DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 21, 2022

Administrator
The Estates At Lynnhurst LLC
471 Lynnhurst Avenue West
Saint Paul, MN 55104

RE: CCN: 245394
Cycle Start Date: January 25, 2022

Dear Administrator:

On February 8, 2022, we notified you a remedy was imposed. On April 3, 2022 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of March 16, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective February 23, 2022 be discontinued as of March 16, 2022. (42 CFR 488.417 (b))

However, as we notified you in our letter of February 8, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from February 23, 2022. This does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 28, 2022

Administrator
The Estates At Lynnhurst LLC
471 Lynnhurst Avenue West
Saint Paul, MN 55104

RE: CCN: 245394
Cycle Start Date: January 25, 2022

Dear Administrator:

On February 8, 2022, we informed you of imposed enforcement remedies.

On March 16, 2022, the Minnesota Department of Health completed a revisit and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

The deficiency not corrected is as follows:

F0609 -- S/S: D -- 483.12(c)(1)(4) -- Reporting Of Alleged Violations

As a result of the revisit findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective February 23, 2022, will remain in effect.

This Department continues to recommend 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 February 23, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 23, 2022.

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.

As we notified you in our letter of February 8, 2022, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from February 23, 2022.

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.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

DEPARTMENT CONTACT

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

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota. 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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 July 25, 2022 (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

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/ 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.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245394	A. BUILDING _____ B. WING _____	R-C 03/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT LYNNHURST LLC	471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104

(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 No Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, CFR §483.73, deficiencies were noted at the time of the COVID-19 Focused Infection Control survey exited on 1/25/22.	{E 000}		
{F 000}	INITIAL COMMENTS On 3/15/22, to 3/16/22, an onsite revisit was conducted to follow up on deficiencies related to a standard abbreviated survey exited 1/25/22. The facility was found NOT to be in compliance with the requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. The following tag was recited: F609. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	{F 000}		
{F 609} SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or	{F 609}		3/16/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/29/2022

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245394	A. BUILDING _____ B. WING _____	R-C 03/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT LYNNHURST LLC	471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104

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{F 609}	Continued From page 1 mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report to the State Agency (SA) and the facility administrator an allegation of sexual abuse, no later than two (2) hours after knowledge of the allegation of abuse for 1 of 3 residents (R 1) reviewed for timely reporting of abuse and neglect. Findings include: R1's annual Minimum Data Set (MDS) dated 2/24/22, identified R1 had diagnoses which included, Parkinson's and unspecified mood disorder. MDS indicated R1 had severe cognitive impairment and required extensive assistance	{F 609}	Facility submitted OHFC report on 3/8/2022 for R1 and initiated investigation immediately upon Administrator becoming aware of the allegation of abuse. All allegations of abuse and neglect will be reported to the State Agency immediately, no later than 2 hours after knowledge of abuse and neglect. The facility completed resident interviews to ensure no abuse/neglect. The facility completed skin assessments on some residents who were not able to answer questions of abuse/neglect. No abuse/neglect was identified.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245394	A. BUILDING _____ B. WING _____	R-C 03/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT LYNNHURST LLC	471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104

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{F 609}	Continued From page 2 with activities of daily living (ADL's) for transfers, bed mobility, and toileting. R1's care plan revised 3/7/22, revealed R1 was at risk for decreased cognitive and physical abilities related to diagnoses of unspecified mood disorder and Parkinsonism (Parkinson's). R1's care plan identified he was a vulnerable adult and directed staff to be aware of statements or signs/symptoms of abuse and if they were present, to update MD, director of nursing (DON), and administrator immediately. The facility SA report dated 3/8/22, at 1:50 p.m. identified R1 had made reference of a sexual relationship with a female staff member to the facility mental health technician (MHT). The facility SA report identified, at an unknown time on the evening of 3/7/22, MHT, spoke with R1 regarding the alleged relationship and revealed R1 made reference to a sexual relationship with the unnamed staff member. The report identified MHT had not reported the alleged sexual abuse to the facility leadership until the following day, over 12 hours after knowledge of the allegation. On 3/16/22, at 8:42 a.m. during an an interview, MHT confirmed she had been made aware of R1's allegation of sexual abuse on 3/7/22, in the evening. The MHT stated she reported the allegation of sexual abuse to the float licensed social worker (LSW) on 3/8/22, at 12:40 p.m., over 12 hours after she was first notified of the incident. The MHT confirmed all allegations of sexual abuse were expected to be reported immediately to the administrator. On 3/16/22, at 8:55 a.m. during an interview, LSW confirmed MHT had made her aware of the	{F 609}	Staff education initiated on facilities Abuse Prohibition/Vulnerable Adult Plan specific to timely reporting of abuse and neglect. Mental Health Tech received 1:1 verbal education regarding facilities Abuse Prohibition/Vulnerable Adult Plan and boundaries education. Facility will complete 5 staff members Abuse & Reporting Quizzes weekly for 4 weeks, monthly for 3 months and PRN based on audit findings. Facility will completed an audit of all OHFC reports specific to timely reporting weekly for 4 weeks, monthly for 3 months and PRN based on audit findings. Facility will review with QAPI to determine if any adjustments are needed. Administrator/Designee is responsible party.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245394	A. BUILDING _____ B. WING _____	R-C 03/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT LYNNHURST LLC	471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104

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{F 609}	Continued From page 3	{F 609}		

sexual abuse allegation on 3/8/22, at 12:40 p.m. and indicated she reported the allegation to the administrator immediately after being made aware. The LSW verified R1's allegation of sexual abuse was not reported to the SA within the required 2 hour time frame.

On 3/16/22, at 9:10 a.m. during an interview the facility administrator confirmed R1's allegation of sexual abuse was not reported to the SA within the 2 hour time frame. The administrator indicated once they had been notified of R1's allegation, the report was submitted to the SA an hour later on 3/8/22, at 1:50 p.m, over 12 hours hours after staff had been made aware of the allegation. The administrator confirmed she had not been notified of R1's allegation of sexual abuse immediately, and had expected to be notified within the 2 hour timeframe.

The facility policy titled, Abuse Prohibition/ Vulnerable Plan revised 8/21, identified once discovered, to report to MDH (Minnesota Department of Health) as follows: Notify MDH immediately after discovery of incident. Suspected abuse was to be reported to the Office of Health Facility Complaints (OHFC) no later than 2 hours after forming the suspicion of neglect, exploitation, or misappropriation of resident property must be reported to OHFC no later than 2 hours if the incident resulted in serious bodily injury. The nurse must immediately assess the situation and protect the resident from possible subsequent incidents while the matter was being investigated. The policy further identified when a vulnerable adult allegation was suspected it should have been reported immediately to the following: immediate supervisor and the administrator.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245394	A. BUILDING _____ B. WING _____	R-C 03/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT LYNNHURST LLC	**471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104**

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DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 28, 2022

Administrator
The Estates At Lynnhurst LLC
471 Lynnhurst Avenue West
Saint Paul, MN 55104

Re: Reinspection Results
Event ID: 1OOO12

Dear Administrator:

On March 16, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of state licensing orders found on the survey completed on January 25, 2022. At this time, the state licensing correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00945	A. BUILDING: _____ B. WING _____	R-C 03/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT LYNNHURST LLC	471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104

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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: On 3/15/22, to 3/16/22, an onsite revisit was completed to follow up on licensing orders issued from the survey exited 1/25/22. The correction order issued at #1390 was corrected. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first	{2 000}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00945	A. BUILDING: _____ B. WING _____	R-C 03/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT LYNNHURST LLC	471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104

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{2 000}	Continued From page 1 page of the CMS-2567 form. Although no plan of correction is required, the facility must acknowledge receipt of the electronic documents.	{2 000}		

Electronically Submitted
February 8, 2022

Administrator
The Estates At Lynnhurst LLC
471 Lynnhurst Avenue West
Saint Paul, MN 55104

RE: CCN: 245394
Cycle Start Date: January 25, 2022

Dear Administrator:

On January 25, 2022, survey was completed at your facility by the Minnesota Department of Health and Public Safety 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 January 25, 2022, the situation of immediate jeopardy to potential health and safety cited at F880 and F886 was removed. However, continued non-compliance remains at the lower scope and severity of F.

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 February 23, 2022.

- 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 February 23, 2022 (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 23, 2022, (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 $11,292; 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 February 23, 2022. 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" and/ or "E" tag), i.e., the plan of correction should be directed to:

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota. 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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 July 25, 2022 (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,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245394	A. BUILDING _____ B. WING _____	C 01/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT LYNNHURST LLC	**471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104**

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E 000	Initial Comments On 1/20/22, to 1/25/22, COVID-19 Focused Infection Control survey was conducted at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.73(b)(6). The facility was found to be 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, the facility must acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 1/19/22, to 1/25/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be UNSUBSTANTIATED: H5394145C (MN00080140), H5394143C (MN00080167), H5394144C (MN00080141) The following complaint was found to be SUBSTANTIATED: H5394146C (MN00080259), with a deficiency cited at F880. In addition, on 1/20/22, to 1/25/22, a COVID-19 Focused Infection Control survey was conducted at your facility by the Minnesota Department of Health to determine compliance with §483.73 Infection Control. The facility was determined to be NOT in compliance. The survey resulted in an Immediate Jeopardy	F 000		

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

Electronically Signed | 02/17/2022

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

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F 000	Continued From page 1 (IJ) at F880 when the facility failed to failed to properly implement appropriate isolation and transmission-based precautions on the second floor secured unit, for R11 and R14. In addition, the facility failed to implement proper use of PPE during a COVID outbreak to prevent further spread of COVID-19. The IJ began on 1/21/22, and the immediacy was removed on 1/25/22. The survey resulted in an Immediate Jeopardy (IJ) at F886 when the facility failed to complete outbreak COVID-19 testing of all staff per Centers for Medicare and Medicaid Services (CMS) guidelines during a COVID-19 outbreak which began on 1/8/22. The IJ began on 1/8/22, and the immediacy was removed on 1/25/22. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or	F 609		2/22/22

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F 609	Continued From page 2 mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report to the State Agency (SA) and the administrator an allegation of sexual abuse, no later than 2 hours after knowledge of the allegation of abuse, for 1 of 3 residents (R1) reviewed for abuse. Findings include: R1's Admission Record dated 1/12/22, identified R1 was recently admitted and had diagnoses which included panic disorder, obsessive compulsive disorder and obstructive pulmonary disease.	F 609	OHFC report was filed on 1/12/22 at 12:37am for R1. Education on facility Abuse Prohibition/Vulnerable adult plan, which includes timely reporting, was immediately provided to CNA and Nurse involved verbally. Other residents were interviewed at the time of the OHFC being filed and no abuse, neglect or exploitation was noted. Facility policy and procedure, Abuse Prohibition/ Vulnerable adult plan remains current. Staff education has been initiated and	

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F 609	Continued From page 3 R1's Progress Notes were reviewed for 1/12/22, and lacked documention of the incident between R1 and R2. Review of the Facility Incident Review and Analysis report dated 1/12/22, identified at 3 a.m. NA- F witnessed R2 inappropriately touching R1 between her legs during the night shift while R2 was visiting R1 in her room. After further review the report indicated staff had been educated on timely reporting of incidents. Review of the Nursing Home Incident Report #345730, submitted to the SA, identified a resident to resident altercation occurred when NA-F had reported to the director of nursing (DON) during an interview on 1/12/22, at 11:45 a.m. R2 had inappropriately touched R1 while she sat on her bed in her room. NA-F stated she proceeded to ask R2 to leave R1's room and R1 had become upset with her. The report identified the allegation of sexual abuse occurred on 1/12/22, at 3:00 a.m. and was reported to the SA on 1/12/22, at 12:37 p.m. over 9 hours and 37 minutes later after the incident had occurred and staff had failed to report the allegation of abuse until later in the day on 1/12/22, at 11:45 a.m. during a interview with the DON. On 1/20/21, at 3:24 p.m. the director of nursing (DON) indicated she became aware of R1's report of abuse at approximately 11:45 a.m.. on 1/12/22, during an interview with NA-F. The DON verified NA-F had not reported the allegation of abuse to the nurse immediately after it had occurred. The DON confirmed the allegation of abuse had not been reported to the AS within two hours of the allegation of abuse occurring, however was reported as soon as NA-F reported	F 609	remains on-going regarding facility policy and procedure as it relates to Abuse Prohibition and Vulnerable Adult Plan specific to timely reporting. The facility will complete audits of all OHFC reports weekly for 4 weeks, then monthly for 3 months, then PRN based on audit findings. Results will be shared with facility QAPI committee for input on the need to increase, decrease, or discontinue audits. Administrator/Designee will be responsible party. Date of Completion: 2/22/2022	

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F 609	Continued From page 4	F 609		

it to her. The DON indicated NA-F was provided education on reporting and RN-C was given education on timely reporting to the SA.

