Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 27, 2025

Administrator
The Shores Of Worthington
1307 South Shore Drive
Worthington, MN 56187

RE: CCN: 245596
Cycle Start Date: December 12, 2025

Dear Administrator:

On January 26, 2024, we notified you a remedy was imposed. On February 14, 2025 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 14, 2025.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective January 10, 2025 be discontinued as of January 14, 2025. (42 CFR 488.417 (b))

In our letter of February 4, 2025, 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 January 10, 2025. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 27, 2025

Administrator
The Shores Of Worthington
1307 South Shore Drive
Worthington, MN 56187

Re: Reinspection Results
Event ID: 1HF412

Dear Administrator:

On February 14, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on January 15, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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Federal Enforcement | Health Regulation Division
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February 4, 2025

Administrator
The Shores Of Worthington
1307 South Shore Drive
Worthington, MN 56187

RE: CCN: 245596
Cycle Start Date: December 12, 2024

Dear Administrator:

On December 26, 2024, we informed you of imposed enforcement remedies.

On January 15, 2025, the Minnesota Department of Health completed a survey 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 widespread deficiencies that constituted immediate jeopardy (Level L), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY

On January 15, 2025, the situation of immediate jeopardy to potential health and safety cited at F880 was removed. However, continued non-compliance remains at the lower scope and severity of F.

As a result of the survey findings:

- Directed plan of correction, Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.
- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective January 10, 2025.

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 location only if CMS agrees with our recommendation.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective January 10, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 10, 2025.

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 December 26, 2024, 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 January 10, 2025.

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:

Lisa Krebs, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 June 12, 2025 (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:

Steven.Delich@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
202-795-7490

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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information

Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolutioN

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

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February 4, 2025

Administrator
The Shores Of Worthington
1307 South Shore Drive
Worthington, MN 56187

Re: State Nursing Home Licensing Orders
Event ID: 1HF411

Dear Administrator:

The above facility was surveyed on January 10, 2025 through January 15, 2025 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:

Lisa Krebs, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING _____ B. WING _____	C 01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SHORES OF WORTHINGTON	1307 SOUTH SHORE DRIVE WORTHINGTON, MN 56187

(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
F 000	INITIAL COMMENTS On 1/10/25, 1/14/25, and 1/15/25, a standard abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH). The facility was not found NOT to be in compliance with the requirements of 42 CFR Part 483, Subpart B, requirements for Long Term Care Facilities. The survey resulted in an immediate jeopardy (IJ) to resident health and safety. An IJ F880 began on 12/28/24, when the facility failed to implement infection control strategies for respiratory protection to mitigate the risk and spread of Respiratory Syncytial Virus. Thirteen residents tested positive, 6 suspected, 3 residents were sent to the emergency department, and 2 residents were hospitalized. The Administrator, director of nursing (DON) (by phone), clinical nurse consultant (CNC)-A (by phone), Infection Preventionist (IP)-A, clinical manager (CM)-A, and assistant DON (ADON) were notified of the IJ on 1/14/24 at 5:37 p.m. The immediate jeopardy was removed on 1/15/25 at 2:49 p.m., The following complaints were reviewed: H55965124C (MN00109874) with a deficiency cited at F880. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/07/2025

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 Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
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 §483.71 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	F 880		1/15/25

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F 880	Continued From page 2 communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct 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 infection control strategies for respiratory protection to mitigate the risk and spread of Respiratory Syncytial Virus (causes infections of the	F 880	R 4, 5, 10, and 7 returned from the hospital and were placed in the appropriate transmission-based precautions upon return to the facility. R8 expired on hospice services on 1/20/2025.	

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F 880	Continued From page 3 respiratory tract) (RSV). As a result, the facility developed an outbreak where 13 residents (R4, R10, R5, R1, R14, R3, R2, R7, R8, R15, R13, R16, and R12) tested positive for RSV, and 7 residents were suspected to have RSV (R17, R19, R18, R21, R20, R6, R9); 3 residents (R4, R5, and R10) had to be seen in the emergency room, and 2 residents (R7, and R8) were hospitalized with RSV. These practices resulted in an immediate jeopardy (IJ) due to the likelihood of spread to the remaining 48 residents in the facility. The IJ began on 12/28/24, when the facility failed to implement infection control strategies to mitigate the risk and spread of RSV in the facility. The Administrator, director of nursing (DON) (by phone), clinical nurse consultant (CNC)-A (by phone), Infection Preventionist (IP)-A, clinical manager (CM)-A, and assistant DON (ADON) were notified of the IJ on 1/14/24 at 5:37 p.m. The immediate jeopardy was removed on 1/15/25 at 2:49 p.m., but noncompliance remained at the lower scope and severity level F, which indicated no actual harm with the potential for more than minimal harm that is not immediate jeopardy. Finding include: Isolation: Isolation separates sick people with a contagious disease from people who are not sick. Quarantine separates and restricts the movement of people who were exposed to a contagious disease to see if they become sick. Personal protective equipment (PPE): Personal protective equipment (PPE) refers to protective items or garments worn to protect the body or clothing from hazards that can cause injury and to protect residents from cross-transmission. These	F 880	R 1, 2, 3, 4, 5, 10, 12, 13, 15 and 16 remained in the facility and were placed in the appropriate transmission-based precautions. R 6, 9, 17, 18, 19, 29 and 21 were suspected to have respiratory signs and symptoms and was placed in transmission based precautions. All resident activities and communal dining were stopped on 1/13/2025. Future residents that experience or is suspected of infection, they will be placed in transmission-based precautions, the appropriate assessment will be initiated, the physician will be notified, and his/her response will be recorded in the resident record. Facility clinical leadership (DON, ADON and MDS coordinator) in-serviced all facility staff on the Transmission Based Precaution Categories with emphasis on item #5 that when a resident is suspected of having an infection, they are placed in transmission-based precautions and the proper signage will be placed to indicate the need for the proper precautions. The Clinical IDT team was also in-serviced on the Isolation – Initiating Transmission based precaution policy and procedure with emphasis on item #4 that precautions remain until the attending physician discontinues them. The IP designee and DON will be responsible for tracking resident infections via the resident electronic infection control portal and will surveillance residents through visual observation, reviewing clinical documentation, employee and community illnesses and antibiotic start orders. A Directed Plan of Correction (DPOC) was	

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F 880	Continued From page 4 items may include a gown, gloves, eye protection and face mask. Enhanced barrier precautions (EBP): refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. Gowns and gloves are used as PPE. Transmission based precautions (TBP): refer to actions (precautions) implemented in addition to standard precautions that are based upon the means of transmission (airborne, contact, and droplet) in order to prevent or control infections. Airborne, contact and droplet are the three subcategories under TBP. Contact precautions: refer to measures that are intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the resident or the resident's environment. Use with gloves, and gowns as PPE. Droplet precautions: refer to actions designed to reduce/prevent the transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions, masks are used as PPE. During an observation and interview on 1/10/25 at 8:30 a.m., registered nurse clinical manager (RNCM)-A stated the facility had Respiratory Syncytial Virus (RSV) and instructed staff to wear surgical masks. No signs were posted in the foyer or entrance area to alert visitors to wear a mask in facility. Fifteen residents were sitting in the dining room with 3-4 residents sitting at each table. No masks were on the residents. The facility staff were masked with surgical masks. Upon entrance to the dining room an unidentified	F 880	issued for this deficient practice. This DPOC intervention will be implemented after root cause has been identified. The Director of Nursing and/or designee is responsible for compliance. Audits on identifying s/s of infection, placing residents in the appropriate transmission-based precautions, every shift documentation on resident infection status, infection control line listing, and MD documentation of completion of resident signs and symptoms will begin 2 x week for 3 weeks, weekly x 3 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Corrected: 1/15/2025	

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F 880	Continued From page 5 nursing assistant (NA) moved the mask from under his chin to cover his nose and mouth while walking between residents. During an interviews on 1/10/25 at 2:06 p.m., infection Preventionist (IP)-A stated the first case of RSV was identified on 12/28/24 (R4) and had a total of seven positive cases to date with a new case identified today 1/10/25 (R2). R4 RSV positive on 12/28/24 R4's medical diagnoses dated 1/16/25, identified congestive heart failure (heart cannot pump blood well enough to meet the body's needs), and dependence on supplemental oxygen. R4's hospital ED note dated 12/28/24, identified R4 was seen due to cough and shortness of breath. R4 had known chronic obstructive pulmonary disease (COPD) and may have a COPD exacerbation. R4's ED identified RSV test was positive and likely the cause of the COPD exacerbation. There was no indication in the medical record, R4 was placed on isolation precautions (Droplet, contact precautions) with PPE upon return from the ED, even though they were diagnosed with RSV. R4's progress note dated 1/6/25, identified R4 had complained of coughing up small amounts of blood clots. Examined the clots to be mucous clots tinged with blood related to R4's harsh cough. The progress note identified R4 was off isolation precautions for RSV today however, the record did not identify precautions had been implemented.	F 880		

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F 880	Continued From page 6 R4's progress note dated 1/9/25, identified R4 needed oxygen at 2 liters/min for shortness of breath with activity. R4's physician orders identified had an order for as needed oxygen. R4's medication administration record identified in December oxygen was used eleven times and in January used on 1/5/25, 1/9/25, and 1/13/25. R4's progress notes dated 1/10/25, identified R4 stated that every time he breathed in it makes him cough and lung sounds with crackles. At 5:30 a.m. R4 was transferred to the hospital due to non-stop coughing. At 1:30 p.m. R4 returned from hospital with diagnoses of RSV, that had continued from 12/28/24. R4's progress note dated 1/13/25, identified R4's cough was at baseline and will be removed from droplet precautions. R4's record did not identify precautions had ever been implemented. R4's respiratory symptom screeners between 1/11/25-1/15/25, identified R4 had a cough on all days between 1/12/25 through 1/15/25. R10 RSV positive on 12/31/25 R10's face sheet dated 1/15/25, identified diagnoses of hypoxemia (low oxygen) and diabetes. R10's progress notes identified the following: -12/28/24, R10 did not feel well and was coughing. -12/30/24, R10 required nebulizer treatment for wheezing. -12/31/24, indicated R10 had adventitious lung sounds, pain when breathing, nasal congestion, left ear pain, and cough. R10 was sent to the	F 880		

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F 880	Continued From page 7 emergency department (ED). R10's ED note dated 12/31/24, identified R10 was positive for RSV and diagnosis of acute bronchiolitis (inflammation of bronchi in the lungs) due to RSV. R10 came to ED with complaints of a cough and feeling ill for more than 10 days and getting worse. R10 stated the cough occurred constantly and had been gradually getting worse. R10's progress note dated 12/31/24, identified ED called facility to notify of positive RSV test. Isolation precaution sign and tray/cart for personal protective equipment (PPE) was set up. Vital signs obtained on return from ED. R10's physician visit note dated 1/9/25, identified R10 continued with a persistent cough after RSV infection and will be taken off isolation today. Increased Duo Neb to three times daily for 7 days. R10's respiratory assessments between 1/11/25 through 1/4/25, identified R10 had diminished lung sounds on 1/12/25. R10's record reviewed between 12/28/24 through 1/13/25, identified R10 had respiratory illness symptoms that began on 12/28/24. R10's record and facility surveillance did not identify immediate implementation of TBP (transmission based precautions) nor ongoing consistent symptom monitoring between 12/28/24 through 1/10/25. R5 RSV positive on 1/2/25 R5's face sheet dated 1/16/25, identified diagnoses of diabetes mellitus type 2, and chronic kidney disease (condition where kidneys have been damaged).	F 880		

