



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 17, 2021

Administrator
Oaklawn Care & Rehabilitation Center
201 Oaklawn Avenue
Mankato, MN 56001

RE: CCN: 245517
Cycle Start Date: December 3, 2020

Dear Administrator:

On December 28, 2020, we notified you a remedy was imposed. On January 19, 2021 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 January 12, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective January 12, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of December 28, 2020, 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 was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 12, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on January 12, 2021, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, 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,

A handwritten signature in black ink, appearing to read 'M. Poepping'.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
December 28, 2020

Administrator
Oaklawn Care & Rehabilitation Center
201 Oaklawn Avenue
Mankato, MN 56001

RE: CCN: 245517
Cycle Start Date: December 3, 2020

Dear Administrator:

On December 3, 2020, 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 a pattern of deficiencies that constituted immediate jeopardy (Level K) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On December 3, 2020, the situation of immediate jeopardy to potential health and safety cited at F880 was removed. However, continued non-compliance remains at the lower scope and severity of E.

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 January 12, 2021.
- 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 January 12, 2021 (42 CFR 488.417 (b)), (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 12, 2021 (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective January 12, 2021. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

DEPARTMENT CONTACT

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

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

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 June 3, 2021 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS DENIAL OF PAYMENT

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

Tamika.Brown@cms.hhs.gov

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

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

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions

are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

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

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping', with a stylized, cursive script.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/13/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245517	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/03/2020
NAME OF PROVIDER OR SUPPLIER OAKLAWN CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 201 OAKLAWN AVENUE MANKATO, MN 56001		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments A COVID-19 Focused Infection Control survey was conducted on 12/2/20 - 12/3/20 at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.73(b)(6). The facility was IN full compliance Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000			
F 000	INITIAL COMMENTS On 12/1/20- 12/3/20, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found NOT to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: #H5517035C, with a deficiency cited at F880. The following complaints were found to be UNSUBSTANTIATED: #H5517035C In addition, a COVID-19 Focused Infection Control survey was conducted at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was determined NOT to be in compliance. The survey resulted in findings of immediate jeopardy (IJ), at F880, when it was determined the facility did not utilize full personal protective	F 000			

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

TITLE

(X6) DATE

Electronically Signed

01/07/2021

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 equipment (PPE) including gowns to prevent the spread of COVID-19 for residents that were new admissions or re-admitted to the facility following hospitalization, during the 14-day quarantine period. The director of nursing (DON), administrator, infection preventionist, and registered nurse (RN) consultant were notified of the IJ, at 7:11 p.m. on 12/2/20. The IJ was removed on 12/3/20, at 9:35 a.m., however, noncompliance remained at the lower scope and severity level of an E, indicating a pattern, with no actual harm with potential for more than minimal harm that is not IJ. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, a revisit of your facility will be conducted to validate substantial compliance with the regulations has been attained in accordance with your verification.	F 000			
F 880 SS=K	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880			1/12/21

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

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F 880	Continued From page 3 disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the Centers for Disease Control (CDC) guidelines to prevent and/or minimize the transmission of COVID-19 resulting in an immediate jeopardy (IJ) due to the increased risk for transmission of COVID-19 for 9 of 12 residents (R2, R3, R4, R5, R6, R7, R8,R9, R11) reviewed for infection control practices. This had the potential to affect all 60 residents who resided in the facility. The IJ began on 12/2/20, when the facility failed to implement transmission based precautions (TBP) utilizing all necessary personal protective equipment (PPE) including gowns, for 14 days for newly admitted residents and residents readmitted from the hospital who required quarantine. The administrator, director of nursing (DON), infection preventionist (IP) and registered	F 880	All affected residents were immediately placed on transmission-based precautions. All necessary PPE was immediately placed for residents 2, 3, 4, 5, 6, 7, 8, 9 and 11 and signage to indicate the quarantine status and the need to keep door closed. Clear signage to indicate the quarantine status as well as type of precautions was placed on the doors of those residents indicated, utilizing proper language to assure resident rights to privacy are being followed. PPE needed was placed outside the resident's doors. The deficient practice has the potential to affect all residents. All residents were reviewed to assure any quarantine needs or transmission-based precaution needs		