On 1/20/22, at 10:30 a.m. the administrator confirmed she had been notified of the allegation of abuse on 1/12/22, at 9 or 10 a.m. in the morning. The administrator indicated NA-F who was on duty at the time of the incident had reported the allegation to the charge nurse immediately, however, the charge nurse did not submit a report to the AS when NA-F informed her of the incident. The administrator confirmed the allegation of abuse had not been reported to the AS within 2 hours of the incident occurring and it should have been. The administrator indicated NA-F and RN-C were both educated on timely reporting. The administrator stated her expectation would be for staff to report all allegations of abuse within two hours to the state agency.

The facility policy titled, Abuse Prohibition/Vulnerable Adult Plan revised 8/21, identified once discovered, report to the MDH (Minnesota Department of Health) as follows: Notify MDH immediately after discovery of incident,. Suspected abuse was to be reported to Office of Health Facility Complaints (OHFC) no later than 2 hrs after forming the suspicion of abuse, suspicion of neglect, exploitation, or misappropriation of resident property must be reported to OHFC no later than 2 hours if the incident resulted in serious bodily injury. The nurse must immediately assess the situation and protect the resident from possible subsequent incidents while the matter was being investigated. The policy further identified when a vulnerable adult allegation was suspected it should have

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F 609	Continued From page 5 been reported immediately to the following: immediate supervisor and the administrator.	F 609		
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 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;	F 880		2/22/22

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F 880	Continued From page 6 (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 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 implement appropriate isolation and transmission based precautions on the second floor secured unit for 2 of 2 residents (R11 and R14) who were positive for COVID-19. In addition, the facility failed to implement proper use of personal protective equipment (PPE) per	F 880	All residents have the potential to be affected by the facility failing to implement appropriate isolation and transmission-based precautions for COVID-19 positive residents. All residents have the potential to be	

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F 880	Continued From page 7 Centers for Disease Control and Prevention (CDC) CDC to prevent and/or minimize further spread of COVID-19. Further, the facility failed to provide appropriative cleaning of bathrooms between resident use during a COVID-19 outbreak. This deficient practice resulted in an immediate jeopardy (IJ) which had the potential to affect all 51 residents, staff, family, and visitors in the facility. The immediate jeopardy began on 1/20/22, when appropriate infection control practices to isolate/quarantine residents and proper use of personal protective equipment (PPE) were not implemented to reduce the spread of COVID-19 in the facility The administrator, associate administrator(AA), director of nursing (DON), regional director of operations (RDO), regional nurse consultant (RNC) were notified of the immediate jeopardy at 5:10 p.m. on 1/21/22. The immediate jeopardy was removed on 1/25/22, at 1:00 p.m. when the facility implemented interventions to ensure residents and all staff were educated on proper isolation precautions and proper use of PPE. However, noncompliance remained at the lower pattern scope and severity level F, which indicated no actual harm with potential for more than minimal harm that was not immediate jeopardy. Findings include: Review of R11, R14, R6, R24, R22, R17, R18, R19, R20, R21, R23, R18 and R4's COVID-19 lab results revealed the following: R11's Simple Laboratories test resulted dated 1/19/22, indicated R11 was positive for COVID 19.	F 880	affected by the facility failing to implement proper use of personal protective equipment (PPE) per CDC to prevent and/or minimize further spread of COVID-19. All residents have the potential to be affected be affected by the facility failing to provide appropriate cleaning of bathrooms between resident use during COVID-19 outbreak. Immediate corrective action: COVID-19 positive residents were immediately placed in transmission-based precautions and room changes were completed to ensure COVID-19 positive residents were not sharing a room or bathroom with COVID-19 negative residents. Staff working were immediately educated on proper use of PPE and competency was completed to ensure staff are wearing appropriate PPE along with resident wearing appropriate PPE and being redirected. Action as it applies to others: The facilities policy Coronavirus (COVID-19) has been reviewed and remains current. The policy has specifics related to proper isolation of COVID-19 positive residents, redirecting of residents to their room who are COVID-19 positive, and all residents are wearing appropriate surgical masks, and appropriate PPE usage including donning/doffing and N95 use. Staff education has been initiated and	

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F 880	Continued From page 8 R14's Simple Laboratories test resulted dated 1/15/22, indicated R14 was positive for COVID 19. R6's Simple Laboratories test resulted dated 1/12/22, indicated R6 was positive for COVID 19. R24's Simple Laboratories test resulted dated 1/15/22, indicated R24 was positive for COVID 19. R22's Simple Laboratories test resulted dated 1/19/22, indicated R22 was positive for COVID 19. R17's Simple Laboratories test resulted dated 1/19/22, indicated R17 was positive for COVID 19. R19's Simple Laboratories test resulted dated 1/19/22, indicated R19 was positive for COVID 19. R20's Simple Laboratories test resulted dated 1/19/22, indicated R20 was positive for COVID 19. R21's Simple Laboratories test resulted dated 1/19/22, indicated R21 was positive for COVID 19. R13's Simple Laboratories test resulted dated 1/12/22, indicated R13 was positive for COVID 19. R23's Simple Laboratories test resulted dated 1/19/22, indicated R23 was positive for COVID 19. R18's Simple Laboratories test resulted dated 1/12/22, indicated R18 was positive for COVID 19. R4's Simple Laboratories test resulted dated 1/15/22, indicated R4 was positive for COVID 19. CDC guidance, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, identified the facility must	F 880	remains on-going regarding Coronavirus (COVID-19) policy regarding appropriate PPE usage including donning/doffing, N95 fit testing, proper isolation of COVID-19 positive residents, redirecting of residents to their rooms who are COVID-19 positive, encourage residents to wear surgical masks and practice proper hand hygiene. Staff will be educated prior to the start of their next scheduled shift and will not provide direct care until they are educated. Staff who are on leave, on-call staff and/or are not frequently in the facility will be mailed an education packet and/or verbal education via phone will be completed. Recurrence will be prevented by: Audits of 5 staff will be conducted on all shifts four times a week for one week, then twice weekly for one week once compliance is met to ensure facility staff are appropriately wearing PPE including with precautions/isolation residents and non-precaution/isolated residents. This is specific to donning and doffing of PPE including appropriate use of N95 and removing PPE appropriately within the room. Audit of all rooms will be conducted on all shifts four times a week for one week, then twice weekly for one week once compliance is met to ensure COVID-19 positive residents are not rooming with COVID-19 negative residents. This includes the use of shared bathrooms.	

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F 880	Continued From page 9 sustain core IPC practices and remain vigilant for SARS-CoV-2 infection among residents and healthcare professionals in order to prevent spread and protect residents and HCP from severe infections, hospitalizations, and death, which included: Recommended infection prevention and control (IPC) practices when caring for a patient with suspected or confirmed SARS-CoV-2 infection, identified the following guidelines: -residents with symptoms of COVID-19 (even before results of diagnostic testing) and asymptomatic patients who have met the criteria for Transmission-Based Precautions (quarantine) based on close contact with someone with SARS-CoV-2 infection. -residents should NOT be cohorted with patients with confirmed SARS-CoV-2 infection unless they are confirmed to have SARS-CoV-2 infection through testing. Ideally, a resident with suspected SARS-CoV-2 infection should be moved to a single-person room with a private bathroom while test results are pending. - healthcare personnel (HCP) who enter the room of a resident with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a approved N95 or equivalent or higher-level respirator, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face). On 1/20/22, at 10:44 a.m. during an observation, several residents on the secured unit were seated out in the dining room area with two staff members completing activities on the secured	F 880	The correction will be monitored by: Director of Nursing/ Infection Preventionist/ Designee	

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unit. R11, who had tested positive for COVID-19 on 1/19/22, was seated at the end of the dining room area sitting alone wearing a surgical mask over his face and was sleeping. R15 who was COVID-19 negative entered the dining room area without a facemask on and sat down in a chair to watch TV. The two activity staff that were in the area were not observed directing R15 to place a mask on his face or redirecting R11 back to his room.

- at 10:54 a.m., R17 who had tested positive for COVID-19 on 1/19//22, had a sign on his door which indicated R17 was in droplet isolation precautions (used for diseases or pathogens including COVID-19 that can spread in tiny droplets caused by coughing or sneezing). Nursing assistant (NA)-E was observed to have a N95 mask on, with a surgical mask over it and a face shield covering his face. NA-E donned a disposable gown, gloves and entered R17's room while licensed practical nurse (LPN)-F who was in the hallway closed the door behind him. NA-E opened R17's door, had removed his gown and gloves. NA-E stood in the door way, removed his surgical mask, disposed of it in in the room, sanitized his hands while exiting the room into the hallway and left his N95 mask on.

- at 10:56 a.m., LPN-F obtained a disposable gown out of a plastic bin in the hallway, walked down to the nurses station, obtained a N95 mask, removed her eye protection and surgical mask. LPN-F proceeded to donn her N95 mask over her nose and mouth, applied a surgical mask over her N95 mask, placed her eye protection back on and walked down the hallway to R14's room. R14 who had tested positive for COVID-19 on 1/15/22, had a sign present on her doorway which

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indicated R14 was in droplet isolation precautions. R14 came out of her room with a surgical mask on her face while LPN-F donned a disposable gown and directed R14 her back to her room. LPN-F proceeded to glove her hands and entered R14's room.

- at 11:13 a.m., R14 exited her room wearing her surgical mask below her nose, walked down the hallway past NA-E and NA-E directed R14 to adjust her mask up. R14 complied and proceeded to walk by several residents and staff in the hallway. NA-E did not re-direct R14 back to her room. LPN-F exited R14's room wearing her eye protection and N95 mask, walked up to the nurses station, placed paper towels on nursing station counter and gloved her hands. LPN-F and NA-E removed their N95 masks, cleaned their eye protection and donned new N95 masks. R14 walked by LPN-F wearing a surgical mask below her nose, LPN-F directed her to adjust her mask up due to R14 pulling it down, R14 complied while walking down the hallway back towards her room.

- at 11:29 a.m., R11 remained sleeping in the dining room and several residents continued to participate in activities while two staff members were present. No staff were observed to redirect R11 back to his room even though he was COVID 19 positive.

- at 11:34 a.m., LPN-A was observed wearing a N95 mask with a surgical mask donned over the N95 mask and had eye protection on. LPN-A proceeded to donn a gown, gloves prior to entering R6 and R22's room with medications. R6 who had tested positive for COVID-19 on 1/12/22, and R22 who had tested positive for

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COVID-19 on 1/19/22, had a sign present on their doorway which indicated R6 and R22 were in droplet isolation precautions.

- at 11:47 a.m., LPN-A exited R6's and R22's room, had removed her gown and gloves and continued to wear her surgical mask over her N95 mask with her eye protection in place. LPN-A entered the bathroom down the hallway, removed her surgical mask and was not observed to removed her N95 mask. LPN-A walked over to her medication cart wearing the same N95 mask, when R7 who was negative for COVID-19 wheeled up to her in his wheel chair and requested a glass of water. LPN-A handed R7 a glass of water and R7 proceeded to pull down his mask and drank the water. LPN-A continued to wear the same N95 mask while she was working COVID-19 positive residents.

- at 12:00 p.m., LPN-A continued to stand by her medication cart reviewing the computer, when R8 who was negative for COVID-19 approached her and began to visit with her. LPN-A continued to wear the same N95 mask.

- at 12:04 p.m., R9 who was negative for COVID-19 wheeled out of his room up to LPN-A's medication cart and requested a pain pill. LPN-A dispensed pain medication, handed R9 the medication and he took it independently with water. LPN-A continued to wear the same N95 mask.

- at 12:12 p.m., LPN-A delivered meals to R9's and R10's room who was negative for COVID-19, while continuing to wear the same N95 mask.