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F 880	Continued From page 8 R5's progress note dated 12/26/24, identified R5 complained of an irritated throat. R5 was given cough drop and cough syrup. R5's progress note did not identify a respiratory assessment or vital testing was done. R5's progress note dated 12/28/24, identified R5 complained of throat irritation but did not indicate if a respiratory assessment, viral testing or provider was notified. R5's progress note dated 1/1/25, identified R5 went to clinic appointment to have an medication injection and on 12/31/24, R5 was transported by a medical van service to location where had unknown labs drawn. R5's record did not identify if R5 was provided with a mask during transport. R5's progress note dated 1/2/25, identified R5 complained of sore throat, congestion, runny nose and wheezing in lungs. COVID-19 test performed and negative results. Primary care provider was notified and ordered RSV test which was completed and sent to the clinic for results. R5's laboratory report dated 1/3/25, identified positive RSV test completed on 1/2/25. R5's progress note dated 1/3/25, identified R5's RSV test was positive. There was no indication that isolation/precautions were initiated even though R5 was positive for RSV. R5's progress note dated 1/7/25, identified R5 went to an outside appointment and was transported by a medical van service at 7:30 a.m. and returned to facility around noon. There was no indication that transportation service or outside	F 880		

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F 880	Continued From page 9 appointment facility were aware of R5's RSV diagnosis to prevent the spread of infection. During an observation on 1/10/25 at 1:49 p.m., R5 was sitting alone at a table in the activity in the dining area playing bingo without a mask on. R5 coughed six times without a mask on and did not cover his mouth or sanitize his hands after coughing. R5's cough was wet/productive. There were ten other residents were in the area also playing bingo at tables spaced approximately 4-6 feet apart, one resident passed approximately 1-2 feet directly by R5. R5's progress note dated 1/10/25 at 7:31 p.m., identified R5 had worsening respiratory symptoms and increasing worsening cough. R5 had bilateral wheezes. R5 stated he has not gotten better and feels worse. Resident requested to be seen in the emergency department for evaluation (ED) R5's emergency department (ED) note dated 1/10/25 at 8:15 p.m., identified diagnoses of subacute cough. Presented to ED with dry cough. R5 was given breathing treatment and returned to the facility. During an interview on 1/10/25 at 1:52 p.m., LPN-A stated R5 just came out of isolation this week for RSV, however unable to give specific date he was removed. LPN-A was not sure how it was determined that residents could be removed from isolation and was unsure when R5 tested positive. LPN-A reviewed R5's record and verified R5 tested positive on 1/2/25 and was on isolation for 7 days. During an interview on 1/10/25 at 1:52 p.m., RN-A	F 880		

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F 880	Continued From page 10 stated staff would monitor residents for symptoms of RSV through a cough and how they sound. They would be under precautions for seven days and then no longer were infectious. R1-positive on 1/3/25 R1's face sheet dated 1/15/25, identified R1 had diagnoses that included diabetes mellitus type 2. R1's record between 12/31/24 through 1/3/25 did not identify respiratory symptoms screening was completed. R1's progress note dated 1/3/25, identified R1 was having a non-productive cough worsening throughout the day, complained of not feeling well in her chest, and had a hoarse voice. R1 was tested for RSV. At 9:10 p.m., R1's lab test returned positive for RSV. Sign placed and staff will wear PPE. The progress note did not identify what type of precautions were implemented nor identify if isolation was implemented on 1/3/25. R1's progress notes dated 1/5/25 and 1/10/25, identified R1 went out to an appointment with a medical van transporting on 1/3/25 for wound care. R1's record did not identify if R1 wore a mask during the transport or if the wound clinic was informed of R1's positive test results. R1's progress note dated 1/11/25, identified R1 was on isolation precautions and slept well. R1 did not include respiratory assessments and monitoring were completed from 1/3/25-1/10/25 for RSV, even though the facility had several residents with RSV.	F 880		

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F 880	Continued From page 11 R1's respiratory assessments were completed once on 1/11/25, 1/14/25, and 1/15/25. Completed four times on 1/12/25, and twice on 1/13/25. The assessments identified on 1/11/25, R1 had a dry non-productive cough and shortness of breath. On 1/13/25 and on 1/14/25, R1 had wheezes throughout lung lobs. During an observation on 1/10/25 at 10:13 a.m., R1 had two signs outside of her room, contact precautions and EBP (enhanced barrier precautions). Staff entered R1's room with no PPE on to transport her to the medical van for an appointment. R1 agreed to wear a mask when exiting room. During an interview on 1/10/25 at 9:13 a.m., licensed practical nurse (LPN)-A stated R1 had two precaution signs outside of her room, contact was for the RSV and EBP was for her wound. LPN-A could not articulate the difference between contact and EBP precautions. LPN-A stated R1 would be finishing contact precautions today, 1/10/25. LPN-A was unsure of the exact date R1 tested positive. LPN was aware of R1 still having a cough because R1 was getting over RSV. R14 RSV positive on 1/3/25 R14's face sheet dated 1/19/25, identified diagnoses of Parkinson's disease and congestive heart failure. R1's record between 12/28/24 through 1/3/25 did not identify respiratory symptom screening was completed, even though the facility had several residents with RSV. R14's progress note dated 1/3/25 at 2:48 p.m., identified R14 was not feeling well, poor appetite,	F 880		

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F 880	Continued From page 12 lethargic, and weakness. Physician sent orders to test residents that are symptomatic for RSV; R14 tested positive for RSV. R14's record did not indicate TBP, and isolation were immediately implemented. R14's progress note dated 1/7/24 identified R14 had all meals in their room and continued to receive therapy services. R14's progress note dated 1/9/25, identified R14 was up in wheelchair for both meals. Progress note did not identify if R14 was in his room for meals. R14's record did not identify if and when TBP and isolation were implemented nor include symptom monitoring between 1/3/25 through 1/9/25. Between 1/9/25 and 1/15/25, R14's record included respiratory assessment which did not identify symptoms of illness. On 1/15/24, R14's was on isolation precautions, however, did not address PPE requirements. R3-positive on 1/3/25 R3's face sheet dated 1/16/25, identified diagnoses of diabetes mellitus type 2, and chronic kidney disease (damaged kidneys). R3's unsigned and undated physician order included place in isolation precautions per facility infection control policy. Corresponding treatment administration records identified "x"' in the boxes indicating the order was not completed. R3's record reviewed between 12/23/24 through 1/13/24, identified R3 had respiratory illness symptoms that began on 12/24/24. R3's record and facility surveillance did not identify immediate	F 880		

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F 880	Continued From page 13 implementation of TBP after (PPE and isolation) on 12/23/24 nor identify ongoing symptom monitoring to determine appropriate discontinuation of PPE and isolation. R3's progress notes identified the following: -12/23/24, R3 had a sore throat and nasal congestion. COVID test negative. -12/24/24, R3 had a cough, an antibiotic and cough syrup was ordered by the physician. -12/29/24, R3 had hoarse voice, adventitious (abnormal) lung sounds, cough with secretions, and nasal congestion. R3's record did not indicate the physician was notified of the ongoing symptoms. -12/31/24, R3 had nasal congestion, crackles in lungs, and cough. Negative COVID test. -1/1/25, R3 had cough, congestion, and not feeling well. -1/2/25, R3 complained not feeling well, loss of appetite, and dry non-productive cough. -1/3/25, R3 tested positive for RSV. -1/4/25, R3 was administered cough medication. -1/12/25, indicated R3 did not receive a shower due to isolation precautions. -R3's progress note dated 1/13/25, identified R3 remained on precautions for RSV symptoms which included raspy voice, and occasional cough. Lung sounds were clear. During an observation on 1/10/25, R3 was in her wheelchair inside her room. R3 was sleeping. Two precaution signs posted on entrance to her room directing staff to use contact precautions and enhanced barrier precautions. A red biohazard bag was noted in R3's recliner with used personal protective gowns coming out of the top and resting on the armrest of the recliner. In addition, a red bin with the top open and multiple isolation gown noted to be hanging out the top	F 880		

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F 880	Continued From page 14 and touching the sides of the bin. R2-RSV positive on 1/8/25 R2's face sheet dated 1/22/25, identified diagnoses of type 2 diabetes. R1's record between 12/31/24 through 1/7/25 did not identify respiratory symptoms screening was completed, even though the facility had several residents with RSV. R2's progress note dated 1/8/25, identified R2 to be coughing, adventitious sounding, tested for COVID and RSV. R2's record did not identify TBP were implemented. During record review on 1/10/24 at 8:00 a.m. R2's RSV test results were not included in her record. During an observation on 1/10/25 at 9:13 a.m., LPN-A stated she was aware R2 had a cough, and she knew she was tested for COVID-19/Influenza A&B and RSV but was unsure if she was negative. LPN-A entered R2's room with gloves on, no mask and no gown. While LPN-A used one of R2's fingers to check her blood sugar, R2 had her face turned toward LPN-A, R2 coughed three times without covering her mouth. LPN-A touched R2's hands then her own clothing. R2' progress note dated 1/10/25 at 1:37 p.m., identified call placed to hospital following up on lab results. R2 was positive for RSV. At 10:20 p.m., R2 was placed on droplet precautions. During an interview on 1/10/25 at 9:22 a.m., registered nurse (RN)-A stated she noted R2 had a cough on 1/8/25 and performed a COVID-19 test in house and did a swab for a quad test	F 880		

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F 880	Continued From page 15 (COVID-19/Influenza A&B/RSV) test and took to the clinic. RN-A stated she was not sure of R2's test results but thought R2 tested negative. RN-A thought RSV would be droplet precautions verses contact precautions because RSV was a respiratory virus which required droplet. RN-A stated as of today 1/10/25, the facility had two active cases of RSV currently in the same unit R1 and R3. During an interview on 1/10/25 at 2:06 p.m., infection preventionist (IP)-A stated the facility had just received R2's positive test results for RSV collected at 4:00 p.m. on 1/8/25 that resulted on 1/8/25 at 5:22 p.m. IP-A stated R2 should have been placed on respiratory precautions on 1/8/25 due to being symptomatic. IP-A stated she was unaware a test had been performed on R2 on 1/8/25. IP-A confirmed R2 was not on contact or droplet precautions since 1/8/25 and would be placed in isolation today, 1/10/25. During an interview on 1/10/25 at 2:33 p.m., (RNCM)-A stated R2 was tested for COVID on the evening of 1/8/25 due to coughing in-house and a quad test was taken to the clinic. R2 was not put on isolation. R2 only had a cough on 1/8/25 and had not had one since. R2 did not leave her room very often; R2 ate in her room and did not attend activities and was not on TBP until 1/10/25 after the facility became aware. R7 RSV positive on 1/8/25 R7's face sheet dated 1/17/25, identified diagnoses of diabetes mellitus type 2, dementia, atrial fibrillation. R7's medical record did not identify respiratory assessment screening between the confirmed	F 880		

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F 880	Continued From page 16 RSV outbreak on 12/31/24 through 1/8/24 the date R7 presented to the hospital with respiratory illness symptoms. R7's progress note dated 1/8/25, indicated R7 had irregular rapid heart rate, was lethargic, nauseated, tired, and pale. R7 was sent to the ED. R7's emergency department (ED) note dated 1/8/25, identified R7 presented in ED from the nursing home with atrial fibrillation and rapid ventricular rate in the context of decreased oral intake, generalized weakness and cough. R7's ED note identified R7 tested positive for RSV with reported symptoms that started on 1/6/25. R7's hospital discharge summary dated 1/10/25, identified R7 was admitted 1/8/25 to 1/10/25 for atrial fibrillation with rapid ventricular rate, RSV with acute bronchiolitis due to RSV, and acute cystitis (bladder infection). R7's discharge summary stated R7's presentation, including the rapid ventricular rate was triggered by acute RSV infection. R7's progress note dated 1/10/25, identified occasional cough due to RSV positive and placed on droplet precautions. R7's progress note did not identify if/when isolation was implemented. R7's respiratory assessments dated 1/10/25 through 1/15/25, identified cough on 1/10/25, 1/13/25 and 1/15/25. During an interview on 1/10/25 at 2:33 p.m., RNCM-A stated residents that were RSV positive did not need to isolate, if they came out of their room they had to wear a mask and distance	F 880		