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F 880	Continued From page 4 nurse consultant (RNC), were notified of the immediate jeopardy at 7:11 p.m. on 12/2/20. The immediate jeopardy was removed on 12/3/20, when the facility implemented corrective action, but noncompliance remained at the lower scope and severity level of an E, pattern with no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R2 was readmitted to the facility on 11/18/20, with quarantine identified as ending 12/3/20. On 12/2/20, at 2:22 p.m. the door to R2's room was observed shut with no signage on the door to indicate R2 was on TBP. In addition, there was no PPE set up in place outside of the resident's room. R3 was admitted to the facility on 12/1/20, with quarantine identified as ending 12/16/20. On 12/2/20, at 2:22 p.m. the door to R3's room was observed open with R3 sitting inside the room. There was no signage on the door to indicate R3 was on TBP. In addition, there was no PPE set up in place outside of the resident's room. R4 was readmitted to the facility after hospitalization on 11/25/20, with quarantine identified as ending 12/10/20. On 12/2/20, at 2:22 p.m. the door to R4's room was observed open with R4 sitting inside the room. There was no signage on the door to indicate R4 was on TBP. In addition, there was no PPE set up in place outside of the resident's room. R5 was admitted to the facility on 11/23/20, with quarantine identified as ending on 12/8/20. On 12/2/20, at 2:23 p.m., the door to R5's room was	F 880	indicated were implemented. All staff were re-educated on 12/2/2020 on the procedures for resident quarantine who are positive for COVID or are in their observation period and transmission-based precautions including necessary PPE to be worn in order to prevent the transmission of COVID or other infectious diseases. Training also included a revised procedure for identifying all residents who are on quarantine so any staff would be aware and able to identify these residents. The Coronavirus Policy and Procedure was reviewed and remains current. The DON or designee conduct transmission-based precaution audits on all shifts four times a week for one week, then twice weekly for one week once compliance is met. The audit results will be taken to the QAPI meeting and the team will decide if audits should be continued or discontinued. In order to identify and implement other systemic changes, an independent Infection Control Consultant meeting the criteria as outlined by MDH will be contracted to work with the facility for a minimum of 2 months. The consultant will assist the facility in completing the CMS Infection Control Self-Assessment. The consultant will also meet with the facility QAPI Committee to review the RCA as to the deficient practice to assure sustainable corrections have been placed		