- at 12:14 p.m., LPN-A set up medications at her

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cart, walked down the hallway and entered R26's and R27's room with medications in hand, who were known to be negative for COVID-19. LPN-A continued to wear the same N95 mask.

-at 12:16 p.m., NA-E had a face shield on, N95 mask and donned a surgical mask over his N95 mask. NA-E proceeded to donn a disposable gown, gloves, while registered nurse (RN)-A had eye protection on, a N95 mask on and surgical mask over her N95 mask and began to donn a disposable gown and gloves. R11, who had tested positive for COVID-19 on 1/19/22, and R12 who was negative for COVID-19 had a sign present on their doorway which indicated R11 and R12 were in droplet isolation precautions. NA-E entered the room with a food tray, delivered it to R12 and the DON handed NA-E another room tray to R11. NA-E removed his gown, gloves, sanitized his hands, removed surgical mask, sanitized his hands and exited the room and continued to have the same N95 mask on and face shield.

- at 12:21 p.m., R14 who had tested positive for COVID-19 on 1/15/22, and R24 who had tested positive for COVID-19 on 1/15/22, had a sign present on their doorway which indicated R14 and R24 were in droplet isolation precautions. RN-A entered R14's and R24's room with a room tray, delivered it and the DON handed RN-A another room tray and she delivered it. NA-E donned a surgical mask over the same N95 mask, a disposable gown, gloves and entered R17's room who had tested positive for COVID-19 on 1/19/22, and R2's room who was negative for COVID-19 while carrying a room tray. NA-E delivered the tray to R17 and the DON handed another room tray for R2. NA-E set the

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room tray on R2's bed side table and closed the door.

- at 12:26 p.m. NA-E exited R17's and R2's room wearing the same N95 mask, walked down the hallway to the bathroom next to the nurse station and washed his hands. NA-E donned a surgical mask over his N95 mask, donned a disposable gown, gloves and walked down the hallway to assist other staff to deliver more room trays to COVID-19 residents.

- at 2:05 p.m., contracted agency staff (CAS)-A was in the hallway with a supply cart, completing COVID-19 testing for residents. CAS-A was wearing a disposable gown, gloves, eye protection and a N95 mask over a surgical mask. R11 who had tested positive for COVID-19 on 1/19/22, wheeled himself out of his room into the hallway. CAS-A performed a nasal swab COVID-19 test on R11 while in the hallway. There were no other residents or staff in the vicinity.

CAS-A removed her gloves, filled out the paperwork, used a wipe to sanitize her hands and applied a new pair of gloves. CAS-A entered R11's room, asked R11's roommate R12 to complete a COVID-19 test and R12 refused. CAS-A did not remove her gown and N95 after completing COVID-19 testing on R11, who was known to be positive for COVID-19, prior to attempting the test on R12 who was COVID-19 negative. CAS-A indicated she completed testing for the facility two times a week for residents and staff.

- at 2:52 p.m., CAS-A was observed while wearing a disposable gown, gloves, a N95 mask over her surgical surgical mask and had eye

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protection, to enter R16's room, CAS-A was wearing the same PPE she wore while testing R11. CAS-A attempted to swab R16, and she refused who was negative for COVID-19.

CAS-A stated she had been fit tested years ago for proper N95 mask use, however had not been recently. CAS-A said she had entered the facility with the surgical mask and just placed her N95 mask over it. CAS-A confirmed she mistakenly tested R11, who was known to be COVID-19 positive, and stated she should have changed her PPE after testing R11. CAS-A verified she continued to test other residents while wearing the same gown, surgical mask and N95 mask. CAS-A indicated she had not received any training on infection control practices and was not fit tested for her N95 mask. CAS-A verified other residents were at risk of transmitting the virus to non COVID-19 patients when proper infection control measures were not followed.

On 1/21/22, at 7:39 a.m., R11 tested positive for COVID-19 on 1/19/22, R12 and R15's were negative for COVID-19 shared bathroom was observed. After the toilet was heard being flushed, R11 was observed to be pulling up his incontinent brief from around his thighs.

- at 8:03 a.m., R11 exited his room independently in his wheelchair, DON attempted to redirect R11 back to his room and he refused. DON assisted R11 by placing a mask on his face and walked away. R11 pulled his surgical mask down below his chin and wheeled passed LPN-A and RN-B towards the dining room area and they did not redirect R11 back to his room. R11 wheeled himself further down the hallway and while passing RN-A who did not redirect him back to his

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room however, did ask him to readjust his mask up and R11 complied.

- at 8:10 a.m. R11 entered the dining room where several other residents were seated and DON directed R11 to go to the other side of the dining room.

- at 8:12 a.m. R11's mask was again noted to be positioned below his nose and noted only over his mouth, and DON asked R11 to readjust his mask however did not attempt to redirect him back to his room. RN-A brought R11 a cup of coffee to drink, while other residents remained in the dining room area. RN-A did not attempt to redirect R11 back to his room.

- at 8:18 a.m. R15 who was negative for COVID-19 without a facemask on, walked independently out of his room and down the entire length of the hallway passing by several staff who did not re-direct him to put a facemask on or return to his room. R15 entered the dining room area where the DON asked R15 to eat in his room. R15 refused and proceeded to sit down in a chair in the dining room area and drank coffee while R11 was eating his breakfast. Regional nurse consultant (RNC) asked R15 to wear a mask and R15 refused saying "I never wore a mask in my life".

- at 8:24 a.m. R15 continued to sit in the dining room area while drinking his coffee approximately 20 feet from R11 as he continued to eat his breakfast independently.

- at 8:25 a.m. R15 stood up from his chair in the dining room, walked independently down the hallway to the nurses station where RN-A asked

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R15 to go back to his room and R15 complied. R11 continued to eat independently in the dining room area.

- at 8:43 a.m., R15 with no facemask on walked independently to the dining room area and sat down in a chair, while R11 continued to be in the dining room area with his mask positioned below his chin. RNC asked R15 to put a mask on and he refused.

- at 8:48 a.m. RNC asked R11 to adjust his mask up, he complied and she wheeled him out of the dining room area back to his room.

- at 9:28 a.m. the shared bathroom for R11, R12 and R15 was not observed to had been cleaned by nursing staff or housekeeping staff after R11 used it earlier.

On 1/20/22, at 1:57 p.m. LPN-F indicated staff were expected to wear full PPE and N95 masks when entering a COVID-19 positive room. LPN-F stated staff were expected to remove PPE when exiting the room including the N95 mask. LPN-F indicated staff were expected to sanitize their hands and place a new surgical mask on after having contact with COVID-19 positive residents. LPN-F indicated she had never been fit tested for her N95 mask and confirmed she was not wearing her N95 mask correctly LPN-F stated she only wore a surgical mask over her N95 mask to provide extra protection from COVID-19.

On 1/20/22, at 2:11 p.m. LPN-A indicated when staff entered a COVID-19 positive room, they were expected to wear a gown, goggles, gloves and a N95 mask. LPN-A confirmed her usual practice was to keep the same N95 mask on

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during the shift and confirmed she had not removed the N95 mask she wore in R6's and R22's positive COVID-19 room. LPN-A indicated sometimes she wore a surgical mask over her N95 mask for extra protection. LPN-A stated she had not been trained to change her N95 mask with every COVID-19 resident and indicated by not changing it the possibility existed of transmitting COVID-19 to other residents. LPN-A indicated she had not been fit tested for her N95 mask either.

On 1/21/22, at 9:14 a.m. NA-A verified R11 was positive for COVID-19 and was independent with his activities of daily living (ADL's) which included using the bathroom. NA-A indicated R12 was not positive for COVID-19 and the facility had tried to move R12, however he refused. NA- A stated R12 was independent with ADL's and used the bathroom independently. NA-A indicated R15 was independent with ADL's and used the bathroom independently. NA-A stated the usual practice was for staff to clean a shared bathroom after each resident use for COVID-19 positive residents. NA-A indicated he had cleaned R11, R12's and R15's bathroom earlier that morning before 7:00 a.m. and verified R11 had used the bathroom after that. NA-A confirmed he had not cleaned it since due to being busy on the floor. R12 was aware of the risk and benefits which was discussed with his family.

On 1/20/22, at 9:18 a.m., nursing assistant (NA)-D was observed to have eye protection and a surgical mask on which covered his nose and mouth area. NA-D donned gloves, hairnet and proceeded to enter R4's room who had tested positive for COVID-19 on 1/15/22, to empty R4's commode. NA- D was not observed wearing a

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gown or an N95 mask when entering R4's room. After a few minutes NA-D exited R4's room wearing his eye protection and surgical mask, discarded a bag of garbage in the soiled utility room and sanitized his hands. NA- D while wearing the same surgical mask, walked into R5's who was COVID-19 negative to check on the him and then immediately exited the room. NA-D walked down the hallway to R28 and R29's room, who were COVID-19 negative, entered the room to check on them and immediately exited the room. NA-D was not observed to change his surgical mask after exiting R4's COVID-19 positive room.

-at 10:57 a.m., NA-C wore eye protection, a surgical mask which covered her nose and mouth area and a hairnet on her head. NA-C proceeded to donn a disposable gown and entered R19's room, who tested positive for COVID-19 on 1/19/22. NA-C began making R19's bed when R20 walked out of the bathroom and sat down on his bed. NA-C removed her gown, washed her hands and immediately walked out of R19's room. NA-C was not observed to wear gloves or a N95 mask and had not removed her surgical mask after exiting R19's room.

- at 11:51 a.m., administrator-B was observed wearing a gown, gloves. eye protection, a N95 mask over her surgical mask and a face shield. Administrator-B proceeded to enter R13's room, who had tested positive for COVID-19 on 1/12/22, and delivered a meal tray. Administrator-B proceeded to remove her gown, gloves and sanitized her hands while leaving R13's room. Administrator-B wore her N95 mask on her chin and her surgical mask was covering her nose and mouth area. Administrator- B walked into the

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bathroom down the hall, removed her N95 mask and surgical mask, and sanitized her hands. Administrator-B applied a clean surgical mask and stated she should have been wearing her surgical mask over her N95 mask when going into a COVID-19 positive room.

-at at 2:55 p.m.., hospice registered nurse (HRN)-A walked out of R6's room wearing eye protection, a N95 mask and sanitized her hands. R6 had tested positive for COVID-19 on 1/12/22. HRN-A proceeded to apply a face shield and sat down behind the nurses desk. At 3:13 p.m., HRN-A continued to be seated behind the nurses desk wearing the same N95 mask. HRN-A stated she was taught through the Hospice agency to apply a surgical mask over her N95 mask and when leaving a resident's room to only remove the surgical mask and to keep the N95 mask on.

On 1/21/22, at 7:58 a.m., R14 who tested positive for COVID-19 on 1/15/22, was observed exiting her room while wearing a surgical mask covering her mouth and exposing her nose. R14 walked down the hallway past registered nurse (RN)-A and RN-B who had not redirected R14 to adjust her mask or return to her room. R14 continued to walk down the hallway, entered the dining room area where other COVID negative residents were present and sat down in a chair.

-at 8:03 a.m., R14 stood up, walked down the hallway past RN-A who instructed her to adjust her mask and R14 did not comply. RN-A was not observed to redirect R14 back to her room and R14 continued to walk independently down the hallway with her surgical mask placed below her nose and not covering her mouth.

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-at 8:06 a.m., R14 returned into the hallway with her mask remaining below her nose and only covering her mouth area. R14 walked to the dining room past RN-B who was not observed to redirect her back to her room or remind her to adjust her mask. R14 sat down in a chair in the middle of the dining room area with multiple residents seated around her. RN-A entered the dining room and began to handout surgical mask to the other residents in the dining room.

-at 8:12 a.m., R14 stood up, walked down the hallway with her surgical mask positioned below her nose. R14 walked past the DON who asked to R14 to adjust her mask. R14 did not comply and was not asked or redirected back to her room.

-at-9:36 a.m., R14 exited her room wearing a surgical mask in the same position, walked down the hallway past RN -B who asked her to adjust her mask and she refused. RN-B was not observed to redirect R14 back to her room. R14 continued to walk further down the hallway into the dining room area and sat down. R14's mask continued to be positioned below her chin exposing her nose and mouth. LPN A approached R14 and talked to her however was not observed to redirect R14 back to her room or to re-position her mask.