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F 880	Continued From page 17 themselves from other residents. Nursing monitored for common signs and symptoms and test if needed. Nursing did not document monitoring for every resident in the electronic record showing that monitoring was done. RNCM-A would start staff and resident tracing if the need developed. During an interview on 1/10/25 at 3:00 p.m., RNCM-A was in-person, and director of nursing (DON) via phone, DON verified that no monitoring had been completed of residents had been completed and no symptom monitoring of all residents had been done. DON stated IP-A should be ensuring these steps were completed. R8 RSV positive on 1/10/25. R8's face sheet dated 1/17/25, identified diagnoses of Alzheimer's, and dementia. R8's record between 12/31/24 through 1/9/25 did not include respiratory illness screening. R8's progress note dated 1/10/25 at 9:12 a.m., identified R8 was not eating this morning and unable to swallow pills and spit everything but water out. R8's progress note dated 1/10/25 at 8:44 p.m., identified outbreak of RSV per resp. screener R8 should be tested for RSV however did not identify if R8 had symptoms. Call placed to medical provider and test sent to lab. R8's progress noted dated 1/11/25 at 6:21 a.m., identified R8 was on droplet precautions for RSV pending results. R8's note indicated R8 had a new cough through the night. R8's record did not address isolation was immediately implemented.	F 880		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 18 R8's progress note dated 1/11/15 at 12:31 p.m., identified lab results were positive for RSV. R8 unable to stay in room and had been wandering mostly in the dining room, sat at a table by himself, and was unable to keep mask pulled up on his face. R8's emergency department (ED) notes dated 1/13/25, identified R8 was seen on 1/13/25 at 9:33 p.m., with diagnoses of sepsis, and RSV. R8 was sent to ED for generalized and weakness and low blood pressure after testing positive at facility for RSV. ED gave breathing treatment and intravenous methylprednisolone, and normal saline. R8 was transferred to hospital. R8's hospital note dated 1/16/25, identified a stay from 1/14/25-1/16/25, with diagnoses of septic shock, with return to facility on hospice care. R15 RSV positive on 1/10/25 R15's face sheet dated 1/17/25, identified diagnoses of bradycardia (slow heart rate), and acute respiratory failure with hypoxia. R15's progress note dated 12/31/24, identified R15 had a large emesis. R15's record did not include further assessment. R15's between 12/28/24 through 1/2/25 did not include respiratory illness screening, even though the facility had several residents with RSV. R15's progress note dated 1/3/25 at 4:00 a.m., identified R15 stated she could not breathe. Oxygen saturation was 84% on 3 liters per minute of oxygen via nasal cannula. Noted clammy skin, and R15 was sweaty. At 3:56 p.m., R15 had a hoarse voice, was lethargic, and low appetite.	F 880		

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F 880	Continued From page 19 Notified hospice. R15's progress note dated 1/5/25, indicated R15 was provided breathing treatment for audible wheezes and chest discomfort. At 10:44 p.m., R15 had non-productive cough, complained of a sore throat, and had an emesis. R15's progress note dated 1/6/25 at 2:30 a.m., identified complaints of pain to lower back and chest area when she coughs. At 3:48 a.m., coughing was at a minimum and wheezing was heard while breathing. R15's progress note dated 1/8/25 at 10:35 p.m., cough syrup had been given and was effective. R15's progress note dated 1/9/25 at 12:27 a.m., identified as needed oxygen was administered and effective. R15's progress notes indicated oxygen remained in place on 1/9/25, and 1/10/25. R15's progress note dated 1/10/25, identified respiratory assessment completed and indicated R15 should be tested for RSV. R15 was put on "precautions" pending test results. R15's record did not identify what type of precautions were implemented. R15's record identified test results on 1/11/25 at 2:27 p.m. were positive for RSV. R15's progress note dated 1/11/25 at 2:41 p.m., identified oxygen in use, moist/loose productive cough. R15's progress note dated 1/12/25, identified left	F 880		

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F 880	Continued From page 20 and right lungs had crackles on auscultation, moist/loose productive cough present with small secretions. R15's progress note dated 1/13/25 at 1:53 p.m., identified R15 was coughing and gagging as she coughed. Although R15 demonstrated respiratory symptoms that began on 1/3/25, there was no indication testing had been completed with the onset of symptoms nor TBP were implemented until 1/10/25, 7 days after symptoms were identified. There was no indication that symptom monitoring was completed between 1/3/25 through 1/10/25. During an interview on 1/14/25 at 9:30 a.m., RN-A stated R15 was positive for RSV and had a roommate. For the roommate we pull the curtain and have her wear a mask when she leaves the room. During an observation on 1/14/25 at 9:34 a.m., R15 and roommate were both sitting in wheelchairs in their room. The curtain was partially drawn. R15 coughed which was very wet sounding, she did not cover her mouth or sanitize hands after. R13 RSV positive on 1/13/25 R13's face sheet dated 1/15/25, identified diagnoses of chronic obstructive pulmonary disease (COPD) (inflammation and obstruction of lung airways). R13's record identified between 12/31/24 through 1/9/25 did not include respiratory illness screening, even though the facility had an onset	F 880		

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F 880	Continued From page 21 of RSV. R13's progress note dated 1/13/25 at 2:15 p.m., identified during respiratory screener R13 complained of cough, coughing up clear phlegm, experienced chest tightness. Placed on droplet precautions. Physician ordered test. At 8:53 p.m., RSV results returned positive. R13's record did not identify if/when isolation was implemented. R16 RSV positive on 1/13/25 R16's face sheet dated 1/19/25, identified diagnoses of congestive heart failure (heart cannot pump blood well enough to meet the body's needs), and acute kidney failure. R16's record identified between 12/28/24 through 1/9/25 did not include respiratory illness screening, even though the facility had several residents with RSV. R16's progress note dated 1/13/25 at 4:30 a.m., identified lung sounds wheezy and persistent non-productive cough. 5:47 a.m., a respiratory assessment was completed, and cough was noted to be dry and non-productive. R16's progress note dated 1/14/25 at 4:35 a.m., identified R16 was placed on droplet/contact precautions for RSV positive test on 1/13/35. At 10:24 p.m., cough was noted to be moist and non-productive with wheezing noted in lungs. During an observation on 1/14/25 at 10:56 a.m., R16 was in the activity/dining area sitting in a recliner without a mask on with multiple other residents in the area who also did not have masks on.	F 880		

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F 880	Continued From page 22 R12-RSV positive on 1/14/25 R12's face sheet dated 1/17/25, identified diagnoses of myalgia (muscle pain). R12's record identified between 12/28/24 through 1/9/25 did not include respiratory illness screening, even though the facility had several residents with RSV. R12's progress note dated 1/13/25, identified new non-productive cough during respiratory screener. Lung sounds clear. Quad test completed and sent to lab. Droplet precautions Education provider to staff to perform hand hygiene, cough etiquette and distancing outside of room. R12's progress note did not indicated isolation was initiated. R12's lab report dated 1/14/25, identified RSV detected from nasal swab. During an interview on 1/14/25 at 9:25 a.m., activity aide (AA)-B stated the staff use hand sanitize prior to doing anything and wipe down things that they reuse. AA-B stated residents have the right to leave their rooms and when they do, they should be encouraged to mask up. AA-B was unsure if the residents had to wear a mask outside of their rooms but thought they did. AA-B thought residents would have to stay farther away from other residents if they were supposed to be on precautions and left their rooms. R17 suspected respiratory disease 1/10/25 R17's face sheet dated 1/19/25, identified R17 had diagnoses that included type 2 diabetes. R17's record between 12/28/24 through 1/7/25 did not include respiratory illness screening, even	F 880		

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F 880	Continued From page 23 though the facility had several residents with RSV. R17's progress noted dated 1/8/25, lungs clear and no cough. R17's record did not include a respiratory screener on 1/9/25. R17's respiratory illness screener dated 1/10/25 thorough 1/15/25 did not identify any respiratory symptoms. R17's progress note dated 1/10/25 at 8:52 p.m., identified outbreak of RSV per respiratory screener resident should be tested for RSV. Test sent to lab. R17's progress note did not identify isolation or PPE was initiated. R17's progress note dated 1/11/25 at 6:28 a.m., identified R17 was placed on droplet precautions for RSV pending lab test results. R17 was noted to have an occasional non-productive cough throughout the night. At 12:23 p.m., cough was moist and non-productive. At 1:45 p.m., identified lab results were negative for RSV, influenza A and B, and COVID. R17's record did not identify an alternative diagnosis for the new cough and did not indicate when precautions were removed. During an observation and interview on 1/14/25 at 9:51 a.m. R17 sat in a recliner in the activity room without a mask on, which was not in accordance with R17's record dated 1/11/25 that directed droplet precautions. NA-A confirmed R17 was sitting in a recliner in the activity room with no mask on.	F 880		

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F 880	Continued From page 24 R19 suspected respiratory disease 1/10/25 R19's face sheet dated 1/19/25, identified R19 had diagnoses that included type 2 diabetes. R19's record reviewed from 12/28/24 through 1/9/25, was not evident of ongoing consistent symptom monitoring was completed between 1/3/25 through 1/9/25, even though the facility had several residents with RSV. R19's progress note dated 1/10/25 at 8:51 p.m., identified the respiratory screener indicated R19 should be tested for RSV. R19's progress note did not specify symptoms or that isolation or TBP were initiated. During an observation on 1/10/25 at 1:10 p.m., R19 was laying in her bed with no respiratory symptoms observed. R19's progress note dated 1/11/25 at 8:08 a.m., identified R19 was placed on droplet precautions. No cough and afebrile. At 1:27 p.m., test results for respiratory diseases returned negative. Moist, non-productive cough noted. R19's progress notes did not indicate isolation or TBP were initiated after symptom onset on 1/11/25. R19's respiratory symptom screeners between 1/10/25-1/14/25, identified a moist non-productive cough on 1/11/25. R19's progress note dated 1/14/25, identified R19 left facility for an appointment out of state and did not return until after supper. R18 suspected respiratory disease 1/10/25	F 880		

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F 880	Continued From page 25 R18's face sheet dated 1/23/25, identified R18 had diagnoses that included type 2 diabetes R18's record reviewed from 12/28/24 through 1/9/25, did not include respiratory symptom screening, even though the facility had several residents with RSV. R18's progress note dated 1/10/25 at 12:36 p.m., identified R18 was very lethargic and moody. Refused breakfast and lunch. At 8:49 p.m., respiratory screener identified R18 should be tested for RSV. R18's record did not identify any specific symptoms and did not identify if TBP were initiated. R18's progress note dated 1/11/25 at 5:35 a.m., identified R18 was placed on droplet precautions pending RSV test results. At 1:33 p.m., R18 noted to have a moist, non-productive cough. R18's lab results dated 1/10/25, that were reviewed and faxed to the facility on 1/11/25 at 12:50 p.m. identified no COVID, influenza A and B or RSV detected. During an observation and interview on 1/14/25 at 9:51 a.m., NA-A confirmed R19 was sitting at the dining room table with three other residents and not wearing mask, including R18. NA-A stated residents did not have to wear masks when they were in the common areas even if they were on precautions. R21 suspected respiratory disease 1/10/25 R21's face sheet dated 1/19/25, identified R21 had diagnoses that included shortness of breath. R21's record reviewed from 12/28/24 through	F 880		