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F 880	Continued From page 5 observed open with R5 sitting inside the room. There was no signage on the door to indicate R5 was on TBP. In addition, there was no PPE set up in place outside of the resident's room. R1 was readmitted to the facility after hospitalization on 12/1/20. On 12/2/20, at 2:23 p.m. the door to room was observed shut with PPE supplies in a cardboard container hanging outside the door. The door also had signage related to use of PPE when entering R1's room. R1's care plan revised 9/14/20, indicated the resident was on contact precautions r/t (related to) VRE (Vancomycin-resistant enterococci- a type of bacteria called enterococci that have developed resistance to many antibiotics, especially vancomycin) in the urine. R6 was admitted to the facility on 11/20/20, with quarantine identified as ending 12/5/20. On 12/2/20, at 2:23 p.m. the door to R6's room was observed open with R6 sitting inside the room. There was no signage on the door to indicate R6 was on TBP. In addition, there was no PPE set up in place outside of the resident's room. R7 was admitted to the facility on 11/23/20, to room 416. R7's quarantine was to end on 12/8/20. On 12/2/20, at 2:23 p.m. the door to R7's room was observed shut with no signage on the door to indicate R7 was on TBP; also, no PPE was observed outside of the resident's room. R8 was readmitted to the facility following hospitalization on 11/27/20, following hospitalization, to room 417. R8's quarantine was to end on 12/12/20. On 12/2/20, at 2:24 p.m. the door to R8's room was observed open with R8 sitting inside the room. There was no signage on	F 880	to prevent recurrence and that corrections are in place for all identified affected residents. The consultant will review the policies and procedures for donning and doffing PPE for transmission-based precautions during COVID 19 with current guidelines to include crisis standard of care, contingency standard of care and standard care as well as standard and transmission-based precautions policies to assure they are current and accurate. Training for all staff to include the DON and Infection Preventionist will be completed to assure proper understanding and practice of transmission-based precautions to include appropriate PPE use and donning and doffing of PPE. This training will be for any department where staff enter resident rooms as well as those who provide direct care. Education on the need for quarantine as well as the required type of precautions and PPE will be provided to the resident and/or resident representative, depending upon the resident's capacity. The DON, Infection Preventionist and other facility leadership will conduct audits of donning/doffing PPE with Transmission Based Precautions i.e. Droplet precautions on all shifts four times a week for one week, then twice weekly for one week once compliance is met. Audits will continue until 100% compliance is met.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245517	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/03/2020
NAME OF PROVIDER OR SUPPLIER OAKLAWN CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 201 OAKLAWN AVENUE MANKATO, MN 56001		
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F 880	Continued From page 6 the door to indicate R8 was on TBP. In addition, there was no PPE set up observed outside of the resident's room. R9 was admitted to the facility on 11/25/20 with quarantine scheduled to end on 12/10/20. On 12/2/20, at 2:24 p.m. the door to R9's room was observed open with R9 sitting inside the room. There was no signage on the door to indicate R9 was on TBP. In addition, there was no PPE set up observed outside of the resident's room. R10 was admitted to the facility on 11/25/20. On 12/2/20, at 2:25 p.m. the door to R10's was observed shut with PPE supplies in a cardboard container hanging from the outside of the door. The door also had signage related to use of PPE when entering R1's room. Review of R10's medical record revealed R10 was tested for COVID-19 on 11/30/20, and received a positive result on 12/1/20. R10's progress note dated 12/1/20 at 17:06 (5:06 p.m.) included the following: Resident was updated has tested positive for COVID-19 and will be in quarantine and on precautions. R11 was admitted to the facility on 11/30/20, with quarantine scheduled to end on 12/15/20. On 12/2/20, at 2:26 p.m. the door to R11's room was observed open with R11 sitting inside the room. There was no signage on the door to indicate R11 was on TBP. In addition, there was no PPE set up observed outside of the resident's room. R12 was readmitted to the facility on 11/23/20, following hospitalization. R11's quarantine was to end on 12/8/20. On 12/2/20, at 2:26 p.m. the door to R12's room was observed shut with PPE supplies in a cardboard container hanging from	F 880	The audits will also verify the placement of each new admission and that transmission-based precautions have been implemented. The audit results will be taken to the QAPI meeting and the team will decide if audits should be continued or discontinued.		

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F 880	Continued From page 7 the outside of the door. The door also had signage related to use of PPE when entering R12's room. Review of R12's progress note dated 11/24/20, at 12:31 p.m. indicated R12 had visited family after discharge from the hospital prior to return to the facility and the family member had tested positive for COVID-19 within the last 1-2 weeks. The note further indicated R12 would be placed on "precautions". When interviewed on 12/2/20, at 2:33 p.m. nursing assistant (NA)-A stated new admissions or residents that returned to the facility following hospitalization were identified on a worksheet at the nurses' station, and also by a sign on their room doors. When asked what the signage would look like, NA-A pointed to R12's room which had PPE hanging over the door and signs with instructions for PPE use prior to entering the room. NA-A stated she was new to her position but thought that all new admissions and readmits from the hospital would have PPE and the signs on their doors, but wasn't sure. When interviewed on 12/2/20, at 2:39 p.m. registered nurse (RN)-A confirmed new admits or residents that were returning from the hospital, were quarantined to their room for 14 days. RN-A stated those residents were identified on a worksheet at the nurses' station and were also identified on a report in the computer which included the date the resident could come off of quarantine. RN-A stated residents on quarantine did not have signage on their door unless they were on TBP that included gowning and gloving with direct care. RN-A further confirmed room doors should be closed for residents on quarantine and NA's should be aware of that. RN-A stated only 3 of the 12 residents on	F 880			