- at-9:51 a.m., R14 continued to be seated in the dining room area with her mask positioned below her chin seated next to R15. R14 stood up, walked over to the smoking room area, when LPN-A approached R14 however was not observed to redirect R14 back to her room or ask her to re-position her mask.

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-at 10:01 a.m.., R11's (who tested positive for COVID-19 on 1/19/22), shared bathroom call light was noted to be on. The toilet was heard flushing and R11 was observed coming out of his bathroom in his wheelchair. RN- B walked up to R11's doorway, stood in the hallway and asked R11 if he needed anything. R11 shook his head no and RN- B instructed R11 to turn off his bathroom call light. R11 proceeded to wheel himself into the bathroom and shut off the bathroom call light. RN -B was not observed to clean or disinfect the bathroom after R11 was done using it.

-at 10:33 a.m., R11's bathroom call light was on and the toilet was heard to be flushing. NA-A was observed to be wearing eye protection, donning a gown, gloves and a N95 mask. NA-A entered R11's room, asked R11 if he had used the bathroom and R11 responded to NA-A by shaking his head up and down indicating he had used the shared bathroom. NA-A proceeded to remove his gown, gloves in the room and sanitized his hands while exiting the room. NA-A walked out into the hallway, removed his N95 mask, threw it away and sanitized his hands. NA- A was not observed cleaning or disinfecting the shared bathroom after R11 used it.

- at 10:44 a.m., R15 was observed going into his room to use the bathroom. OTA-A entered R15's room, verified R15 was using the bathroom and the toilet was heard to be flushing. No nursing staff or housekeeping staff were observed cleaning or disinfecting the bathroom before or after R15 had used it.

On 1/20/22, at 9:25 a.m. NA-D confirmed he had not worn a gown or a N95 when entering R4's

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room as he was only emptying his commode. NA-D indicated he should have worn a gown and N95 before entering R4's room however did not do so since he had not completed direct cares with R4.

On 1/20/22, at 11:06 a.m. NA-C verified R19 was positive for COVID-19 and her usual practice was to wear full PPE which included: a N95 mask, gown, gloves and eye protection. NA-C indicated she only wore her N95 mask and gloves when doing direct cares with a resident known to be positive with COVID-19. NA-C confirmed she did not have a N95 mask and gloves on before she entered R19's room.

1/20/22 at 12:00 p.m., administrator-B confirmed R13 was positive for COVID-19-19 and indicated when entering a positive COVID-19 room staff were expected to wear a gown, gloves, eyewear and a surgical mask covering the N95 mask. Administrator-B indicated her usual practice was if she pulled her surgical mask down three times then she needed to change it. Administrator-B confirmed she had worn her N95 mask over her surgical mask when she entered R13's room and verified she was wearing her N95 mask incorrectly.

1/20/22 at 1:54 p.m.. NA-E indicated when a resident was positive for COVID-19 staff were expected to place a sign on the door and were to encourage the resident to remain in their room. NA-E indicated residents did not always listen to staff and continued to come out of their rooms when they have COVID-19. NA-E stated staff should have been wearing a gown, a N95 mask, face shield, and gloves before entering a COVID-19 room and before exiting the room they

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should have removed their gown and gloves and sanitized their hands. NA-E indicated nursing staff received education weekly on COVID-19 by text messages from the administration.

1/20/22 at 2:07 p.m.. RN-A confirmed R14 was positive for COVID-19 and indicated when a resident tested positive for COVID-19 staff were expected to place a sign on the door and isolate them to their room. RN-A stated staff should have been wearing a gown, gloves and a N95 mask before entering a COVID-19 room and staff should have removed the gown and sanitized hands before exiting the room. RN-A indicated staff were expected to remove their N95 mask in the hallway, sanitize their hands and place a clean surgical mask on. RN-A stated staff should have encouraged all residents that are positive with COVID-19 to remain in their rooms and staff should have been redirecting them back to their rooms if they are coming out of their rooms. RN-A confirmed she had not redirected R14 back to her room when she came out into the hallway.

R4

On 1/20/22, at 8:33 a.m. nursing assistant (NA)-C who was only wearing a surgical mask and eye protection came out of R4's (who had tested positive for COVID-19 on 1/15/22) room while carrying a meal tray and put in on the serving cart. R4's door had a sign on his door which identified R4 was in droplet isolation precautions. NA-C verified she did not wear PPE when picking up the meal trays and only wore PPE while providing direct cares to residents who had COVID-19. NA-C verified she was not wearing a N95 mask, a gown and gloves while picking up meal trays.

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R11
On 1/20/22, at 8:47 a.m. facility scheduler (FS)-A who wore a surgical mask and eye goggles left R11's (who had tested positive for COVID-19 on 1/19/22) room carrying a meal tray to serving cart, then walked down the hallway. FS-A was noted to not have a gown or gloves on. R11's door had a sign present on his door which indicated R11 was in droplet isolation precautions.

R17
On 1/21/22, at 7:57 a.m. NA-A was observed in the shared bathroom of R2, R25, and R17 (who tested positive for COVID-19 on 1/19/22) and filled a basin with water. R2 (who was COVID-19 negative) was seated on the edge of his bed by the door and a curtain divided the two residents. NA-A proceeded to provide morning cares for R17, while he sat on the edge of his bed. After NA-A was done completing morning cares for R17, NA-A went to the shared bathroom, emptied the basin water into the toilet, turned on the water faucet, rinsed the basin, emptied it again and filled the basin with soap and water. NA-A proceeded to assist R17 to complete the rest of his morning cares. At 8:14 a.m. NA-A again returned to the shared bathroom, emptied the basin, turned on the faucets, rinsed the basin and emptied the water into the toilet. At 8:15 a.m. while NA-A was still in the bathroom, R25 (who was COVID-19 negative) opened the door from the adjoining room and informed NA-A he needed to use the bathroom. NA-A left the shared bathroom into R17's room without cleaning or disinfecting the bathroom before R25 used the bathroom.

1/20/22, at 11:10 a.m. during a follow up interview

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with NA-C stated she had sanitized her hands after she picked up breakfast trays that morning. NA-C indicated she wore eye protection and a surgical mask for source control, and wore other PPE when providing cares in rooms of residents who had COVID-19. NA-C indicated she had not worn N95 masks, gowns or gloves when picking up trays from COVID positive residents that morning.

On 1/20/22, at 11:56 a.m. NA-D indicated he had assisted R4 by emptying his commode earlier and was not able to remember if he had applied a gown prior to entering R4's room. NA-D stated his usual practice was to apply full PPE, including gown, gloves, N95 mask and eye protection when entering any COVID-19 positive residents' rooms and to dispose of his N95 when he exited the room.

On 1/21/22, at 8:24 a.m. NA-A indicated R17 did not use the bathroom, however R2 and R25 used the bathroom independently. NA-A confirmed R25 had used the bathroom right after he had emptied R17's basin and verified he had not disinfected the bathroom prior to R25 using it. NA-A stated at times R17 would leave his room at times to go out to smoke. NA-A indicated it was difficult to redirect residents to their rooms who were positive with COVID-19 and to remind them to wear their masks.

On 1/20/22, at 2:53 p.m. director of nursing (DON) indicated infection preventionist (IP)-A currently had COVID-19 and DON was responsible for the infection prevention program while IP-A was out of the facility. The DON stated the last time the facility had completed fit testing for N95 masks was last year, and confirmed not

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all staff had been fit tested at that time. DON verified she expected staff to wear full PPE (gown, gloves, eye protection) for any reason when entering a resident's room who was known to be positive with COVID-19, which included wearing a N95 mask and to remove the N95 when leaving the room. The DON indicated this was important to prevent the spread of COVID-19 to other residents. The DON stated the facility isolated residents who were COVID-19 positive for 14 days. The DON verified staff were allowed to wear a surgical mask over their N95 mask, if they were going from one resident COVID-19 room to another resident's room who had COVID-19. The DON indicated the staff were expected to remove the surgical mask covering their N95 mask before entering a different resident's room who was positive for COVID-19 to save time. The DON stated staff were expected to remove their N95 mask and dispose of it after leaving a COVID-19 room. The DON indicated staff were allowed to wear their N95 mask more than once if going from one COVID-19 positive room and to another. DON confirmed the facility had no concerns with PPE supplies, and was not in contingency or crisis mode for PPE supplies.

On 1/21/22, at 9:29 a.m. registered nurse (RN)-A confirmed R11 and R12 shared a room, and R11, R12 and R15 shared a bathroom. RN-A verified R11 was positive for COVID-19, and R12 and R15 were negative for COVID-19. RN-A stated R11, R12 and R15 independently used the bathroom. RN-A stated the facility had not disinfected the bathroom after each resident use. RN-A indicated she had spoken to R12 and asked him to change rooms so he would not share rooms with R11, however he had refused.

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RN-A stated it had been difficult to change R15's routine due to a noted increase in his behaviors and the facility had not changed his room. RN-A stated the facility had offered to move R2, who was known to be COVID-19 negative, from R17's room who was positive with COVID-19, however R2 refused to move. RN-A indicated the facility tried to isolate residents who were positive as much as possible and reminded them to wear their masks. RN-A confirmed R11 was not compliant with isolating to his room, and he freely went out to public areas. RN-A stated she expected staff to attempt to redirect R11 back to his room whenever he was out of his room. RN-A indicated she expected staff to disinfect the shared bathrooms after a COVID-19 resident used it, or staff used it after caring for COVID-19 positive residents. RN-A stated it was important to isolate the residents who were COVID-19 positive to prevent COVID-19 transmission from positive residents to negative residents. RN-A did not identify she had provided any education, or risk vs benefits related to staying in his room.

On 1/21/22, at 10:03 a.m. LPN-C confirmed several COVID-19 positive residents were non-compliant to isolate in their rooms. LPN-C indicated when a COVID-19 positive resident left their room she attempted to redirect them back to their room and educated them, however, she indicated it was only effective for short periods of time due to their behaviors and refusal to comply. LPN-C stated residents who were COVID-19 negative were allowed out of their rooms, however they were encouraged to wear masks. LPN-C confirmed COVID-19 positive and negative residents were out of their rooms at the same time and indicated it was difficult to keep them separated due to the facility's challenged

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population.

On 1/21/22, at 10:26 a.m. in a follow-up interview, the DON confirmed the facility was in a COVID outbreak and had 13 residents who had currently tested positive for COVID-19. The DON indicated the facility was attempting to cohort COVID positive residents and had made some room changes. The DON stated R2 refused to move out of R17's room who had COVID-19, and R12 refused to move out of R11's room who had COVID-19. The DON indicated those residents who shared bathrooms with residents who were known to have COVID-19 had been offered to move. The DON indicated their plan was to have staff sanitize the shared bathrooms used by COVID-19 positive and negative residents twice a shift. The DON confirmed residents who had COVID-19 were not being isolated to their rooms and staff attempted to redirect them, to make sure they were not around residents who did not have COVID-19. The DON confirmed R11 and R14 were not compliant with isolating to their rooms and were out in common areas with residents who did not have COVID-19, and confirmed most of their residents were non-compliant.

On 1/21/22, at 11:35 a.m. the DON confirmed the facility had a contract with an outside vendor who conducted the facility COVID-19 testing. The DON indicated she expected the vendor staff to wear proper PPE which included eye protection, gown, gloves and N95 mask when swabbing residents for COVID-19. The DON stated she expected staff to donn new PPE after working with positive COVID-19 residents and after having exposure to them. The DON verified CAS-A had not been educated on proper infection

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control measures by the facility regarding testing and was not sure if CAS-A had been fit tested. The DON indicated her expectation for vender staff was to be properly educated on the use of PPE and to be fit tested to prevent further spread of COVID-19 to other residents and staff.

The facility form titled Fit Testing Record updated 8/20/21, identified 69 staff members. The form identified 22 staff were fit tested between 6/18/21, to 8/6/21, and 47 staff members had not received fit testing.