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F 880	Continued From page 26 1/9/25, did not include respiratory symptom screening, even though the facility had several residents with RSV. R21's progress note dated 1/10/25, identified from respiratory screener that an RSV test needed to be completed due to new dry, non-productive cough. Test sent to lab. R21's progress note dated 1/11/25 at 5:14 a.m., resident on isolation for droplet precautions. At 1:47 p.m., moist, non-productive cough noted. Lab returned with negative results; daughter requested R21 be sent to the ED for evaluation. At 8:44 p.m., diagnosis of pneumonia and antibiotic prescribed. R21's respiratory symptom screener between 1/12/25 through 1/14/25 indicated R21 continued to have moist productive cough and non-productive cough. During an observation on 1/14/25 at 9:51 a.m., R21 had isolation precautions sign on room door but R21 was sitting in a chair in the main area next to another resident with no mask on. R20 suspected respiratory disease 1/10/25 R20's face sheet dated 1/19/25, identified diagnoses of atrial fibrillation (irregular heart rhythm in the heart's upper chambers). R20's record reviewed from 12/28/24 through 1/9/25, did not include respiratory symptom screening, even though the facility had several residents with RSV. R20's progress note dated 1/10/25, identified respiratory screener indicated R20 should be	F 880		

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F 880	Continued From page 27 tested for RSV. Test sent to lab. The progress note did not identify if TBP were implemented. R20's progress note dated 1/11/25 at 5:32 a.m., identified R20 was on droplet precautions. No cough noted and remained afebrile. At 1:22 p.m., moist, non-productive cough noted. At 1:25 p.m., lab results returned negative. At 9:36 p.m., no cough noted. R20 did not have any symptoms noted between 1/12/25-1/14/25 from the respiratory screener. R6-suspected respiratory disease 1/10/25 R6's face sheet dated 1/22/25, identified diagnoses of dementia, and acute kidney failure. R6's record reviewed from 12/28/24 through 1/10/25, did not include respiratory symptom screening, even though the facility had several residents with RSV. R6's symptom screener between 1/10/25 through 1/12/25 identified R6 did not have respiratory illness symptoms. R6's progress note dated 1/13/25, identified R6 was noted to have a new cough on 1/12/25 and tested per standing order for RSV. R6's record did not identify TBP were initiated upon identification of symptoms. During an observation on 1/14/25 at 9:24 a.m., R6 and R12 were identified as roommates. Droplet precaution sign on door, cart with PPE supplies was at the next room over. R12 positive (for RSV) was in the room, R6 (suspected) was not in the room. The room door was open and curtain divider was open.	F 880		

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F 880	Continued From page 28 During an interview on 1/14/25 at 9:30 a.m., RN-A stated R6 was out of her room and in the dining room so she could be assisted with eating breakfast. R6 was not under precautions because she was tested on 1/13/25 and had negative results. R6's roommate (R12) was on droplet precautions and was positive for RSV. We have been trying to pull curtains and doing hand hygiene before doing cares on either resident. During an interview on 1/14/25 at 9:39 a.m., RNCM-A stated R6 did leave her room this morning to have breakfast in the dining room as she needed complete assistance. We ruled out the negative test and lab this morning from the DON. During an interview on 1/14/25 at 10:37 a.m., IP-A stated R6 should be in her room and not out in the facility. R6's progress note dated 1/14/25 at 6:31 p.m., identified RSV test was negative. Encouraged staff hand hygiene, separation in room with curtain. R9 suspected respiratory disease 1/14/25 R9's face sheet dated 1/17/25, identified diagnoses of COPD. R9's record between 12/28/24 through 1/9/25 did not include respiratory illness screening, even though the facility had several residents with RSV. R9's respiratory illness screener dated 1/10/25 through 1/13/25 did not identify any respiratory symptoms.	F 880		

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F 880	Continued From page 29 During an observation on 1/14/25 at 10:09 a.m., R9 was in the dining room and working on a puzzle with another resident and a nursing assistant. R9 wore a mask and was coughing and sneezing. At 10:11 a.m., took off mask and blew nose, did not sanitize hands. Activity aide brought R9 back to her room at 10:20 a.m. R9's record did not identify a respiratory symptoms screener prior to coming out of her room. During an observation on 1/14/25 at 10:09 a.m., R9 was in the dining room and working on a puzzle with another resident and a nursing assistant. R9 wore a mask and was coughing and sneezing. At 10:11 a.m., took off mask and blew nose, did not sanitize hands. Activity aide brought R9 back to her room at 10:20 a.m. R9's respiratory illness screener completed on 1/14/25 at 11:18 a.m., with symptoms of new cough and mucus production. R9's progress note dated 1/14/25 at 11:40 a.m. identified a new onset of productive cough with runny nose. R9 put in isolation and will be tested for RSV Progress note dated 1/15/25 identified RSV results were negative, R9 will remain on droplet precautions and medication for cough. R9's progress note did not identify isolation was implemented. During an interview on 1/14/25 at 9:30 a.m., RN-A stated all residents have been getting a respiratory assessment completed daily since 1/10/25, and symptomatic and positive residents were to have a respiratory assessment completed	F 880		

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F 880	Continued From page 30 every shift. During an interview on 1/14/25 at 9:39 a.m., RNCM-A stated after surveyors left the building on 1/10/25, nursing screened all the residents for illness and tested anyone that had a positive screen. Because the screening was implemented, we were able to identify a resident new onset of symptoms who ended up testing positive for RSV. RNCM-A indicated by completing active screener we were able to take measures sooner to prevent the spread. RNCM-A further explained it was difficult to keep positive/symptomatic resident in their rooms. Staff had been directed to communicate if they were feeling ill and their symptoms were monitored. During an observation on 1/14/25 at 9:54 a.m., memory care residents R19, R17, R21, R18 (suspected positive) were in the dining room and adjoining television area with no masks on. Several other residents who were not symptomatic were also in this area. During an interview on 1/14/25 at 10:07 a.m., nursing assistant (NA)-A stated residents under precautions in the memory care did not need to wear masks when they were in the dining room or living room areas. During an observation on 1/14/25 at 10:44 a.m., R6 who had respiratory symptoms however, was not demonstrating symptoms as she was sitting in the hallway in her wheelchair with her mask under her nose, housekeeper (HSK)-A was in the hallway with R6. HSK-A with gloved hands touched R6's hand. HSK-A did not remove her soiled gloves or perform hand hygiene and then	F 880		

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F 880	Continued From page 31 entered R11's room to clean. HSK-A moved items on bedside table and touched top and sides of bedside table with her soiled gloves. During an interview on 1/14/25 at 9:20 a.m., IP-A stated eight residents were tested on 1/10/25 and two were positive. Tested again on 1/13/25 and found three more positive cases. One resident was sent to the hospital (R8). Residents with upper respiratory symptoms should be tested and placed under precautions. No staff had tested positive as of 1/14/25 but one activity staff had worked on 1/11/25, called in to work on 1/12/25 with cough, sore throat, and fever and tested positive for influenza. No other staff with respiratory symptoms. Since 1/10/25, to mitigate the spread of RSV daily respiratory assessments was implemented for all residents. If the assessment identified symptoms quad testing was completed, symptomatic residents were isolated, droplet precautions were implemented, and staff were educated. Staff education was not documented. When residents are symptomatic/positive isolation is implemented, then on the 7th day, nursing reviewed to see if residents remained symptomatic, if there is no symptoms isolation is discontinued, if symptom continue then isolation should be continued. At 10:37 a.m., IP-A stated suspected residents even if tested negative should remain in their rooms and only come out for bathing. At 11:11 a.m. IP-A stated it was difficult to keep masks on residents who resided in memory care and keep them in there room. During an interview on 1/14/25 at 1:06 p.m., IP-A stated she talked with facility nurse consultant (NC)-A who advised that all residents that were symptomatic but tested negative on the quad test	F 880		

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	245596	A. BUILDING _____ B. WING _____	C 01/15/2025

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F 880	Continued From page 32 could be removed from precautions. During an interview on 1/14/25 at 2:45 p.m., medical director (MD)-A stated he would expect the facility to review with the providers signs and symptoms of infection prior to removing them from precautions. We would like to isolate the residents that are symptomatic or positive for seven days and treat them just how we would treat positive COVID or influenza and isolate as such. Rarely would RSV cause death in a resident unless they are severely immunocompromised. The facilities Infection Control Plan, tracking and trending logs and any meeting minutes were request but never provided by the facility. During various interviews on 1/14/25 at 9:20 a.m., and 1/15/25 at 9:20 a.m. infection preventionist (IP)-A indicated there was no infection control logs; there was no real time tracking of illness symptoms for residents and staff, no trending of infections, no analysis of spread, and no infection prevention/containment activities were documented or identified. IP-A identified she was keeping track of RSV positive residents in her head until 1/10/25 when the survey team entered the facility. IP-A explained staff were monitoring residents for fever, cough, and respiratory signs and symptoms, however, indicated no active screening for illness was in place. If a resident had symptoms a quad test (influenza A&B, COVID, RSV) was obtained and documented in a progress note. If the test was positive the resident would be put on precautions; staff were required to gown, glove, and mask when they entered the room. Residents should eat in their rooms for meals and if a resident left their room, they would	F 880		

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F 880	Continued From page 33 need to wear a mask. Residents who resided in a double rooms remained in the double room and staff would monitor the roommate for signs and symptoms. "The facility did not want to test and treat symptomatic hospice residents" Staff should be donning and doffing (putting on and taking off) gowns, gloves, and masks after leaving the room, and applying a new mask. IP-A stated the "physician reviewed with interdisciplinary team (IDT) that RSV viral shedding should be completed in seven days and isolation can be discontinued." If a resident was symptomatic, they should be on precautions and not allowed to "run around the facility." During an interview on 1/15/25 at 2:24 p.m., infection preventionist (IP)-A stated she is supposed to get reports of employee illnesses from all departments and is not getting them consistently. IP-A stated for this outbreak she would use this data to look for correlations of staff infections and current resident infections to look for infections that could cause and outbreak, but not getting all the infection reports from staff it would be difficult to evaluate. Policies Facility standing order, undated, effective 1/3/25-1/31/25, identified all residents that have a specific primary care provider, and condition of >100.4 Fahrenheit (F) fever, new or worsening cough, difficulty breathing, new loss of taste or smell, new myalgia (muscle weakness), excessive fatigue, new severe headache, new nasal congestion were directed to have a Quad lab completed that tested for COVID, Influenza A and B, and RSV. The facility Employee Pre/Post Exposure	F 880		

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F 880	Continued From page 34 (Respiratory) facility policy that was updated 1/14/25, identified infected healthcare workers will be monitored and managed by the IP. Staff that develop fever and respiratory symptoms will be: -instructed not to report to work, if at work to stop resident care activities, don a facemask, and notify designee before leaving work. -IP will work with the staff to determine appropriate time to return to work and appropriateness of contact with residents. Standard precautions will be used during the care of all residents, including frequent hand hygiene. Droplet precautions will be implemented for residents with suspected or confirmed respiratory illness for seven days after illness onset or until 24 hours after the resolution of fever and respiratory symptoms, whichever is longer. Residents under droplet precautions will be discharged from care when clinically appropriate, not based on the period of potential virus shedding or recommended duration of droplet precautions. Before discharge, the resident's diagnosis and current precautions will be provided to care providers as well as transporting personnel. The facility Surveillance for Infections, revised September 2017, identified IP will conduct ongoing surveillance for healthcare associated infections (HAI) and other epidemiologically significant infections that have substantial impact on potential resident outcome and may require transmission-based precautions and other preventative interventions. Purpose of the surveillance of infections is to identify both individual cases and trends of significant organisms and HAI, to guide appropriate interventions, and to prevent future infections.	F 880		