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F 880	Continued From page 8 quarantine that were on transmission-based precautions due to known such as R12 who had a known COVID exposure, R10 who had a COVID positive test, and R1 who had another infections requiring TBP due to an infection in the urine. On 12/2/20, at 3:40 p.m. NA-A was observed entering R6's room. NA-A did not don a gown or gloves prior to entering the room. Upon exiting R6's room at 3:50 p.m., the surveyor asked NA-A if R6 was quarantined with TBP. NA-A stated she didn't think so, because there wasn't a sign on the outside of the door to his room. When asked where the information was kept that identified residents on quarantine, NA-A went to the nurses' desk but was unable to locate the worksheet of quarantined residents. NA-A then asked NA-B where to find the information. NA-B showed NA-A where to locate the documented worksheet of quarantined residents which was located in a binder at the nurses' desk. The worksheet confirmed R6 was quarantined. NA-B acknowledged being aware of which residents were quarantined, and confirmed only the residents with PPE set ups on the door outside their room were on TBP. NA-B further confirmed when doing direct cares with quarantined residents without the PPE set ups, staff did not don gowns prior to care such as bathing and toileting. When interviewed on 12/2/20, at 4:35 p.m. NA-C confirmed residents who were new admissions or were re-admitted from the hospital were quarantined to their room for 14 days. NA-C stated staff were informed during report if there was a new admission or readmission from the hospital. NA-C could not state off the top of her	F 880			

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F 880	Continued From page 9 head which residents were still on quarantine other than stating, "The ones with PPE outside of their room". NA-C confirmed R10 was recently put on TBP after testing positive for COVID-19. NA-C was not aware of which residents remained on quarantine other than the 3 with PPE outside of their room, and did not know where to locate the information identifying who was on quarantine. NA-C stated, other than the residents with PPE set ups, staff did not don gowns when providing direct cares such as bathing and toileting. NA-C was unable to state where staff could obtain extra PPE but thought it may be available "downstairs or in the nurses' office". When interviewed on 12/2/20, at 4:45 p.m. the director of nursing (DON) confirmed staff had not been directed to implement TBP for all new admissions and readmissions from the hospital as they were trying to conserve their gowns in case of an outbreak of COVID-19. The DON further confirmed there was no signage on the resident's doors to identify new admissions or readmissions from the hospital, and stated moving forward they would be adding that information to the the NA's care sheets. The facility's policy Coronavirus (COVID-19) revised 11/24/20, included: Create a plan for managing new admissions and readmissions whose COVID-19 status is unknown. Options include placement in a single room or in a separate observation area so the resident can be monitored for evidence of COVID-19. Resident can be transferred out of the observation area to the main facility if they remain afebrile and without symptoms for 14 days after their admission. All recommended COVID-19 PPE should be worn during care of residents under observation which	F 880			

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F 880	Continued From page 10 includes: use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown (if facility supplies allow). At a minimum, facemask and eye protection should be utilized. The immediate jeopardy that began on 12/2/20, was removed on 12/3/20 at 9:35 a.m., when it could be verified the facility had developed and implemented interventions to ensure newly admitted, and hospital readmissions, were appropriately quarantine with TBP implemented. In addition, the facility had placed PPE set ups outside of the quarantine residents rooms along with a "Welcome" sign to indicate resident on quarantine. The facility also initiated training to ensure all staff were knowledgeable regarding quarantine, and use of TBP, prior to starting their next shifts.			F 880			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 28, 2020

Administrator
Oaklawn Care & Rehabilitation Center
201 Oaklawn Avenue
Mankato, MN 56001

Re: Event ID: NIO811

Dear Administrator:

The above facility survey was completed on December 3, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping'.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
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: 00038	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/03/2020
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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 12/1/20 - 12/3/20, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be IN compliance with the MN State Licensure. The following complaint was found to be SUBSTANTIATED: #H5517035C, with a	2 000		

Minnesota Department of Health

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

TITLE

(X6) DATE

Electronically Signed

01/07/21

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00038	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 12/03/2020
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2 000	Continued From page 1 deficiency cited at F880. NO licensing orders were issued The following complaint was found to be UNSUBSTANTIATED: #H5517034C The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000			

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

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

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

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

<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/GuidanceforRCA.pdf>.