On 1/24/22, at 12:34 p.m. infection preventionist (IP)-A confirmed the Fit Testing Record the facility had provided was the only documentation the facility had completed for fit testing. IP-A confirmed she was trained to fit test staff and had last completed N95 mask fit testing in June of 2021. IP-A stated fit testing of N95 masks was important to assure they sealed correctly and to protect the staff member from contracting or transmitting COVID-19. IP-A indicated fit testing should have been completed annually or more often if the person had weight loss, facial surgery or any changes in their facial structure for all staff who required a N95 mask.

The IJ, which began on 1/21/22, was removed on 1/25/22, at 1:00 p.m. when it could be verified through observation, interview and document review the facility cohorted residents together whom were COVID-19 positive and COVID-19 negative. The facility explained risk and benefits to the resident whom were non-complaint and added this to their care plan. The facility employees responsible for testing had

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competencies completed for proper PPE usage during testing and training for antigen testing for COVID-19. Staff education was initiated and remains on-going for appropriate PPE usage which included donning/doffing, proper isolation of COVID-19 positive residents, redirection of residents to their rooms who are COVID-19 positive, encouraging surgical mask use and hand hygiene for residents and disinfection of high touch areas. Staff were educated prior to the start of their next shift and would not provide direct care until education was completed. Staff that were on leave, on-call and/or not frequently in the facility were mailed an education packet or verbal education would be completed on the phone. Lastly, audits had been conducted on the above interventions.

Review of facility policy titled, Coronavirus (COVID-19) revised 9/2021, indicated the facility had initiated steps to minimize exposure to respiratory pathogens, promptly identify residents with clinical features and at risk for COVID-19 and to adhere to appropriate infection control practices. The strategies indicated within this policy would remain fluid as CDC and Department of Health recommendations to prepare for and respond to the community spread of Coronavirus Disease -2019 (COVID-19) changed. Monarch healthcare management facilities would continue to provide care for our residents as indicated within their plan of care and at the appropriate level of care. Under Facility Outbreak Protocol: to place residents in private rooms with private bathroom (if possible) and initiate droplet and contact precautions and cohort residents identified with same symptoms/COVID-19 conformation, if possible. Under Nursing PPE, Equipment and Supplies:

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F 880	Continued From page 32 Appropriate PPE (gloves, gown, mask, eye protection, per isolation precautions guidelines) would be applied and removed when entering or before exiting the resident rooms, per CDC and Department of Health donning and doffing guidance. Resident with known or suspected COVID-19 would be cared for using all recommended PPE, which included use of N95 or higher level respirator. Facilities would optimize and utilize PPE according to the CDC/CMS/ Department of Health current guidelines. The facility document titled Fit Testing Steps, undated, identified the mask type for the next year, barring any major changes in facial structure (weight gain/loss, surgery etc). The document instructed if the facility changed to a different type of respirator for any reason, they would need to be re-tested for the new type. The document identified some staff wore a surgical mask over the respirator to make it last longer. The facility policy titled Personal Protective Equipment-Contingency and Crisis Use of N-95 Respirators (COVID-19 Outbreak) dated 9/21, identified during conventional capacity the N95 mask use included discarding any previously used respirators. The policy identified adopting "just in time" fit testing when feasible.	F 880		
F 886 SS=L	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement	F 886		2/22/22

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	245394	A. BUILDING _____ B. WING _____	C 01/25/2022

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F 886	Continued From page 33 and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms	F 886		

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F 886	Continued From page 34 consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete outbreak COVID-19 testing of all staff according to Center for Disease Control (CDC) guidelines for outbreak testing. As a result the facility was in outbreak status on 1/08/22. This practice resulted in an immediate jeopardy (IJ) situation related to the high likelihood of serious illness, harm or death that had the potential to affect all 51 residents, staff, family and visitors in the facility. The immediate jeopardy began on 1/8/22, when the facility failed to test all staff during a COVID-19 outbreak which began on 1/8/22. The administrator and the director of nursing (DON) were notified of the immediate jeopardy at 6:48 p.m. on 1/24/22. The immediate jeopardy was removed on 1/25/22, at 4:50 p.m. when the facility implemented interventions to ensure all staff were tested for COVID-19 was completed however, noncompliance remained at the lower pattern scope and severity level F, which	F 886	The facility immediately implemented testing protocol per CDC guidance and in accordance with the facilities COVID-19 Testing Policy which was reviewed and remains current. The policy has specifics to staff testing during an outbreak which includes documentation and tracking of staff testing. The facility has initiated outbreak testing of all residents and staff on 1/24/2022 per CDC guidance and in accordance with the facilities COVID-19 Testing Policy. The facility conducted an analysis of staff testing, to include tracking, and has updated facility procedure to ensure compliance with CDC guidance. Facility LNHA, Associate Administrator, DON, and Infection Preventionist have been educated on facility staff testing procedure and the facilities COVID-19	

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F 886	Continued From page 35 indicated no actual harm with potential for more than minimal harm that was not immediate jeopardy. Findings Include: The CDC: Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, directed healthcare facilities to develop and implement a testing plan for testing residents and healthcare professionals SARS-CoV-2. The CDC guidance recommended any new COVID-19 infection in any staff or any nursing home-onset COVID-19 resident infection triggered an outbreak investigation. In an outbreak investigation, rapid identification and isolation of new cases was critical in stopping further viral transmission. Upon identification of a single new case of COVID-19 infection in any staff or residents, testing should begin immediately. On 1/20/22, at 2:53 p.m. director of nursing (DON) indicated the facility staff were being tested two times a week, on Monday and Thursday due to their outbreak status. On 1/20/22, at 5:09 p.m. Administrator sent an e-mail, which identified the facility outbreak testing was initiated on 1/10/2022. On 1/24/22, at 9:20 a.m. the infection preventionist confirmed at current, 11 residents and three staff were positive with COVID-19. Review of the facility untitled list undated, identified the facility currently had 53 employees.	F 886	Testing Policy including immediate outbreak testing to begin upon identification of a single new case of COVID-19 and tracking. Staff education initiated on testing protocol per CDC guidance and in accordance with the facilities COVID-19 Testing Policy. This has been initiated and remains on-going. Staff who are on leave, on-call and/or are not frequently in the facility were mailed education and/or verbal education via phone completed. Staff will prove competence to perform self-COVID-19 testing if the facility deems necessary due to staff shortages Audits of testing will be completed weekly for 4 weeks, then monthly for 3 months, then PRN based on audit findings. Results will be shared with facility QAPI committee for input on the need to increase, decrease, or discontinue audits. Administrator/Designee will be responsible party	

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F 886	Continued From page 36	F 886		

Review of facility forms titled Staff COVID-19 Outbreak Testing, from 1/10/22, to 1/17/22, revealed the following:
-1/10/22, identified 26 of 53 staff members were tested.
-1/13/22, identified 16 of 53 staff members were tested.
-1/17/22, identified 17 of 53 staff members were tested.

No further testing results were provided.

On 1/24/22, at 12:34 p.m. IP-A indicated the facility was currently in COVID-19 outbreak status, and began testing all staff and residents, regardless of their vaccination status on 1/10/22, and every Monday and Thursday. The IP indicated residents and staff were currently being tested with a combination of antigen and PCR tests and provided the list of the staff she had tested to the administrator and DON. IP-A indicated she had instructed the DON and administrator to have staff complete an antigen test prior to their next shift if they missed the PCR COVID-19 testing. IP-A stated she expected the DON or administrator to keep track of which staff had completed the COVID-19 tests, and assumed it was the administrator who had kept track of the testing.

On 1/24/22, at 2:22 p.m. DON stated the facility process to assure all employees had been tested for COVID-19 began with the facility sending out text messages to all employees informing them when the testing was scheduled. DON indicated the process to assure all staff had their testing completed relied on the employees informing the facility if they had testing completed at another facility. DON confirmed IP-A kept track

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of the staff tested and sent the information to her. DON indicated the facility has been attempting to put a better process in place to assure all staff were tested. DON stated the associate administrator kept a checklist too.

On 1/24/22, at 2:28 p.m. during a joint interview with associate administrator and administrator, the administrator indicated the facility tracking process they had in place was not accurate in keeping track of which staff had been tested. Associate administrator confirmed she used a staff listing of all employees to check off those staff who completed the testing. She did not keep the list when they completed testing and they were unable to determine which staff still had to complete the testing. Associate administrator stated she assumed IP-A kept track of the staff who had antigen testing done between their regular testing's completed on Mondays and Thursdays. Administrator confirmed the testing logs they had provided were the only documentation the facility had during their outbreak testing. Administrator confirmed outbreak testing had not been completed on all staff per CDC recommendations.

On 1/24/22, at 2:39 p.m. during a follow up interview IP-A confirmed she had not been tracking COVID-19 testing of staff during the outbreak and was not certain who was responsible to assure all staff were being tested. IP-A stated she was not able to confirm if all staff had been tested. IP-A verified she was not aware of any staff receiving antigen testing prior to working their shifts if they had missed the testing, and stated she had not been notified of any antigen testing being completed in the facility.

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On 1/24/22, at 3:16 p.m. nursing assistant (NA)-B indicated he got tested in the facility last week, however, was not tested the week before.

On 1/24/22, at 4:14 p.m. director of infection control (DIC)-A confirmed the facility had not been conducting COVID-19 outbreak testing of staff per CDC recommendations. DIC-A verified the facility did not have a system in place to assure all staff were tested.

On 1/24/22, at 4:24 p.m. during a follow-up interview DON confirmed the facility did not have a tracking system in place to determine all staff had been tested during the outbreak. The DON indicated there had been no contact tracing in place to compare residents and staff who had tested positive for COVID-19. The DON confirmed she was not aware how many staff had been tested since the outbreak was identified on 1/8/22. The DON indicated it was important to complete outbreak COVID-19 testing of staff to control the spread of COVID-19 during the outbreak.

The facility lacked any documentation of staff and resident contact tracing or any evidence of a process for testing staff and residents during an outbreak.

On 1/24/22, at 5:53 p.m. administrator confirmed the facility outbreak began on 1/8/22, when licensed practical nurse (LPN)-E was found COVID-19 positive on 1/8/22.

The facility policy titled COVID-19 Testing Policy revised 10/5/21, identified any new COVID-19 in any staff or any nursing home-onset COVID-19 infection in a resident triggered an outbreak

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investigation. In an outbreak investigation rapid identification and isolation of new cases was critical in stopping further viral transmission. The policy identified all health care workers, regardless of vaccination status, would be tested for SARS-CoV-2 when working in a facility experiencing an outbreak. The policy identified the facility would conduct testing of all residents and staff every 3 to 7 days, until 14 days had passed since the last positive case. The policy identified upon identification of a new COVID-19 case in the facility, they would document the date the case was identified, the date the other residents and staff were tested, the dates the residents and staff who tested negative were retested, and the results of all tests.

The IJ, which began on 1/24/22, was removed on 1/25/22, at 4:50 p.m. when it could be verified through observation, interview and document review the facility implemented testing for COVID-19 for all current residents and staff per CDC guidance. The facility started a process to review the community transmission rate every other week on Monday and determine frequency of testing of unvaccinated staff per CDC COVID Data Tracker. All unvaccinated employees would be contacted every Monday by the facility human resources director or designee to ensure staff are tested per CDC frequency. If an unvaccinated employee failed to test per frequency they would be removed from the schedule until corrected and correction action was completed. The facility human resources director or designee would maintain all testing records to include testing day attendance, follow up with employees who did not test and test results. Employee schedules would be audited daily to ensure all employees were tested. Staff received the above education prior to

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F 886	Continued From page 40 the start of their next shift. Staff that were on leave, on-call and/or not frequently in the facility were mailed an education packet or verbal education would be completed on the phone. Lastly, staff competency testing was initiated for COVID-19 antigen self testing if the facility ends up deeming this necessary due to staff shortages.	F 886		

Electronically delivered
February 8, 2022

Administrator
The Estates At Lynnhurst LLC
471 Lynnhurst Avenue West
Saint Paul, MN 55104

Re: State Nursing Home Licensing Orders
Event ID: 1OOO11

Dear Administrator:

The above facility was surveyed on January 19, 2022 through January 25, 2022 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:

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota. 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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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: On 1/19/22, to 1/25/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found not in compliance with the MN State Licensure. The following complaints were found to be	2 000		

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2 000	Continued From page 1 UNSUBSTANTIATED: H5394145C (MN00080140), H5394143C (MN00080167), H5394144C (MN00080141) The following complaint was found to be SUBSTANTIATED: H5394146C (MN00080259) with a licensing order issued at 1390. 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. 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/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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. The facility	2 000		

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2 000	Continued From page 2 is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.	2 000		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of	21390		2/22/22

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21390	Continued From page 3 current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement appropriate isolation and transmission based precautions on the second floor secured unit for 2 of 2 residents (R11 and R14) who were positive for COVID-19. In addition, the facility failed to implement proper use of personal protective equipment (PPE) per Centers for Disease Control and Prevention (CDC) CDC to prevent and/or minimize further spread of COVID-19. Further, the facility failed to provide appropriative cleaning of bathrooms between resident use during a COVID-19 outbreak. This deficient practice resulted in an immediate jeopardy (IJ) which had the potential to affect all 51 residents, staff, family, and visitors in the facility. The immediate jeopardy began on 1/20/22, when appropriate infection control practices to isolate/quarantine residents and proper use of personal protective equipment (PPE) were not implemented to reduce the spread of COVID-19 in the facility The administrator, associate administrator(AA), director of nursing (DON), regional director of operations (RDO), regional nurse consultant (RNC) were notified of the immediate jeopardy at 5:10 p.m. on 1/21/22. The immediate jeopardy was removed on 1/25/22, at 1:00 p.m. when the facility implemented interventions to ensure residents and all staff were educated on proper isolation precautions and proper use of PPE. However, noncompliance remained at the lower pattern scope and severity level F, which indicated no	21390	Corrected.	