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F 880	Continued From page 35 5. nursing staff will monitor residents for signs and symptoms that may suggest infection and will document and report suspected infections to the charge nurse as soon as possible. 6. if a communicable disease outbreak is suspected, this information will be communicated to the charge nurse and IP immediately. 8. IP and attending physician will determine if lab tests are indicated, whether special precautions are warranted, the attending physician and interdisciplinary team (IDT) will determine treatment plan. 9. if transmission-based precautions or other preventative measures are implemented to slow or stop the spread of infection, the IP will collect data to help determine the effectiveness of such measures. The facility Isolation-Categories of Transmission-Based Precautions revised September 2022, identified transmission-based precautions are initiated when a resident develops signs and symptoms of transmissible infection; arrives for admission with symptoms of an infections; or has a laboratory confirmed infections; and is at risk of transmitting the infection to other residents. The facility Handwashing/Hand Hygiene policy, revised August 2019, identified hand hygiene as the primary means to prevent the spread of infections: The IJ that began on 12/26/24 was removed on 1/15/25 when it was verified the facility implemented the following: 1. The isolation categories Transmission Based Precautions Policy and Procedure was reviewed by IDT and no changes warranted on 1/14/25. 2. Facility clinical leadership would in-service all	F 880		

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F 880	Continued From page 36 staff on Transmission Based Precaution Categories with emphasis on item #5 that when a resident is suspected of having an infection, they are placed in transmission-based precaution and the proper signage will be placed to indicate the need for the proper precautions. Facility staff will also be in-serviced on hand hygiene policy with emphasis on item #7 which lists when hand hygiene must take place. 3. The clinical IDT was in-serviced on the Isolation-Initiating Transmission based precautions policy and procedure with emphasis on item #4 that precautions remain until the attending physician discontinues them. 4. The facility nurses will continue to use the Respiratory Infection Screening Tool Assessment for residents every shift and for residents who are confirmed, the Nurse Advantage Respiratory Evaluation will be utilized daily until the MD has discontinued isolation precautions after IDT assesses that resident symptoms have resolved. Any resident who is suspected of infection, the physician will be notified, and his/her response will be recorded in the resident record. 5. Current residents will not partake in communal activities or dining unless feeding assistance is needed until the outbreak has been resolved. Any positive or suspected resident will remain in room and receive feeding assistance in rooms. Non-symptomatic residents will be allowed to eat in dining room. 6. Facility staff will be in-serviced on the Employee Illness Policy with emphasis on item #1 that instructs any employee who suspects that them may be ill, must don a mask and will be instructed not to return to work until 24 hours after symptoms have resolved. 7. Facility clinical staff who missed the above in-service education and hand hygiene	F 880		

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F 880	Continued From page 37 competency will be in-serviced prior to the beginning of their shift. A mass message was sent to all employees, posting was placed at door and clinical leadership will be present prior to beginning of the shift for in-service education. 8. For residents who are in a room with suspected/positive roommate, staff will use clean PPE for non-symptomatic resident, keep curtain closed, encourage mask use if ambulating in the room, educate on hand hygiene and cough etiquette and offer hand sanitizer frequently.	F 880		

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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 1/10/25, 1/14/25, and 1/15/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued: 1375. Please indicate in your electronic plan of	2 000		

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2 000	Continued From page 1 correction you have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed: H55965124C (MN00109874) with a licensing order issued at 1375. 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 is enrolled in ePOC and therefore a signature is	2 000		

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2 000	Continued From page 2 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		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to implement infection control strategies for respiratory protection to mitigate the risk and spread of Respiratory Syncytial Virus (causes infections of the respiratory tract) (RSV). As a result, the facility developed an outbreak where 13 residents (R4, R10, R5, R1, R14, R3, R2, R7, R8, R15, R13, R16, and R12) tested positive for RSV, and 7 residents were suspected to have RSV (R17, R19, R18, R21, R20, R6, R9); 3 residents (R4, R5, and R10) had to be seen in the emergency room, and 2 residents (R7, and R8) were hospitalized with RSV. These practices resulted in an immediate jeopardy (IJ) due to the likelihood of spread to the remaining 48 residents in the facility. The IJ began on 12/28/24, when the facility failed	21375	Corrected.	1/15/25

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21375	Continued From page 3 to implement infection control strategies to mitigate the risk and spread of RSV in the facility. The Administrator, director of nursing (DON) (by phone), clinical nurse consultant (CNC)-A (by phone), Infection Preventionist (IP)-A, clinical manager (CM)-A, and assistant DON (ADON) were notified of the IJ on 1/14/24 at 5:37 p.m. The immediate jeopardy was removed on 1/15/25 at 2:49 p.m., but noncompliance remained at the lower scope and severity level F, which indicated no actual harm with the potential for more than minimal harm that is not immediate jeopardy. Finding include: Isolation: Isolation separates sick people with a contagious disease from people who are not sick. Quarantine separates and restricts the movement of people who were exposed to a contagious disease to see if they become sick. Personal protective equipment (PPE): Personal protective equipment (PPE) refers to protective items or garments worn to protect the body or clothing from hazards that can cause injury and to protect residents from cross-transmission. These items may include a gown, gloves, eye protection and face mask. Enhanced barrier precautions (EBP): refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. Gowns and gloves are used as PPE. Transmission based precautions (TBP): refer to actions (precautions) implemented in addition to standard precautions that are based upon the means of transmission (airborne, contact, and droplet) in order to prevent or control infections. Airborne, contact and droplet are the three subcategories under TBP.	21375		

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21375	Continued From page 4 Contact precautions: refer to measures that are intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the resident or the resident's environment. Use with gloves, and gowns as PPE. Droplet precautions: refer to actions designed to reduce/prevent the transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions, masks are used as PPE. During an observation and interview on 1/10/25 at 8:30 a.m., registered nurse clinical manager (RNCM)-A stated the facility had Respiratory Syncytial Virus (RSV) and instructed staff to wear surgical masks. No signs were posted in the foyer or entrance area to alert visitors to wear a mask in facility. Fifteen residents were sitting in the dining room with 3-4 residents sitting at each table. No masks were on the residents. The facility staff were masked with surgical masks. Upon entrance to the dining room an unidentified nursing assistant (NA) moved the mask from under his chin to cover his nose and mouth while walking between residents. During an interviews on 1/10/25 at 2:06 p.m., infection Preventionist (IP)-A stated the first case of RSV was identified on 12/28/24 (R4) and had a total of seven positive cases to date with a new case identified today 1/10/25 (R2). R4 RSV positive on 12/28/24 R4's medical diagnoses dated 1/16/25, identified congestive heart failure (heart cannot pump blood well enough to meet the body's needs), and dependence on supplemental oxygen.	21375		

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21375	Continued From page 5 R4's hospital ED note dated 12/28/24, identified R4 was seen due to cough and shortness of breath. R4 had known chronic obstructive pulmonary disease (COPD) and may have a COPD exacerbation. R4's ED identified RSV test was positive and likely the cause of the COPD exacerbation. There was no indication in the medical record, R4 was placed on isolation precautions (Droplet, contact precautions) with PPE upon return from the ED, even though they were diagnosed with RSV. R4's progress note dated 1/6/25, identified R4 had complained of coughing up small amounts of blood clots. Examined the clots to be mucous clots tinged with blood related to R4's harsh cough. The progress note identified R4 was off isolation precautions for RSV today however, the record did not identify precautions had been implemented. R4's progress note dated 1/9/25, identified R4 needed oxygen at 2 liters/min for shortness of breath with activity. R4's physician orders identified had an order for as needed oxygen. R4's medication administration record identified in December oxygen was used eleven times and in January used on 1/5/25, 1/9/25, and 1/13/25. R4's progress notes dated 1/10/25, identified R4 stated that every time he breathed in it makes him cough and lung sounds with crackles. At 5:30 a.m. R4 was transferred to the hospital due to non-stop coughing. At 1:30 p.m. R4 returned from hospital with diagnoses of RSV, that had continued from 12/28/24. R4's progress note dated 1/13/25, identified R4's	21375		

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21375	Continued From page 6 cough was at baseline and will be removed from droplet precautions. R4's record did not identify precautions had ever been implemented. R4's respiratory symptom screeners between 1/11/25-1/15/25, identified R4 had a cough on all days between 1/12/25 through 1/15/25. R10 RSV positive on 12/31/25 R10's face sheet dated 1/15/25, identified diagnoses of hypoxemia (low oxygen) and diabetes. R10's progress notes identified the following: -12/28/24, R10 did not feel well and was coughing. -12/30/24, R10 required nebulizer treatment for wheezing. -12/31/24, indicated R10 had adventitious lung sounds, pain when breathing, nasal congestion, left ear pain, and cough. R10 was sent to the emergency department (ED). R10's ED note dated 12/31/24, identified R10 was positive for RSV and diagnosis of acute bronchiolitis (inflammation of bronchi in the lungs) due to RSV. R10 came to ED with complaints of a cough and feeling ill for more than 10 days and getting worse. R10 stated the cough occurred constantly and had been gradually getting worse. R10's progress note dated 12/31/24, identified ED called facility to notify of positive RSV test. Isolation precaution sign and tray/cart for personal protective equipment (PPE) was set up. Vital signs obtained on return from ED. R10's physician visit note dated 1/9/25, identified R10 continued with a persistent cough after RSV	21375		

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THE SHORES OF WORTHINGTON	1307 SOUTH SHORE DRIVE WORTHINGTON, MN 56187

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 7 infection and will be taken off isolation today. Increased Duo Neb to three times daily for 7 days. R10's respiratory assessments between 1/11/25 through 1/4/25, identified R10 had diminished lung sounds on 1/12/25. R10's record reviewed between 12/28/24 through 1/13/25, identified R10 had respiratory illness symptoms that began on 12/28/24. R10's record and facility surveillance did not identify immediate implementation of TBP (transmission based precautions) nor ongoing consistent symptom monitoring between 12/28/24 through 1/10/25. R5 RSV positive on 1/2/25 R5's face sheet dated 1/16/25, identified diagnoses of diabetes mellitus type 2, and chronic kidney disease (condition where kidneys have been damaged). R5's progress note dated 12/26/24, identified R5 complained of an irritated throat. R5 was given cough drop and cough syrup. R5's progress note did not identify a respiratory assessment or vital testing was done. R5's progress note dated 12/28/24, identified R5 complained of throat irritation but did not indicate if a respiratory assessment, viral testing or provider was notified. R5's progress note dated 1/1/25, identified R5 went to clinic appointment to have an medication injection and on 12/31/24, R5 was transported by a medical van service to location where had unknown labs drawn. R5's record did not identify if R5 was provided with a mask during transport.	21375		