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

PERSONAL PROTECTIVE EQUIPMENT (PPE)

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

POLICIES/PROCEDURES/SYSTEM CHANGES:

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

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

- Review policies and procedures for donning/doffing PPE for TBD and during COVID-19 with current guidelines to include crisis standard of care, contingency standard of care and standard care.
- Review policies regarding standard and transmission based precautions and revise as needed.

TRAINING/EDUCATION:

As a part of corrective action plan, the facility must provide training for the Infection Preventionist, the Director of Nursing, all staff providing direct care to residents, and all staff entering resident's rooms, whether it be for residents' dietary needs or cleaning and maintenance services. The training must cover standard infection control practices, including but not limited to, transmission-based precautions, appropriate PPE use, and donning and doffing of PPE.

- The training may be provided by the Director of Nursing, Infection Preventionist, or Medical Director with an attestation statement of completion.
- The training must include competency testing of staff and this must be documented.
- Online infection prevention training courses may be utilized. The CDC and MDH websites have several infection control training modules and materials.

CDC RESOURCES:

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

CDC: Isolation Precautions Guideline:

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

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

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

Healthcare Infection Prevention and Control FAQs for COVID-19:

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

MDH RESOURCES:

Personal Protective Equipment (PPE) for Infection Control:

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

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

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

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

Interim Guidance on Alternative Facemasks (PDF):

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

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

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

Droplet Precautions:

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

Airborne Precautions:

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

MONITORING/AUDITING:

- The Director of Nursing, the Infection Preventionist, and other facility leadership will conduct audits of donning/doffing PPE with Transmission Based Precautions i.e. Droplet precautions.
- The Director of Nursing, Infection Preventionist, and other facility leadership will conduct routine audits on all shifts four times a week for one week, then twice weekly for one week once compliance is met. Audits should continue until 100% compliance is met on source control masking for staff, visitors and residents.
- The Director of Nursing, Infection Preventionist, or designee will review the results of audits and monitoring with the Quality Assurance Program Improvement (QAPI) program.

COHORTING RESIDENTS/TRANSMISSION BASED PRECAUTION "ISOLATION"

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

POLICIES/PROCEDURES/SYSTEM CHANGES:

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

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

- Grouping of residents, or "cohorting," should be done when possible to separate residents with an infectious disease (positive residents) from residents who are not affected. Plans to cohort should be carefully established in advance and should be centered on implementation of infection control practices. Room should have clear signage for staff with applicable direction of PPE use.

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

following:

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

TRAINING/EDUCATION:

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

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

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

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

Healthcare Infection Prevention and Control FAQs for COVID-19:

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

MDH RESOURCES:

Personal Protective Equipment (PPE) for Infection Control:

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

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

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

<https://www.health.state.mn.us/diseases/coronavirus/hcp/masksource.pdf>

Interim Guidance on Alternative Facemasks (PDF):

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

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

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

Droplet Precautions:

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

Airborne Precautions:

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

MONITORING/AUDITING:

- The Director of Nursing, the Infection Preventionist and other facility leadership will verify the placement of each new admission and location and audit for transmission based precautions are being appropriately implemented.

- Conduct a Root Cause Analysis (RCA) which will be done with assistance from the Infection Preventionist, Quality Assurance and Performance Improvement (QAPI) committee and Governing Body. The RCA should be incorporated into the intervention plan. Information regarding RCAs can be found in the document: Guidance for Performing Root Cause Analysis (RCA) with Performance Improvement Projects (PIPs)

<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/GuidanceforRCA.pdf>

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

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

Imposition of this DPOC does not replace the requirement that the facility must submit a complete POC for all cited deficiencies (including F880) within 10 days after receipt of the Form CMS 2567.

Item	Checklist: Documents Required for Successful Completion of the Directed Plan
1	Consultant name and credentials meeting the criteria outlined above
2	Executed contract with the consultant
3	Documentation demonstrating that the RCA was completed as described above
4	List of facility policies and procedures reviewed by the consultant.
5	Infection control self-assessment
6	Summary of all changes as a result of the RCA and consultant review – to include a summary of how staff were notified and trained on the changes

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

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