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21390	Continued From page 4 actual harm with potential for more than minimal harm that was not immediate jeopardy. Findings include: Review of R11, R14, R6, R24, R22, R17, R18, R19, R20, R21, R23, R18 and R4's COVID-19 lab results revealed the following: R11's Simple Laboratories test resulted dated 1/19/22, indicated R11 was positive for COVID 19. R14's Simple Laboratories test resulted dated 1/15/22, indicated R14 was positive for COVID 19. R6's Simple Laboratories test resulted dated 1/12/22, indicated R6 was positive for COVID 19. R24's Simple Laboratories test resulted dated 1/15/22, indicated R24 was positive for COVID 19. R22's Simple Laboratories test resulted dated 1/19/22, indicated R22 was positive for COVID 19. R17's Simple Laboratories test resulted dated 1/19/22, indicated R17 was positive for COVID 19. R19's Simple Laboratories test resulted dated 1/19/22, indicated R19 was positive for COVID 19. R20's Simple Laboratories test resulted dated 1/19/22, indicated R20 was positive for COVID 19. R21's Simple Laboratories test resulted dated 1/19/22, indicated R21 was positive for COVID 19. R13's Simple Laboratories test resulted dated 1/12/22, indicated R13 was positive for COVID 19. R23's Simple Laboratories test resulted dated 1/19/22, indicated R23 was positive for COVID 19.	21390		

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21390	Continued From page 5 R18's Simple Laboratories test resulted dated 1/12/22, indicated R18 was positive for COVID 19. R4's Simple Laboratories test resulted dated 1/15/22, indicated R4 was positive for COVID 19. CDC guidance, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, identified the facility must sustain core IPC practices and remain vigilant for SARS-CoV-2 infection among residents and healthcare professionals in order to prevent spread and protect residents and HCP from severe infections, hospitalizations, and death, which included: Recommended infection prevention and control (IPC) practices when caring for a patient with suspected or confirmed SARS-CoV-2 infection, identified the following guidelines: -residents with symptoms of COVID-19 (even before results of diagnostic testing) and asymptomatic patients who have met the criteria for Transmission-Based Precautions (quarantine) based on close contact with someone with SARS-CoV-2 infection. -residents should NOT be cohorted with patients with confirmed SARS-CoV-2 infection unless they are confirmed to have SARS-CoV-2 infection through testing. Ideally, a resident with suspected SARS-CoV-2 infection should be moved to a single-person room with a private bathroom while test results are pending. - healthcare personnel (HCP) who enter the room of a resident with suspected or confirmed SARS-CoV-2 infection should adhere to Standard	21390		

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21390	Continued From page 6 Precautions and use a approved N95 or equivalent or higher-level respirator, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face). On 1/20/22, at 10:44 a.m. during an observation, several residents on the secured unit were seated out in the dining room area with two staff members completing activities on the secured unit. R11, who had tested positive for COVID-19 on 1/19/22, was seated at the end of the dining room area sitting alone wearing a surgical mask over his face and was sleeping. R15 who was COVID-19 negative entered the dining room area without a facemask on and sat down in a chair to watch TV. The two activity staff that were in the area were not observed directing R15 to place a mask on his face or redirecting R11 back to his room. - at 10:54 a.m., R17 who had tested positive for COVID-19 on 1/19//22, had a sign on his door which indicated R17 was in droplet isolation precautions (used for diseases or pathogens including COVID-19 that can spread in tiny droplets caused by coughing or sneezing). Nursing assistant (NA)-E was observed to have a N95 mask on, with a surgical mask over it and a face shield covering his face. NA-E donned a disposable gown, gloves and entered R17's room while licensed practical nurse (LPN)-F who was in the hallway closed the door behind him. NA-E opened R17's door, had removed his gown and gloves. NA-E stood in the door way, removed his surgical mask, disposed of it in in the room, sanitized his hands while exiting the room into the hallway and left his N95 mask on. - at 10:56 a.m., LPN-F obtained a disposable gown out of a plastic bin in the hallway, walked	21390		

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down to the nurses station, obtained a N95 mask, removed her eye protection and surgical mask. LPN-F proceeded to donn her N95 mask over her nose and mouth, applied a surgical mask over her N95 mask, placed her eye protection back on and walked down the hallway to R14's room. R14 who had tested positive for COVID-19 on 1/15/22, had a sign present on her doorway which indicated R14 was in droplet isolation precautions. R14 came out of her room with a surgical mask on her face while LPN-F donned a disposable gown and directed R14 her back to her room. LPN-F proceeded to glove her hands and entered R14's room.

- at 11:13 a.m., R14 exited her room wearing her surgical mask below her nose, walked down the hallway past NA-E and NA-E directed R14 to adjust her mask up. R14 complied and proceeded to walk by several residents and staff in the hallway. NA-E did not re-direct R14 back to her room. LPN-F exited R14's room wearing her eye protection and N95 mask, walked up to the nurses station, placed paper towels on nursing station counter and gloved her hands. LPN-F and NA-E removed their N95 masks, cleaned their eye protection and donned new N95 masks. R14 walked by LPN-F wearing a surgical mask below her nose, LPN-F directed her to adjust her mask up due to R14 pulling it down, R14 complied while walking down the hallway back towards her room.

- at 11:29 a.m., R11 remained sleeping in the dining room and several residents continued to participate in activities while two staff members were present. No staff were observed to redirect R11 back to his room even though he was COVID 19 positive.

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21390	Continued From page 8 - at 11:34 a.m., LPN-A was observed wearing a N95 mask with a surgical mask donned over the N95 mask and had eye protection on. LPN-A proceeded to donn a gown, gloves prior to entering R6 and R22's room with medications. R6 who had tested positive for COVID-19 on 1/12/22, and R22 who had tested positive for COVID-19 on 1/19/22, had a sign present on their doorway which indicated R6 and R22 were in droplet isolation precautions. - at 11:47 a.m., LPN-A exited R6's and R22's room, had removed her gown and gloves and continued to wear her surgical mask over her N95 mask with her eye protection in place. LPN-A entered the bathroom down the hallway, removed her surgical mask and was not observed to removed her N95 mask. LPN-A walked over to her medication cart wearing the same N95 mask, when R7 who was negative for COVID-19 wheeled up to her in his wheel chair and requested a glass of water. LPN-A handed R7 a glass of water and R7 proceeded to pull down his mask and drank the water. LPN-A continued to wear the same N95 mask while she was working COVID-19 positive residents. - at 12:00 p.m., LPN-A continued to stand by her medication cart reviewing the computer, when R8 who was negative for COVID-19 approached her and began to visit with her. LPN-A continued to wear the same N95 mask. - at 12:04 p.m., R9 who was negative for COVID-19 wheeled out of his room up to LPN-A's medication cart and requested a pain pill. LPN-A dispensed pain medication, handed R9 the medication and he took it independently with water. LPN-A continued to wear the same N95 mask.	21390		

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21390	Continued From page 9 - at 12:12 p.m., LPN-A delivered meals to R9's and R10's room who was negative for COVID-19, while continuing to wear the same N95 mask. - at 12:14 p.m., LPN-A set up medications at her cart, walked down the hallway and entered R26's and R27's room with medications in hand, who were known to be negative for COVID-19. LPN-A continued to wear the same N95 mask. -at 12:16 p.m., NA-E had a face shield on, N95 mask and donned a surgical mask over his N95 mask. NA-E proceeded to donn a disposable gown, gloves, while registered nurse (RN)-A had eye protection on, a N95 mask on and surgical mask over her N95 mask and began to donn a disposable gown and gloves. R11, who had tested positive for COVID-19 on 1/19/22, and R12 who was negative for COVID-19 had a sign present on their doorway which indicated R11 and R12 were in droplet isolation precautions. NA-E entered the room with a food tray, delivered it to R12 and the DON handed NA-E another room tray to R11. NA-E removed his gown, gloves, sanitized his hands, removed surgical mask, sanitized his hands and exited the room and continued to have the same N95 mask on and face shield. - at 12:21 p.m., R14 who had tested positive for COVID-19 on 1/15/22, and R24 who had tested positive for COVID-19 on 1/15/22, had a sign present on their doorway which indicated R14 and R24 were in droplet isolation precautions. RN-A entered R14's and R24's room with a room tray, delivered it and the DON handed RN-A another room tray and she delivered it. NA-E donned a surgical mask over the same N95 mask, a disposable gown, gloves and entered	21390		

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21390	Continued From page 10 R17's room who had tested positive for COVID-19 on 1/19/22, and R2's room who was negative for COVID-19 while carrying a room tray. NA-E delivered the tray to R17 and the DON handed another room tray for R2. NA-E set the room tray on R2's bed side table and closed the door. - at 12:26 p.m. NA-E exited R17's and R2's room wearing the same N95 mask, walked down the hallway to the bathroom next to the nurse station and washed his hands. NA-E donned a surgical mask over his N95 mask, donned a disposable gown, gloves and walked down the hallway to assist other staff to deliver more room trays to COVID-19 residents. - at 2:05 p.m., contracted agency staff (CAS)-A was in the hallway with a supply cart, completing COVID-19 testing for residents. CAS-A was wearing a disposable gown, gloves, eye protection and a N95 mask over a surgical mask. R11 who had tested positive for COVID-19 on 1/19/22, wheeled himself out of his room into the hallway. CAS-A performed a nasal swab COVID-19 test on R11 while in the hallway. There were no other residents or staff in the vicinity. CAS-A removed her gloves, filled out the paperwork, used a wipe to sanitize her hands and applied a new pair of gloves. CAS-A entered R11's room, asked R11's roommate R12 to complete a COVID-19 test and R12 refused. CAS-A did not remove her gown and N95 after completing COVID-19 testing on R11, who was known to be positive for COVID-19, prior to attempting the test on R12 who was COVID-19 negative. CAS-A indicated she completed testing for the facility two times a week for residents and staff.	21390		

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21390	Continued From page 11 - at 2:52 p.m., CAS-A was observed while wearing a disposable gown, gloves, a N95 mask over her surgical surgical mask and had eye protection, to enter R16's room, CAS-A was wearing the same PPE she wore while testing R11. CAS-A attempted to swab R16, and she refused who was negative for COVID-19. CAS-A stated she had been fit tested years ago for proper N95 mask use, however had not been recently. CAS-A said she had entered the facility with the surgical mask and just placed her N95 mask over it. CAS-A confirmed she mistakenly tested R11, who was known to be COVID-19 positive, and stated she should have changed her PPE after testing R11. CAS-A verified she continued to test other residents while wearing the same gown, surgical mask and N95 mask. CAS-A indicated she had not received any training on infection control practices and was not fit tested for her N95 mask. CAS-A verified other residents were at risk of transmitting the virus to non COVID-19 patients when proper infection control measures were not followed. On 1/21/22, at 7:39 a.m., R11 tested positive for COVID-19 on 1/19/22, R12 and R15's were negative for COVID-19 shared bathroom was observed. After the toilet was heard being flushed, R11 was observed to be pulling up his incontinent brief from around his thighs. - at 8:03 a.m., R11 exited his room independently in his wheelchair, DON attempted to redirect R11 back to his room and he refused. DON assisted R11 by placing a mask on his face and walked away. R11 pulled his surgical mask down below his chin and wheeled passed LPN-A and RN-B towards the dining room area and they did not	21390		

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redirect R11 back to his room. R11 wheeled himself further down the hallway and while passing RN-A who did not redirect him back to his room however, did ask him to readjust his mask up and R11 complied.