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21375	Continued From page 8 R5's progress note dated 1/2/25, identified R5 complained of sore throat, congestion, runny nose and wheezing in lungs. COVID-19 test performed and negative results. Primary care provider was notified and ordered RSV test which was completed and sent to the clinic for results. R5's laboratory report dated 1/3/25, identified positive RSV test completed on 1/2/25. R5's progress note dated 1/3/25, identified R5's RSV test was positive. There was no indication that isolation/precautions were initiated even though R5 was positive for RSV. R5's progress note dated 1/7/25, identified R5 went to an outside appointment and was transported by a medical van service at 7:30 a.m. and returned to facility around noon. There was no indication that transportation service or outside appointment facility were aware of R5's RSV diagnosis to prevent the spread of infection. During an observation on 1/10/25 at 1:49 p.m., R5 was sitting alone at a table in the activity in the dining area playing bingo without a mask on. R5 coughed six times without a mask on and did not cover his mouth or sanitize his hands after coughing. R5's cough was wet/productive. There were ten other residents were in the area also playing bingo at tables spaced approximately 4-6 feet apart, one resident passed approximately 1-2 feet directly by R5. R5's progress note dated 1/10/25 at 7:31 p.m., identified R5 had worsening respiratory symptoms and increasing worsening cough. R5 had bilateral wheezes. R5 stated he has not gotten better and feels worse. Resident requested to be seen in the emergency	21375		

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21375	Continued From page 9 department for evaluation (ED) R5's emergency department (ED) note dated 1/10/25 at 8:15 p.m., identified diagnoses of subacute cough. Presented to ED with dry cough. R5 was given breathing treatment and returned to the facility. During an interview on 1/10/25 at 1:52 p.m., LPN-A stated R5 just came out of isolation this week for RSV, however unable to give specific date he was removed. LPN-A was not sure how it was determined that residents could be removed from isolation and was unsure when R5 tested positive. LPN-A reviewed R5's record and verified R5 tested positive on 1/2/25 and was on isolation for 7 days. During an interview on 1/10/25 at 1:52 p.m., RN-A stated staff would monitor residents for symptoms of RSV through a cough and how they sound. They would be under precautions for seven days and then no longer were infectious. R1-positive on 1/3/25 R1's face sheet dated 1/15/25, identified R1 had diagnoses that included diabetes mellitus type 2. R1's record between 12/31/24 through 1/3/25 did not identify respiratory symptoms screening was completed. R1's progress note dated 1/3/25, identified R1 was having a non-productive cough worsening throughout the day, complained of not feeling well in her chest, and had a hoarse voice. R1 was tested for RSV. At 9:10 p.m., R1's lab test returned positive for RSV. Sign placed and staff will wear PPE. The progress note did not identify	21375		

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21375	Continued From page 10 what type of precautions were implemented nor identify if isolation was implemented on 1/3/25. R1's progress notes dated 1/5/25 and 1/10/25, identified R1 went out to an appointment with a medical van transporting on 1/3/25 for wound care. R1's record did not identify if R1 wore a mask during the transport or if the wound clinic was informed of R1's positive test results. R1's progress note dated 1/11/25, identified R1 was on isolation precautions and slept well. R1 did not include respiratory assessments and monitoring were completed from 1/3/25-1/10/25 for RSV, even though the facility had several residents with RSV. R1's respiratory assessments were completed once on 1/11/25, 1/14/25, and 1/15/25. Completed four times on 1/12/25, and twice on 1/13/25. The assessments identified on 1/11/25, R1 had a dry non-productive cough and shortness of breath. On 1/13/25 and on 1/14/25, R1 had wheezes throughout lung lobs. During an observation on 1/10/25 at 10:13 a.m., R1 had two signs outside of her room, contact precautions and EBP (enhanced barrier precautions). Staff entered R1's room with no PPE on to transport her to the medical van for an appointment. R1 agreed to wear a mask when exiting room. During an interview on 1/10/25 at 9:13 a.m., licensed practical nurse (LPN)-A stated R1 had two precaution signs outside of her room, contact was for the RSV and EBP was for her wound. LPN-A could not articulate the difference between contact and EBP precautions. LPN-A stated R1	21375		

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21375	Continued From page 11 would be finishing contact precautions today, 1/10/25. LPN-A was unsure of the exact date R1 tested positive. LPN was aware of R1 still having a cough because R1 was getting over RSV. R14 RSV positive on 1/3/25 R14's face sheet dated 1/19/25, identified diagnoses of Parkinson's disease and congestive heart failure. R1's record between 12/28/24 through 1/3/25 did not identify respiratory symptom screening was completed, even though the facility had several residents with RSV. R14's progress note dated 1/3/25 at 2:48 p.m., identified R14 was not feeling well, poor appetite, lethargic, and weakness. Physician sent orders to test residents that are symptomatic for RSV; R14 tested positive for RSV. R14's record did not indicate TBP, and isolation were immediately implemented. R14's progress note dated 1/7/24 identified R14 had all meals in their room and continued to receive therapy services. R14's progress note dated 1/9/25, identified R14 was up in wheelchair for both meals. Progress note did not identify if R14 was in his room for meals. R14's record did not identify if and when TBP and isolation were implemented nor include symptom monitoring between 1/3/25 through 1/9/25. Between 1/9/25 and 1/15/25, R14's record included respiratory assessment which did not identify symptoms of illness. On 1/15/24, R14's was on isolation precautions, however, did not address PPE requirements.	21375		

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21375	Continued From page 12 R3-positive on 1/3/25 R3's face sheet dated 1/16/25, identified diagnoses of diabetes mellitus type 2, and chronic kidney disease (damaged kidneys). R3's unsigned and undated physician order included place in isolation precautions per facility infection control policy. Corresponding treatment administration records identified "x'" in the boxes indicating the order was not completed. R3's record reviewed between 12/23/24 through 1/13/24, identified R3 had respiratory illness symptoms that began on 12/24/24. R3's record and facility surveillance did not identify immediate implementation of TBP after (PPE and isolation) on 12/23/24 nor identify ongoing symptom monitoring to determine appropriate discontinuation of PPE and isolation. R3's progress notes identified the following: -12/23/24, R3 had a sore throat and nasal congestion. COVID test negative. -12/24/24, R3 had a cough, an antibiotic and cough syrup was ordered by the physician. -12/29/24, R3 had hoarse voice, adventitious (abnormal) lung sounds, cough with secretions, and nasal congestion. R3's record did not indicate the physician was notified of the ongoing symptoms. -12/31/24, R3 had nasal congestion, crackles in lungs, and cough. Negative COVID test. -1/1/25, R3 had cough, congestion, and not feeling well. -1/2/25, R3 complained not feeling well, loss of appetite, and dry non-productive cough. -1/3/25, R3 tested positive for RSV. -1/4/25, R3 was administered cough medication. -1/12/25, indicated R3 did not receive a shower due to isolation precautions.	21375		

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21375	Continued From page 13 -R3's progress note dated 1/13/25, identified R3 remained on precautions for RSV symptoms which included raspy voice, and occasional cough. Lung sounds were clear. During an observation on 1/10/25, R3 was in her wheelchair inside her room. R3 was sleeping. Two precaution signs posted on entrance to her room directing staff to use contact precautions and enhanced barrier precautions. A red biohazard bag was noted in R3's recliner with used personal protective gowns coming out of the top and resting on the armrest of the recliner. In addition, a red bin with the top open and multiple isolation gown noted to be hanging out the top and touching the sides of the bin. R2-RSV positive on 1/8/25 R2's face sheet dated 1/22/25, identified diagnoses of type 2 diabetes. R1's record between 12/31/24 through 1/7/25 did not identify respiratory symptoms screening was completed, even though the facility had several residents with RSV. R2's progress note dated 1/8/25, identified R2 to be coughing, adventitious sounding, tested for COVID and RSV. R2's record did not identify TBP were implemented. During record review on 1/10/24 at 8:00 a.m. R2's RSV test results were not included in her record. During an observation on 1/10/25 at 9:13 a.m., LPN-A stated she was aware R2 had a cough, and she knew she was tested for COVID-19/Influenza A&B and RSV but was unsure if she was negative. LPN-A entered R2's room with gloves on, no mask and no gown. While LPN-A used one of R2's fingers to check	21375		

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21375	Continued From page 14 her blood sugar, R2 had her face turned toward LPN-A, R2 coughed three times without covering her mouth. LPN-A touched R2's hands then her own clothing. R2' progress note dated 1/10/25 at 1:37 p.m., identified call placed to hospital following up on lab results. R2 was positive for RSV. At 10:20 p.m., R2 was placed on droplet precautions. During an interview on 1/10/25 at 9:22 a.m., registered nurse (RN)-A stated she noted R2 had a cough on 1/8/25 and performed a COVID-19 test in house and did a swab for a quad test (COVID-19/Influenza A&B/RSV) test and took to the clinic. RN-A stated she was not sure of R2's test results but thought R2 tested negative. RN-A thought RSV would be droplet precautions verses contact precautions because RSV was a respiratory virus which required droplet. RN-A stated as of today 1/10/25, the facility had two active cases of RSV currently in the same unit R1 and R3. During an interview on 1/10/25 at 2:06 p.m., infection preventionist (IP)-A stated the facility had just received R2's positive test results for RSV collected at 4:00 p.m. on 1/8/25 that resulted on 1/8/25 at 5:22 p.m. IP-A stated R2 should have been placed on respiratory precautions on 1/8/25 due to being symptomatic. IP-A stated she was unaware a test had been performed on R2 on 1/8/25. IP-A confirmed R2 was not on contact or droplet precautions since 1/8/25 and would be placed in isolation today, 1/10/25. During an interview on 1/10/25 at 2:33 p.m., (RNCM)-A stated R2 was tested for COVID on the evening of 1/8/25 due to coughing in-house and a quad test was taken to the clinic. R2 was	21375		

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21375	Continued From page 15 not put on isolation. R2 only had a cough on 1/8/25 and had not had one since. R2 did not leave her room very often; R2 ate in her room and did not attend activities and was not on TBP until 1/10/25 after the facility became aware. R7 RSV positive on 1/8/25 R7's face sheet dated 1/17/25, identified diagnoses of diabetes mellitus type 2, dementia, atrial fibrillation. R7's medical record did not identify respiratory assessment screening between the confirmed RSV outbreak on 12/31/24 through 1/8/24 the date R7 presented to the hospital with respiratory illness symptoms. R7's progress note dated 1/8/25, indicated R7 had irregular rapid heart rate, was lethargic, nauseated, tired, and pale. R7 was sent to the ED. R7's emergency department (ED) note dated 1/8/25, identified R7 presented in ED from the nursing home with atrial fibrillation and rapid ventricular rate in the context of decreased oral intake, generalized weakness and cough. R7's ED note identified R7 tested positive for RSV with reported symptoms that started on 1/6/25. R7's hospital discharge summary dated 1/10/25, identified R7 was admitted 1/8/25 to 1/10/25 for atrial fibrillation with rapid ventricular rate, RSV with acute bronchiolitis due to RSV, and acute cystitis (bladder infection). R7's discharge summary stated R7's presentation, including the rapid ventricular rate was triggered by acute RSV infection. R7's progress note dated 1/10/25, identified	21375		

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21375	Continued From page 16 occasional cough due to RSV positive and placed on droplet precautions. R7's progress note did not identify if/when isolation was implemented. R7's respiratory assessments dated 1/10/25 through 1/15/25, identified cough on 1/10/25, 1/13/25 and 1/15/25. During an interview on 1/10/25 at 2:33 p.m., RNCM-A stated residents that were RSV positive did not need to isolate, if they came out of their room they had to wear a mask and distance themselves from other residents. Nursing monitored for common signs and symptoms and test if needed. Nursing did not document monitoring for every resident in the electronic record showing that monitoring was done. RNCM-A would start staff and resident tracing if the need developed. During an interview on 1/10/25 at 3:00 p.m., RNCM-A was in-person, and director of nursing (DON) via phone, DON verified that no monitoring had been completed of residents had been completed and no symptom monitoring of all residents had been done. DON stated IP-A should be ensuring these steps were completed. R8 RSV positive on 1/10/25. R8's face sheet dated 1/17/25, identified diagnoses of Alzheimer's, and dementia. R8's record between 12/31/24 through 1/9/25 did not include respiratory illness screening. R8's progress note dated 1/10/25 at 9:12 a.m., identified R8 was not eating this morning and unable to swallow pills and spit everything but water out.	21375		

