and other leadership members will conduct audits on all shifts. It will start with 4x/week and progress to bi-weekly until 100% compliance is achieved to ensure active screening is being completed. The results will be reviewed at QAPI by the IP, DON, or designee. The audits, logs and monitoring will be in place by 1/21/2021. Active Screening All residents had the potential of being affected by this deficient practice. All employees, visitors, and vendors will be actively screened as they enter the facility as directed in the DPOC. The facility will conduct vital signs checks twice daily and observe for symptoms every shift. The Covid and Respiratory Illness Policy and resident tracking have been updated and if a resident has one or symptoms they will be placed into transmission based precautions. The facility has implemented procedures, policies and forms for active screening.	

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F 880	Continued From page 13 5. NA-H had called into work with with potential symptom of COVID-19 reporting sore throat, tired, and cough on 10/20/20. NA-H then returned to work on 10/23/20 three days later. 6. NA-G had called into work with with potential symptom of COVID-19 reporting low grade temperature, sore throat, and cough on 10/21/20. NA-G then returned to work on 10/27/20 six days later. 7. LA-A had called into work with potential symptom of COVID-19 reporting sore throat, slight fever, and cough on 10/22/20. LA-A then returned to work on 10/30/20 eight days later. 8. RN-B had called into work with potential symptom of COVID-19 reporting fever and body aches on 10/26/20. RN-B then returned to work on 10/30/20 four days later. 9. NA-I had called into work with potential symptom of COVID-19 reporting stomach issues and body aches on 10/30/20. NA-I then returned to work on 11/2/20 three days later. November 2020: 1. LA-B had called into work with potential symptom of COVID-19 reporting sore throat, temperature of 100.5, and diarrhea on 11/10/20. LA-B then returned to work on 11/11/20 one day later. 2. NA-K had called into work with potential symptom of COVID-19 reporting sore throat and fever on 11/11/20. NA-K then returned to work on 11/14/20 three days later. There was no indication the facility followed CDC guidance on returning to work for the above staff after potential signs and symptoms of COVID-19 were identified. Interview on 11/16/20 at 11:56 a.m., with DON identified for staff call-ins how long they are out	F 880		

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	245259	A. BUILDING _____ B. WING _____	C 11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER HAVEN	**1109 EAST HIGHWAY 7 MONTEVIDEO, MN 56265**

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for depended on their symptoms. She would attempt to clarify symptoms to make sure they truly had symptoms and would check to see if they had two symptoms before they stayed home unless they had a fever then they stayed home for sure. DON confirmed staff should stay home if they have symptoms for fourteen days but there are staff that may have not been off work for the recommended time frame. DON further, confirmed she had just not had time to document the infections on the line list or complete all the infection event review as there just was not enough hours in a day

SURVEILLANCE

Review of infection control surveillance identified the facility used two types of documentation to monitor and track infections for residents and staff, the Event Summary Report and The Monthly Surveillance Line List Form.
1) Review of the Monthly Surveillance Line list revealed that the facility had not tracked any infections since February 2020. The facility used a computer system identified as Calloff Report that was used as part of the Monthly Surveillance Line list to log employee call-ins that included date and time called in, notice given, employee name, shift, department, and reason for call-in. Further review of the employee Calloff reports identified that the facility had a scabies (skin mite) outbreak as there were 3 days in August that 13 different staff had called in identifying being treated for scabies. There was no tracking and trending completed or correlation between staff and resident illnesses including the scabies outbreak in August.
2) Review of infection Event Summary Reports, from February 2020 through October 2020

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F 880	Continued From page 15 revealed a lack of active surveillance as the following had been identified. In: April 2020, 3 of 8 reports had not been reviewed, evaluated, and closed. May 2020, 4 of 10 reports had not been reviewed, evaluated, and closed. June 2020, 1 of 8 reports had not been reviewed, evaluated, and closed. July 2020, 3 of 8 reports had not been reviewed, evaluated, and closed. August 2020, 4 of 11 had not been reviewed, evaluated, and closed. September 2020, none of the 14 infection event reports were reviewed, evaluated, or closed. October 2020, none of the 15 infection event reports were reviewed, evaluated, or closed. Interview on 11/13/20 at 2:00 p.m., with director of nursing (DON) who was also the infection preventionist in the facility identified she was responsible for the IC surveillance program. She was to review all infection events in the computer system including those the nurse potentially entered, and make an evaluation note before closing the report. She was to document infections with the details on the line list as a tracking tool and to monitor for trends. The DON confirmed there had been no documentation since February 2020, on the line list for tracking and trending infections as she had not had time to devote to the IP program. She confirmed she had not consistently reviewed, evaluated and infection event reports on the computer system documented by nursing staff. The DON revealed the surveillance process had not been appropriately completed since the onset of the national COVID-19 pandemic. DON confirmed that the facility went through a scabies event in August, one staff and one resident had been	F 880		

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diagnosed with possible scabies. We had a lot of staff call in during that time worried about getting scabies or having scabies. DON reported it had been discussed at the Quality Assurance Performance Improvement (QAPI) meeting even though there had been no documentation of the event in the minutes.

Interview on 11/16/20 at 9:15 a.m., with RN-C identified one night in August the facility treated all of the residents and staff for scabies with all the linens being bagged and washed. Staff had to monitor residents for rashes and they were treated if needed, the facility also completed a follow up treatment on everyone again the next week.

Review of Quality Assurance Performance Improvement (QAPI) meeting minutes for July 2020 identified no infection tracking or trending had been discussed. August 2020, QAPI meeting minutes identified infection control data reviewed at that meeting included COVID-19 positive cases and testing information, the presence of resident urinary tract infections and an update of the influenza vaccination. There was no documentation the August scabies outbreak had been discussed or a summary for infection surveillance for tracking and trending was monitored, or that QAPI had been advised of the DON's inability to perform her IP duties appropriately after February.

Interview on 11/16/20 at 1:52 p.m., with administrator (A) identified the expectation would be that infections for both residents and staff are documented for tracking and identifying trends. The A was aware the DON was unable to perform her IP duties since February 20202, but made no

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comment on why he had not intervened to assist the DON with help with the IP program. he felt other staff were also to busy to assist with the IP role. The confirmed if staff had symptoms of COVID-19 that they should be quarantining for 10 to 14 days and be symptom free before returning to work. The A was unaware staff had not followed CDC guidance on employees returning to work after signs and symptoms of COVID-19.

Review of the 3/15/20, Suspected (or Confirmed) Coronavirus (COVID-19) Outbreak policy, identified employees with symptoms of respiratory infection and fever higher than 100.4 degrees should not report to work. If an employee had sore throat or cough, and no temperature they would be asked to wear a mask while at work. There was no mention in the policy staff should immediately report the illness and leave the facility. The policy lacked current CDC guidance for health care providers and had the potential to expose all 72 residents to ill workers.

Review of the 8/25/17, Infection Control policy, identified the purpose was to prevent the development and transmission of disease and infection. Staff should be providing surveillance, investigation and monitoring infection to prevent, as much as possible, the onset and spread of an infection. The surveillance data system was a way to identify infection, reduce the risk of transmission, and control outbreaks. The process was to evaluate environmental controls and enforce proper infection control practices. There was no indication the facility had reviewed or revised the policy with input from the medical director to ensure the most current IC guidelines from the CDC and CMS were used.