- at 8:10 a.m. R11 entered the dining room where several other residents were seated and DON directed R11 to go to the other side of the dining room.

- at 8:12 a.m. R11's mask was again noted to be positioned below his nose and noted only over his mouth, and DON asked R11 to readjust his mask however did not attempt to redirect him back to his room. RN-A brought R11 a cup of coffee to drink, while other residents remained in the dining room area. RN-A did not attempt to redirect R11 back to his room.

- at 8:18 a.m. R15 who was negative for COVID-19 without a facemask on, walked independently out of his room and down the entire length of the hallway passing by several staff who did not re-direct him to put a facemask on or return to his room. R15 entered the dining room area where the DON asked R15 to eat in his room. R15 refused and proceeded to sit down in a chair in the dining room area and drank coffee while R11 was eating his breakfast. Regional nurse consultant (RNC) asked R15 to wear a mask and R15 refused saying "I never wore a mask in my life".

- at 8:24 a.m. R15 continued to sit in the dining room area while drinking his coffee approximately 20 feet from R11 as he continued to eat his breakfast independently.

- at 8:25 a.m. R15 stood up from his chair in the

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21390	Continued From page 13 dining room, walked independently down the hallway to the nurses station where RN-A asked R15 to go back to his room and R15 complied. R11 continued to eat independently in the dining room area. - at 8:43 a.m., R15 with no facemask on walked independently to the dining room area and sat down in a chair, while R11 continued to be in the dining room area with his mask positioned below his chin. RNC asked R15 to put a mask on and he refused. - at 8:48 a.m. RNC asked R11 to adjust his mask up, he complied and she wheeled him out of the dining room area back to his room. - at 9:28 a.m. the shared bathroom for R11, R12 and R15 was not observed to had been cleaned by nursing staff or housekeeping staff after R11 used it earlier. On 1/20/22, at 1:57 p.m. LPN-F indicated staff were expected to wear full PPE and N95 masks when entering a COVID-19 positive room. LPN-F stated staff were expected to remove PPE when exiting the room including the N95 mask. LPN-F indicated staff were expected to sanitize their hands and place a new surgical mask on after having contact with COVID-19 positive residents. LPN-F indicated she had never been fit tested for her N95 mask and confirmed she was not wearing her N95 mask correctly LPN-F stated she only wore a surgical mask over her N95 mask to provide extra protection from COVID-19. On 1/20/22, at 2:11 p.m. LPN-A indicated when staff entered a COVID-19 positive room, they were expected to wear a gown, goggles, gloves and a N95 mask. LPN-A confirmed her usual	21390		

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practice was to keep the same N95 mask on during the shift and confirmed she had not removed the N95 mask she wore in R6's and R22's positive COVID-19 room. LPN-A indicated sometimes she wore a surgical mask over her N95 mask for extra protection. LPN-A stated she had not been trained to change her N95 mask with every COVID-19 resident and indicated by not changing it the possibility existed of transmitting COVID-19 to other residents. LPN-A indicated she had not been fit tested for her N95 mask either.

On 1/21/22, at 9:14 a.m. NA-A verified R11 was positive for COVID-19 and was independent with his activities of daily living (ADL's) which included using the bathroom. NA-A indicated R12 was not positive for COVID-19 and the facility had tried to move R12, however he refused. NA- A stated R12 was independent with ADL's and used the bathroom independently. NA-A indicated R15 was independent with ADL's and used the bathroom independently. NA-A stated the usual practice was for staff to clean a shared bathroom after each resident use for COVID-19 positive residents. NA-A indicated he had cleaned R11, R12's and R15's bathroom earlier that morning before 7:00 a.m. and verified R11 had used the bathroom after that. NA-A confirmed he had not cleaned it since due

On 1/20/22, at 9:18 a.m., nursing assistant (NA)-D was observed to have eye protection and a surgical mask on which covered his nose and mouth area. NA-D donned gloves, hairnet and proceeded to enter R4's room who had tested positive for COVID-19 on 1/15/22, to empty R4's commode. NA- D was not observed wearing a gown or an N95 mask when entering R4's room. After a few minutes NA-D exited R4's room

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THE ESTATES AT LYNNHURST LLC	471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104

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21390	Continued From page 15 wearing his eye protection and surgical mask, discarded a bag of garbage in the soiled utility room and sanitized his hands. NA- D while wearing the same surgical mask, walked into R5's who was COVID-19 negative to check on the him and then immediately exited the room. NA-D walked down the hallway to R28 and R29's room, who were COVID-19 negative, entered the room to check on them and immediately exited the room. NA-D was not observed to change his surgical mask after exiting R4's COVID-19 positive room. -at 10:57 a.m., NA-C wore eye protection, a surgical mask which covered her nose and mouth area and a hairnet on her head. NA-C proceeded to donn a disposable gown and entered R19's room, who tested positive for COVID-19 on 1/19/22. NA-C began making R19's bed when R20 walked out of the bathroom and sat down on his bed. NA-C removed her gown, washed her hands and immediately walked out of R19's room. NA-C was not observed to wear gloves or a N95 mask and had not removed her surgical mask after exiting R19's room. - at 11:51 a.m., administrator-B was observed wearing a gown, gloves. eye protection, a N95 mask over her surgical mask and a face shield. Administrator-B proceeded to enter R13's room, who had tested positive for COVID-19 on 1/12/22, and delivered a meal tray. Administrator-B proceeded to remove her gown, gloves and sanitized her hands while leaving R13's room. Administrator-B wore her N95 mask on her chin and her surgical mask was covering her nose and mouth area. Administrator- B walked into the bathroom down the hall, removed her N95 mask and surgical mask, and sanitized her hands. Administrator-B applied a clean surgical mask	21390		

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21390	Continued From page 16 and stated she should have been wearing her surgical mask over her N95 mask when going into a COVID-19 positive room. -at at 2:55 p.m.., hospice registered nurse (HRN)-A walked out of R6's room wearing eye protection, a N95 mask and sanitized her hands. R6 had tested positive for COVID-19 on 1/12/22. HRN-A proceeded to apply a face shield and sat down behind the nurses desk. At 3:13 p.m., HRN-A continued to be seated behind the nurses desk wearing the same N95 mask. HRN-A stated she was taught through the Hospice agency to apply a surgical mask over her N95 mask and when leaving a resident's room to only remove the surgical mask and to keep the N95 mask on. On 1/21/22, at 7:58 a.m., R14 who tested positive for COVID-19 on 1/15/22, was observed exiting her room while wearing a surgical mask covering her mouth and exposing her nose. R14 walked down the hallway past registered nurse (RN)-A and RN-B who had not redirected R14 to adjust her mask or return to her room. R14 continued to walk down the hallway, entered the dining room area where other COVID negative residents were present and sat down in a chair. -at 8:03 a.m., R14 stood up, walked down the hallway past RN-A who instructed her to adjust her mask and R14 did not comply. RN-A was not observed to redirect R14 back to her room and R14 continued to walk independently down the hallway with her surgical mask placed below her nose and not covering her mouth. -at 8:06 a.m., R14 returned into the hallway with her mask remaining below her nose and only covering her mouth area. R14 walked to the dining room past RN-B who was not observed to	21390		

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21390	Continued From page 17	21390		

redirect her back to her room or remind her to adjust her mask. R14 sat down in a chair in the middle of the dining room area with multiple residents seated around her. RN-A entered the dining room and began to handout surgical mask to the other residents in the dining room.

-at 8:12 a.m., R14 stood up, walked down the hallway with her surgical mask positioned below her nose. R14 walked past the DON who asked to R14 to adjust her mask. R14 did not comply and was not asked or redirected back to her room.

-at-9:36 a.m., R14 exited her room wearing a surgical mask in the same position, walked down the hallway past RN -B who asked her to adjust her mask and she refused. RN-B was not observed to redirect R14 back to her room. R14 continued to walk further down the hallway into the dining room area and sat down. R14's mask continued to be positioned below her chin exposing her nose and mouth. LPN A approached R14 and talked to her however was not observed to redirect R14 back to her room or to re-position her mask.

- at-9:51 a.m., R14 continued to be seated in the dining room area with her mask positioned below her chin seated next to R15. R14 stood up, walked over to the smoking room area, when LPN-A approached R14 however was not observed to redirect R14 back to her room or ask her to re-position her mask.

-at 10:01 a.m.., R11's (who tested positive for COVID-19 on 1/19/22), shared bathroom call light was noted to be on. The toilet was heard flushing and R11 was observed coming out of his bathroom in his wheelchair. RN- B walked up to

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21390	Continued From page 18 R11's doorway, stood in the hallway and asked R11 if he needed anything. R11 shook his head no and RN- B instructed R11 to turn off his bathroom call light. R11 proceeded to wheel himself into the bathroom and shut off the bathroom call light. RN -B was not observed to clean or disinfect the bathroom after R11 was done using it. -at 10:33 a.m., R11's bathroom call light was on and the toilet was heard to be flushing. NA-A was observed to be wearing eye protection, donning a gown, gloves and a N95 mask. NA-A entered R11's room, asked R11 if he had used the bathroom and R11 responded to NA-A by shaking his head up and down indicating he had used the shared bathroom. NA-A proceeded to remove his gown, gloves in the room and sanitized his hands while exiting the room. NA-A walked out into the hallway, removed his N95 mask, threw it away and sanitized his hands. NA- A was not observed cleaning or disinfecting the shared bathroom after R11 used it. - at 10:44 a.m., R15 was observed going into his room to use the bathroom. OTA-A entered R15's room, verified R15 was using the bathroom and the toilet was heard to be flushing. No nursing staff or housekeeping staff were observed cleaning or disinfecting the bathroom before or after R15 had used it. On 1/20/22, at 9:25 a.m. NA-D confirmed he had not worn a gown or a N95 when entering R4's room as he was only emptying his commode. NA-D indicated he should have worn a gown and N95 before entering R4's room however did not do so since he had not completed direct cares with R4.	21390		

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21390	Continued From page 19 On 1/20/22, at 11:06 a.m. NA-C verified R19 was positive for COVID-19 and her usual practice was to wear full PPE which included: a N95 mask, gown, gloves and eye protection. NA-C indicated she only wore her N95 mask and gloves when doing direct cares with a resident known to be positive with COVID-19. NA-C confirmed she did not have a N95 mask and gloves on before she entered R19's room. 1/20/22 at 12:00 p.m., administrator-B confirmed R13 was positive for COVID-19-19 and indicated when entering a positive COVID-19 room staff were expected to wear a gown, gloves, eyewear and a surgical mask covering the N95 mask. Administrator-B indicated her usual practice was if she pulled her surgical mask down three times then she needed to change it. Administrator-B confirmed she had worn her N95 mask over her surgical mask when she entered R13's room and verified she was wearing her N95 mask incorrectly. 1/20/22 at 1:54 p.m.. NA-E indicated when a resident was positive for COVID-19 staff were expected to place a sign on the door and were to encourage the resident to remain in their room. NA-E indicated residents did not always listen to staff and continued to come out of their rooms when they have COVID-19. NA-E stated staff should have been wearing a gown, a N95 mask, face shield, and gloves before entering a COVID-19 room and before exiting the room they should have removed their gown and gloves and sanitized their hands. NA-E indicated nursing staff received education weekly on COVID-19 by text messages from the administration. 1/20/22 at 2:07 p.m.. RN-A confirmed R14 was positive for COVID-19 and indicated when a	21390		