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21375	Continued From page 17 R8's progress note dated 1/10/25 at 8:44 p.m., identified outbreak of RSV per resp. screener R8 should be tested for RSV however did not identify if R8 had symptoms. Call placed to medical provider and test sent to lab. R8's progress noted dated 1/11/25 at 6:21 a.m., identified R8 was on droplet precautions for RSV pending results. R8's note indicated R8 had a new cough through the night. R8's record did not address isolation was immediately implemented. R8's progress note dated 1/11/15 at 12:31 p.m., identified lab results were positive for RSV. R8 unable to stay in room and had been wandering mostly in the dining room, sat at a table by himself, and was unable to keep mask pulled up on his face. R8's emergency department (ED) notes dated 1/13/25, identified R8 was seen on 1/13/25 at 9:33 p.m., with diagnoses of sepsis, and RSV. R8 was sent to ED for generalized and weakness and low blood pressure after testing positive at facility for RSV. ED gave breathing treatment and intravenous methylprednisolone, and normal saline. R8 was transferred to hospital. R8's hospital note dated 1/16/25, identified a stay from 1/14/25-1/16/25, with diagnoses of septic shock, with return to facility on hospice care. R15 RSV positive on 1/10/25 R15's face sheet dated 1/17/25, identified diagnoses of bradycardia (slow heart rate), and acute respiratory failure with hypoxia. R15's progress note dated 12/31/24, identified R15 had a large emesis. R15's record did not include further assessment.	21375		

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21375	Continued From page 18 R15's between 12/28/24 through 1/2/25 did not include respiratory illness screening, even though the facility had several residents with RSV. R15's progress note dated 1/3/25 at 4:00 a.m., identified R15 stated she could not breathe. Oxygen saturation was 84% on 3 liters per minute of oxygen via nasal cannula. Noted clammy skin, and R15 was sweaty. At 3:56 p.m., R15 had a hoarse voice, was lethargic, and low appetite. Notified hospice. R15's progress note dated 1/5/25, indicated R15 was provided breathing treatment for audible wheezes and chest discomfort. At 10:44 p.m., R15 had non-productive cough, complained of a sore throat, and had an emesis. R15's progress note dated 1/6/25 at 2:30 a.m., identified complaints of pain to lower back and chest area when she coughs. At 3:48 a.m., coughing was at a minimum and wheezing was heard while breathing. R15's progress note dated 1/8/25 at 10:35 p.m., cough syrup had been given and was effective. R15's progress note dated 1/9/25 at 12:27 a.m., identified as needed oxygen was administered and effective. R15's progress notes indicated oxygen remained in place on 1/9/25, and 1/10/25. R15's progress note dated 1/10/25, identified respiratory assessment completed and indicated R15 should be tested for RSV. R15 was put on "precautions" pending test results. R15's record did not identify what type of precautions were implemented.	21375		

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21375	Continued From page 19 R15's record identified test results on 1/11/25 at 2:27 p.m. were positive for RSV. R15's progress note dated 1/11/25 at 2:41 p.m., identified oxygen in use, moist/loose productive cough. R15's progress note dated 1/12/25, identified left and right lungs had crackles on auscultation, moist/loose productive cough present with small secretions. R15's progress note dated 1/13/25 at 1:53 p.m., identified R15 was coughing and gagging as she coughed. Although R15 demonstrated respiratory symptoms that began on 1/3/25, there was no indication testing had been completed with the onset of symptoms nor TBP were implemented until 1/10/25, 7 days after symptoms were identified. There was no indication that symptom monitoring was completed between 1/3/25 through 1/10/25. During an interview on 1/14/25 at 9:30 a.m., RN-A stated R15 was positive for RSV and had a roommate. For the roommate we pull the curtain and have her wear a mask when she leaves the room. During an observation on 1/14/25 at 9:34 a.m., R15 and roommate were both sitting in wheelchairs in their room. The curtain was partially drawn. R15 coughed which was very wet sounding, she did not cover her mouth or sanitize hands after. R13 RSV positive on 1/13/25	21375		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SHORES OF WORTHINGTON	1307 SOUTH SHORE DRIVE WORTHINGTON, MN 56187

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21375	Continued From page 20 R13's face sheet dated 1/15/25, identified diagnoses of chronic obstructive pulmonary disease (COPD) (inflammation and obstruction of lung airways). R13's record identified between 12/31/24 through 1/9/25 did not include respiratory illness screening, even though the facility had an onset of RSV. R13's progress note dated 1/13/25 at 2:15 p.m., identified during respiratory screener R13 complained of cough, coughing up clear phlegm, experienced chest tightness. Placed on droplet precautions. Physician ordered test. At 8:53 p.m., RSV results returned positive. R13's record did not identify if/when isolation was implemented. R16 RSV positive on 1/13/25 R16's face sheet dated 1/19/25, identified diagnoses of congestive heart failure (heart cannot pump blood well enough to meet the body's needs), and acute kidney failure. R16's record identified between 12/28/24 through 1/9/25 did not include respiratory illness screening, even though the facility had several residents with RSV. R16's progress note dated 1/13/25 at 4:30 a.m., identified lung sounds wheezy and persistent non-productive cough. 5:47 a.m., a respiratory assessment was completed, and cough was noted to be dry and non-productive. R16's progress note dated 1/14/25 at 4:35 a.m., identified R16 was placed on droplet/contact precautions for RSV positive test on 1/13/35. At 10:24 p.m., cough was noted to be moist and non-productive with wheezing noted in lungs.	21375		

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21375	Continued From page 21 During an observation on 1/14/25 at 10:56 a.m., R16 was in the activity/dining area sitting in a recliner without a mask on with multiple other residents in the area who also did not have masks on. R12-RSV positive on 1/14/25 R12's face sheet dated 1/17/25, identified diagnoses of myalgia (muscle pain). R12's record identified between 12/28/24 through 1/9/25 did not include respiratory illness screening, even though the facility had several residents with RSV. R12's progress note dated 1/13/25, identified new non-productive cough during respiratory screener. Lung sounds clear. Quad test completed and sent to lab. Droplet precautions Education provider to staff to perform hand hygiene, cough etiquette and distancing outside of room. R12's progress note did not indicated isolation was initiated. R12's lab report dated 1/14/25, identified RSV detected from nasal swab. During an interview on 1/14/25 at 9:25 a.m., activity aide (AA)-B stated the staff use hand sanitize prior to doing anything and wipe down things that they reuse. AA-B stated residents have the right to leave their rooms and when they do, they should be encouraged to mask up. AA-B was unsure if the residents had to wear a mask outside of their rooms but thought they did. AA-B thought residents would have to stay farther away from other residents if they were supposed to be on precautions and left their rooms.	21375		

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21375	Continued From page 22 R17 suspected respiratory disease 1/10/25 R17's face sheet dated 1/19/25, identified R17 had diagnoses that included type 2 diabetes. R17's record between 12/28/24 through 1/7/25 did not include respiratory illness screening, even though the facility had several residents with RSV. R17's progress noted dated 1/8/25, lungs clear and no cough. R17's record did not include a respiratory screener on 1/9/25. R17's respiratory illness screener dated 1/10/25 thorough 1/15/25 did not identify any respiratory symptoms. R17's progress note dated 1/10/25 at 8:52 p.m., identified outbreak of RSV per respiratory screener resident should be tested for RSV. Test sent to lab. R17's progress note did not identify isolation or PPE was initiated. R17's progress note dated 1/11/25 at 6:28 a.m., identified R17 was placed on droplet precautions for RSV pending lab test results. R17 was noted to have an occasional non-productive cough throughout the night. At 12:23 p.m., cough was moist and non-productive. At 1:45 p.m., identified lab results were negative for RSV, influenza A and B, and COVID. R17's record did not identify an alternative diagnosis for the new cough and did not indicate when precautions were removed. During an observation and interview on 1/14/25 at 9:51 a.m. R17 sat in a recliner in the activity room	21375		

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21375	Continued From page 23 without a mask on, which was not in accordance with R17's record dated 1/11/25 that directed droplet precautions. NA-A confirmed R17 was sitting in a recliner in the activity room with no mask on. R19 suspected respiratory disease 1/10/25 R19's face sheet dated 1/19/25, identified R19 had diagnoses that included type 2 diabetes. R19's record reviewed from 12/28/24 through 1/9/25, was not evident of ongoing consistent symptom monitoring was completed between 1/3/25 through 1/9/25, even though the facility had several residents with RSV. R19's progress note dated 1/10/25 at 8:51 p.m., identified the respiratory screener indicated R19 should be tested for RSV. R19's progress note did not specify symptoms or that isolation or TBP were initiated. During an observation on 1/10/25 at 1:10 p.m., R19 was laying in her bed with no respiratory symptoms observed. R19's progress note dated 1/11/25 at 8:08 a.m., identified R19 was placed on droplet precautions. No cough and afebrile. At 1:27 p.m., test results for respiratory diseases returned negative. Moist, non-productive cough noted. R19's progress notes did not indicate isolation or TBP were initiated after symptom onset on 1/11/25. R19's respiratory symptom screeners between 1/10/25-1/14/25, identified a moist non-productive cough on 1/11/25. R19's progress note dated 1/14/25, identified R19	21375		

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21375	Continued From page 24 left facility for an appointment out of state and did not return until after supper. R18 suspected respiratory disease 1/10/25 R18's face sheet dated 1/23/25, identified R18 had diagnoses that included type 2 diabetes R18's record reviewed from 12/28/24 through 1/9/25, did not include respiratory symptom screening, even though the facility had several residents with RSV. R18's progress note dated 1/10/25 at 12:36 p.m., identified R18 was very lethargic and moody. Refused breakfast and lunch. At 8:49 p.m., respiratory screener identified R18 should be tested for RSV. R18's record did not identify any specific symptoms and did not identify if TBP were initiated. R18's progress note dated 1/11/25 at 5:35 a.m., identified R18 was placed on droplet precautions pending RSV test results. At 1:33 p.m., R18 noted to have a moist, non-productive cough. R18's lab results dated 1/10/25, that were reviewed and faxed to the facility on 1/11/25 at 12:50 p.m. identified no COVID, influenza A and B or RSV detected. During an observation and interview on 1/14/25 at 9:51 a.m., NA-A confirmed R19 was sitting at the dining room table with three other residents and not wearing mask, including R18. NA-A stated residents did not have to wear masks when they were in the common areas even if they were on precautions. R21 suspected respiratory disease 1/10/25 R21's face sheet dated 1/19/25, identified R21	21375		

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21375	Continued From page 25 had diagnoses that included shortness of breath. R21's record reviewed from 12/28/24 through 1/9/25, did not include respiratory symptom screening, even though the facility had several residents with RSV. R21's progress note dated 1/10/25, identified from respiratory screener that an RSV test needed to be completed due to new dry, non-productive cough. Test sent to lab. R21's progress note dated 1/11/25 at 5:14 a.m., resident on isolation for droplet precautions. At 1:47 p.m., moist, non-productive cough noted. Lab returned with negative results; daughter requested R21 be sent to the ED for evaluation. At 8:44 p.m., diagnosis of pneumonia and antibiotic prescribed. R21's respiratory symptom screener between 1/12/25 through 1/14/25 indicated R21 continued to have moist productive cough and non-productive cough. During an observation on 1/14/25 at 9:51 a.m., R21 had isolation precautions sign on room door but R21 was sitting in a chair in the main area next to another resident with no mask on. R20 suspected respiratory disease 1/10/25 R20's face sheet dated 1/19/25, identified diagnoses of atrial fibrillation (irregular heart rhythm in the heart's upper chambers). R20's record reviewed from 12/28/24 through 1/9/25, did not include respiratory symptom screening, even though the facility had several residents with RSV.	21375		