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21390	Continued From page 20 resident tested positive for COVID-19 staff were expected to place a sign on the door and isolate them to their room. RN-A stated staff should have been wearing a gown, gloves and a N95 mask before entering a COVID-19 room and staff should have removed the gown and sanitized hands before exiting the room. RN-A indicated staff were expected to remove their N95 mask in the hallway, sanitize their hands and place a clean surgical mask on. RN-A stated staff should have encouraged all residents that are positive with COVID-19 to remain in their rooms and staff should have been redirecting them back to their rooms if they are coming out of their rooms. RN-A confirmed she had not redirected R14 back to her room when she came out into the hallway. R4 On 1/20/22, at 8:33 a.m. nursing assistant (NA)-C who was only wearing a surgical mask and eye protection came out of R4's (who had tested positive for COVID-19 on 1/15/22) room while carrying a meal tray and put in on the serving cart. R4's door had a sign on his door which identified R4 was in droplet isolation precautions. NA-C verified she did not wear PPE when picking up the meal trays and only wore PPE while providing direct cares to residents who had COVID-19. NA-C verified she was not wearing a N95 mask, a gown and gloves while picking up meal trays. R11 On 1/20/22, at 8:47 a.m. facility scheduler (FS)-A who wore a surgical mask and eye goggles left R11's (who had tested positive for COVID-19 on 1/19/22) room carrying a meal tray to serving cart, then walked down the hallway. FS-A was noted to not have a gown or gloves on. R11's	21390		

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21390	Continued From page 21 door had a sign present on his door which indicated R11 was in droplet isolation precautions. R17 On 1/21/22, at 7:57 a.m. NA-A was observed in the shared bathroom of R2, R25, and R17 (who tested positive for COVID-19 on 1/19/22) and filled a basin with water. R2 (who was COVID-19 negative) was seated on the edge of his bed by the door and a curtain divided the two residents. NA-A proceeded to provide morning cares for R17, while he sat on the edge of his bed. After NA-A was done completing morning cares for R17, NA-A went to the shared bathroom, emptied the basin water into the toilet, turned on the water faucet, rinsed the basin, emptied it again and filled the basin with soap and water. NA-A proceeded to assist R17 to complete the rest of his morning cares. At 8:14 a.m. NA-A again returned to the shared bathroom, emptied the basin, turned on the faucets, rinsed the basin and emptied the water into the toilet. At 8:15 a.m. while NA-A was still in the bathroom, R25 (who was COVID-19 negative) opened the door from the adjoining room and informed NA-A he needed to use the bathroom. NA-A left the shared bathroom into R17's room without cleaning or disinfecting the bathroom before R25 used the bathroom. 1/20/22, at 11:10 a.m. during a follow up interview with NA-C stated she had sanitized her hands after she picked up breakfast trays that morning. NA-C indicated she wore eye protection and a surgical mask for source control, and wore other PPE when providing cares in rooms of residents who had COVID-19. NA-C indicated she had not worn N95 masks, gowns or gloves when picking up trays from COVID positive residents that	21390		

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21390	Continued From page 22 morning. On 1/20/22, at 11:56 a.m. NA-D indicated he had assisted R4 by emptying his commode earlier and was not able to remember if he had applied a gown prior to entering R4's room. NA-D stated his usual practice was to apply full PPE, including gown, gloves, N95 mask and eye protection when entering any COVID-19 positive residents' rooms and to dispose of his N95 when he exited the room. On 1/21/22, at 8:24 a.m. NA-A indicated R17 did not use the bathroom, however R2 and R25 used the bathroom independently. NA-A confirmed R25 had used the bathroom right after he had emptied R17's basin and verified he had not disinfected the bathroom prior to R25 using it. NA-A stated at times R17 would leave his room at times to go out to smoke. NA-A indicated it was difficult to redirect residents to their rooms who were positive with COVID-19 and to remind them to wear their masks. On 1/20/22, at 2:53 p.m. director of nursing (DON) indicated infection preventionist (IP)-A currently had COVID-19 and DON was responsible for the infection prevention program while IP-A was out of the facility. The DON stated the last time the facility had completed fit testing for N95 masks was last year, and confirmed not all staff had been fit tested at that time. DON verified she expected staff to wear full PPE (gown, gloves, eye protection) for any reason when entering a resident's room who was known to be positive with COVID-19, which included wearing a N95 mask and to remove the N95 when leaving the room. The DON indicated this was important to prevent the spread of COVID-19 to other residents. The DON stated the facility	21390		

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21390	Continued From page 23 isolated residents who were COVID-19 positive for 14 days. The DON verified staff were allowed to wear a surgical mask over their N95 mask, if they were going from one resident COVID-19 room to another resident's room who had COVID-19. The DON indicated the staff were expected to remove the surgical mask covering their N95 mask before entering a different resident's room who was positive for COVID-19 to save time. The DON stated staff were expected to remove their N95 mask and dispose of it after leaving a COVID-19 room. The DON indicated staff were allowed to wear their N95 mask more than once if going from one COVID-19 positive room and to another. DON confirmed the facility had no concerns with PPE supplies, and was not in contingency or crisis mode for PPE supplies. On 1/21/22, at 9:29 a.m. registered nurse (RN)-A confirmed R11 and R12 shared a room, and R11, R12 and R15 shared a bathroom. RN-A verified R11 was positive for COVID-19, and R12 and R15 were negative for COVID-19. RN-A stated R11, R12 and R15 independently used the bathroom. RN-A stated the facility had not disinfected the bathroom after each resident use. RN-A indicated she had spoken to R12 and asked him to change rooms so he would not share rooms with R11, however he had refused. RN-A stated it had been difficult to change R15's routine due to a noted increase in his behaviors and the facility had not changed his room. RN-A stated the facility had offered to move R2, who was known to be COVID-19 negative, from R17's room who was positive with COVID-19, however R2 refused to move. RN-A indicated the facility tried to isolate residents who were positive as much as possible and reminded them to wear their masks. RN-A confirmed R11 was not	21390		

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compliant with isolating to his room, and he freely went out to public areas. RN-A stated she expected staff to attempt to redirect R11 back to his room whenever he was out of his room. RN-A indicated she expected staff to disinfect the shared bathrooms after a COVID-19 resident used it, or staff used it after caring for COVID-19 positive residents. RN-A stated it was important to isolate the residents who were COVID-19 positive to prevent COVID-19 transmission from positive residents to negative residents. RN-A did not identify she had provided any education, or risk vs benefits related to staying in his room.

On 1/21/22, at 10:03 a.m. LPN-C confirmed several COVID-19 positive residents were non-compliant to isolate in their rooms. LPN-C indicated when a COVID-19 positive resident left their room she attempted to redirect them back to their room and educated them, however, she indicated it was only effective for short periods of time due to their behaviors and refusal to comply. LPN-C stated residents who were COVID-19 negative were allowed out of their rooms, however they were encouraged to wear masks. LPN-C confirmed COVID-19 positive and negative residents were out of their rooms at the same time and indicated it was difficult to keep them separated due to the facility's challenged population.

On 1/21/22, at 10:26 a.m. in a follow-up interview, the DON confirmed the facility was in a COVID outbreak and had 13 residents who had currently tested positive for COVID-19. The DON indicated the facility was attempting to cohort COVID positive residents and had made some room changes. The DON stated R2 refused to move out of R17's room who had COVID-19, and R12 refused to move out of R11's room who had

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21390	Continued From page 25 COVID-19. The DON indicated those residents who shared bathrooms with residents who were known to have COVID-19 had been offered to move. The DON indicated their plan was to have staff sanitize the shared bathrooms used by COVID-19 positive and negative residents twice a shift. The DON confirmed residents who had COVID-19 were not being isolated to their rooms and staff attempted to redirect them, to make sure they were not around residents who did not have COVID-19. The DON confirmed R11 and R14 were not compliant with isolating to their rooms and were out in common areas with residents who did not have COVID-19, and confirmed most of their residents were non-compliant. On 1/21/22, at 11:35 a.m. the DON confirmed the facility had a contract with an outside vendor who conducted the facility COVID-19 testing. The DON indicated she expected the vendor staff to wear proper PPE which included eye protection, gown, gloves and N95 mask when swabbing residents for COVID-19. The DON stated she expected staff to donn new PPE after working with positive COVID-19 residents and after having exposure to them. The DON verified CAS-A had not been educated on proper infection control measures by the facility regarding testing and was not sure if CAS-A had been fit tested. The DON indicated her expectation for vender staff was to be properly educated on the use of PPE and to be fit tested to prevent further spread of COVID-19 to other residents and staff. The facility form titled Fit Testing Record updated 8/20/21, identified 69 staff members. The form identified 22 staff were fit tested between 6/18/21, to 8/6/21, and 47 staff members had not received fit testing.	21390		

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21390	Continued From page 26 On 1/24/22, at 12:34 p.m. infection preventionist (IP)-A confirmed the Fit Testing Record the facility had provided was the only documentation the facility had completed for fit testing. IP-A confirmed she was trained to fit test staff and had last completed N95 mask fit testing in June of 2021. IP-A stated fit testing of N95 masks was important to assure they sealed correctly and to protect the staff member from contracting or transmitting COVID-19. IP-A indicated fit testing should have been completed annually or more often if the person had weight loss, facial surgery or any changes in their facial structure for all staff who required a N95 mask. The IJ, which began on 1/21/22, was removed on 1/25/22, at 1:00 p.m. when it could be verified through observation, interview and document review the facility cohorted residents together whom were COVID-19 positive and COVID-19 negative. The facility explained risk and benefits to the resident whom were non-complaint and added this to their care plan. The facility employees responsible for testing had competencies completed for proper PPE usage during testing and training for antigen testing for COVID-19. Staff education was initiated and remains on-going for appropriate PPE usage which included donning/doffing, proper isolation of COVID-19 positive residents, redirection of residents to their rooms who are COVID-19 positive, encouraging surgical mask use and hand hygiene for residents and disinfection of high touch areas. Staff were educated prior to the start of their next shift and would not provide direct care until education was completed. Staff that were on leave, on-call and/or not frequently in the facility were mailed an education packet or verbal education would be completed on the	21390		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00945	A. BUILDING: _____ B. WING _____	C 01/25/2022

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21390	Continued From page 27	21390		

phone. Lastly, audits had been conducted on the above interventions.

Review of facility policy titled, Coronavirus (COVID-19) revised 9/2021, indicated the facility had initiated steps to minimize exposure to respiratory pathogens, promptly identify residents with clinical features and at risk for COVID-19 and to adhere to appropriate infection control practices. The strategies indicated within this policy would remain fluid as CDC and Department of Health recommendations to prepare for and respond to the community spread of Coronavirus Disease -2019 (COVID-19) changed. Monarch healthcare management facilities would continue to provide care for our residents as indicated within their plan of care and at the appropriate level of care. Under Facility Outbreak Protocol: to place residents in private rooms with private bathroom (if possible) and initiate droplet and contact precautions and cohort residents identified with same symptoms/COVID-19 conformation, if possible. Under Nursing PPE, Equipment and Supplies: Appropriate PPE (gloves, gown, mask, eye protection, per isolation precautions guidelines) would be applied and removed when entering or before exiting the resident rooms, per CDC and Department of Health donning and doffing guidance. Resident with known or suspected COVID-19 would be cared for using all recommended PPE, which included use of N95 or higher level respirator. Facilities would optimize and utilize PPE according to the CDC/CMS/ Department of Health current guidelines.

The facility document titled Fit Testing Steps, undated, identified the mask type for the next year, barring any major changes in facial structure (weight gain/loss, surgery etc). The

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21390	Continued From page 28 document instructed if the facility changed to a different type of respirator for any reason, they would need to be re-tested for the new type. The document identified some staff wore a surgical mask over the respirator to make it last longer. The facility policy titled Personal Protective Equipment-Contingency and Crisis Use of N-95 Respirators (COVID-19 Outbreak) dated 9/21, identified during conventional capacity the N95 mask use included discarding any previously used respirators. The policy identified adopting "just in time" fit testing when feasible. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review policies and procedures to ensure proper infection control policies included up to date COVID 19 infection control techniques are followed per CDC and CMS guidelines. Facility staff could be re-educated on identifying potential infectious symptoms, implementing appropriate transmission based precautions, and auditing the infection control processes developed to ensure compliance and help control/prevent exposure and spread of COVID 19 and infectious diseases. TIME PERIOD FOR CORRECTION: seven (7) days.	21390		