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21375	Continued From page 26 R20's progress note dated 1/10/25, identified respiratory screener indicated R20 should be tested for RSV. Test sent to lab. The progress note did not identify if TBP were implemented. R20's progress note dated 1/11/25 at 5:32 a.m., identified R20 was on droplet precautions. No cough noted and remained afebrile. At 1:22 p.m., moist, non-productive cough noted. At 1:25 p.m., lab results returned negative. At 9:36 p.m., no cough noted. R20 did not have any symptoms noted between 1/12/25-1/14/25 from the respiratory screener. R6-suspected respiratory disease 1/10/25 R6's face sheet dated 1/22/25, identified diagnoses of dementia, and acute kidney failure. R6's record reviewed from 12/28/24 through 1/10/25, did not include respiratory symptom screening, even though the facility had several residents with RSV. R6's symptom screener between 1/10/25 through 1/12/25 identified R6 did not have respiratory illness symptoms. R6's progress note dated 1/13/25, identified R6 was noted to have a new cough on 1/12/25 and tested per standing order for RSV. R6's record did not identify TBP were initiated upon identification of symptoms. During an observation on 1/14/25 at 9:24 a.m., R6 and R12 were identified as roommates. Droplet precaution sign on door, cart with PPE supplies was at the next room over. R12 positive (for RSV) was in the room, R6 (suspected) was not in the room. The room door was open and	21375		

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21375	Continued From page 27 curtain divider was open. During an interview on 1/14/25 at 9:30 a.m., RN-A stated R6 was out of her room and in the dining room so she could be assisted with eating breakfast. R6 was not under precautions because she was tested on 1/13/25 and had negative results. R6's roommate (R12) was on droplet precautions and was positive for RSV. We have been trying to pull curtains and doing hand hygiene before doing cares on either resident. During an interview on 1/14/25 at 9:39 a.m., RNCM-A stated R6 did leave her room this morning to have breakfast in the dining room as she needed complete assistance. We ruled out the negative test and lab this morning from the DON. During an interview on 1/14/25 at 10:37 a.m., IP-A stated R6 should be in her room and not out in the facility. R6's progress note dated 1/14/25 at 6:31 p.m., identified RSV test was negative. Encouraged staff hand hygiene, separation in room with curtain. R9 suspected respiratory disease 1/14/25 R9's face sheet dated 1/17/25, identified diagnoses of COPD. R9's record between 12/28/24 through 1/9/25 did not include respiratory illness screening, even though the facility had several residents with RSV. R9's respiratory illness screener dated 1/10/25 through 1/13/25 did not identify any respiratory symptoms.	21375		

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21375	Continued From page 28 During an observation on 1/14/25 at 10:09 a.m., R9 was in the dining room and working on a puzzle with another resident and a nursing assistant. R9 wore a mask and was coughing and sneezing. At 10:11 a.m., took off mask and blew nose, did not sanitize hands. Activity aide brought R9 back to her room at 10:20 a.m. R9's record did not identify a respiratory symptoms screener prior to coming out of her room. During an observation on 1/14/25 at 10:09 a.m., R9 was in the dining room and working on a puzzle with another resident and a nursing assistant. R9 wore a mask and was coughing and sneezing. At 10:11 a.m., took off mask and blew nose, did not sanitize hands. Activity aide brought R9 back to her room at 10:20 a.m. R9's respiratory illness screener completed on 1/14/25 at 11:18 a.m., with symptoms of new cough and mucus production. R9's progress note dated 1/14/25 at 11:40 a.m. identified a new onset of productive cough with runny nose. R9 put in isolation and will be tested for RSV Progress note dated 1/15/25 identified RSV results were negative, R9 will remain on droplet precautions and medication for cough. R9's progress note did not identify isolation was implemented. During an interview on 1/14/25 at 9:30 a.m., RN-A stated all residents have been getting a respiratory assessment completed daily since 1/10/25, and symptomatic and positive residents were to have a respiratory assessment completed every shift.	21375		

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21375	Continued From page 29 During an interview on 1/14/25 at 9:39 a.m., RNCM-A stated after surveyors left the building on 1/10/25, nursing screened all the residents for illness and tested anyone that had a positive screen. Because the screening was implemented, we were able to identify a resident new onset of symptoms who ended up testing positive for RSV. RNCM-A indicated by completing active screener we were able to take measures sooner to prevent the spread. RNCM-A further explained it was difficult to keep positive/symptomatic resident in their rooms. Staff had been directed to communicate if they were feeling ill and their symptoms were monitored. During an observation on 1/14/25 at 9:54 a.m., memory care residents R19, R17, R21, R18 (suspected positive) were in the dining room and adjoining television area with no masks on. Several other residents who were not symptomatic were also in this area. During an interview on 1/14/25 at 10:07 a.m., nursing assistant (NA)-A stated residents under precautions in the memory care did not need to wear masks when they were in the dining room or living room areas. During an observation on 1/14/25 at 10:44 a.m., R6 who had respiratory symptoms however, was not demonstrating symptoms as she was sitting in the hallway in her wheelchair with her mask under her nose, housekeeper (HSK)-A was in the hallway with R6. HSK-A with gloved hands touched R6's hand. HSK-A did not remove her soiled gloves or perform hand hygiene and then entered R11's room to clean. HSK-A moved items on bedside table and touched top and sides	21375		

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21375	Continued From page 30 of bedside table with her soiled gloves. During an interview on 1/14/25 at 9:20 a.m., IP-A stated eight residents were tested on 1/10/25 and two were positive. Tested again on 1/13/25 and found three more positive cases. One resident was sent to the hospital (R8). Residents with upper respiratory symptoms should be tested and placed under precautions. No staff had tested positive as of 1/14/25 but one activity staff had worked on 1/11/25, called in to work on 1/12/25 with cough, sore throat, and fever and tested positive for influenza. No other staff with respiratory symptoms. Since 1/10/25, to mitigate the spread of RSV daily respiratory assessments was implemented for all residents. If the assessment identified symptoms quad testing was completed, symptomatic residents were isolated, droplet precautions were implemented, and staff were educated. Staff education was not documented. When residents are symptomatic/positive isolation is implemented, then on the 7th day, nursing reviewed to see if residents remained symptomatic, if there is no symptoms isolation is discontinued, if symptom continue then isolation should be continued. At 10:37 a.m., IP-A stated suspected residents even if tested negative should remain in their rooms and only come out for bathing. At 11:11 a.m. IP-A stated it was difficult to keep masks on residents who resided in memory care and keep them in there room. During an interview on 1/14/25 at 1:06 p.m., IP-A stated she talked with facility nurse consultant (NC)-A who advised that all residents that were symptomatic but tested negative on the quad test could be removed from precautions. During an interview on 1/14/25 at 2:45 p.m.,	21375		

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21375	Continued From page 31 medical director (MD)-A stated he would expect the facility to review with the providers signs and symptoms of infection prior to removing them from precautions. We would like to isolate the residents that are symptomatic or positive for seven days and treat them just how we would treat positive COVID or influenza and isolate as such. Rarely would RSV cause death in a resident unless they are severely immunocompromised. The facilities Infection Control Plan, tracking and trending logs and any meeting minutes were request but never provided by the facility. During various interviews on 1/14/25 at 9:20 a.m., and 1/15/25 at 9:20 a.m. infection preventionist (IP)-A indicated there was no infection control logs; there was no real time tracking of illness symptoms for residents and staff, no trending of infections, no analysis of spread, and no infection prevention/containment activities were documented or identified. IP-A identified she was keeping track of RSV positive residents in her head until 1/10/25 when the survey team entered the facility. IP-A explained staff were monitoring residents for fever, cough, and respiratory signs and symptoms, however, indicated no active screening for illness was in place. If a resident had symptoms a quad test (influenza A&B, COVID, RSV) was obtained and documented in a progress note. If the test was positive the resident would be put on precautions; staff were required to gown, glove, and mask when they entered the room. Residents should eat in their rooms for meals and if a resident left their room, they would need to wear a mask. Residents who resided in a double rooms remained in the double room and staff would monitor the roommate for signs and symptoms. "The facility did not want to test and	21375		

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21375	Continued From page 32 treat symptomatic hospice residents" Staff should be donning and doffing (putting on and taking off) gowns, gloves, and masks after leaving the room, and applying a new mask. IP-A stated the "physician reviewed with interdisciplinary team (IDT) that RSV viral shedding should be completed in seven days and isolation can be discontinued." If a resident was symptomatic, they should be on precautions and not allowed to "run around the facility." During an interview on 1/15/25 at 2:24 p.m., infection preventionist (IP)-A stated she is supposed to get reports of employee illnesses from all departments and is not getting them consistently. IP-A stated for this outbreak she would use this data to look for correlations of staff infections and current resident infections to look for infections that could cause and outbreak, but not getting all the infection reports from staff it would be difficult to evaluate. Policies Facility standing order, undated, effective 1/3/25-1/31/25, identified all residents that have a specific primary care provider, and condition of >100.4 Fahrenheit (F) fever, new or worsening cough, difficulty breathing, new loss of taste or smell, new myalgia (muscle weakness), excessive fatigue, new severe headache, new nasal congestion were directed to have a Quad lab completed that tested for COVID, Influenza A and B, and RSV. The facility Employee Pre/Post Exposure (Respiratory) facility policy that was updated 1/14/25, identified infected healthcare workers will be monitored and managed by the IP. Staff that develop fever and respiratory symptoms will be:	21375		

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	00885	A. BUILDING: _____ B. WING _____	C 01/15/2025

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21375	Continued From page 33 -instructed not to report to work, if at work to stop resident care activities, don a facemask, and notify designee before leaving work. -IP will work with the staff to determine appropriate time to return to work and appropriateness of contact with residents. Standard precautions will be used during the care of all residents, including frequent hand hygiene. Droplet precautions will be implemented for residents with suspected or confirmed respiratory illness for seven days after illness onset or until 24 hours after the resolution of fever and respiratory symptoms, whichever is longer. Residents under droplet precautions will be discharged from care when clinically appropriate, not based on the period of potential virus shedding or recommended duration of droplet precautions. Before discharge, the resident's diagnosis and current precautions will be provided to care providers as well as transporting personnel. The facility Surveillance for Infections, revised September 2017, identified IP will conduct ongoing surveillance for healthcare associated infections (HAI) and other epidemiologically significant infections that have substantial impact on potential resident outcome and may require transmission-based precautions and other preventative interventions. Purpose of the surveillance of infections is to identify both individual cases and trends of significant organisms and HAI, to guide appropriate interventions, and to prevent future infections. 5. nursing staff will monitor residents for signs and symptoms that may suggest infection and will document and report suspected infections to the charge nurse as soon as possible. 6. if a communicable disease outbreak is suspected, this information will be communicated	21375		

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21375	Continued From page 34 to the charge nurse and IP immediately. 8. IP and attending physician will determine if lab tests are indicated, whether special precautions are warranted, the attending physician and interdisciplinary team (IDT) will determine treatment plan. 9. if transmission-based precautions or other preventative measures are implemented to slow or stop the spread of infection, the IP will collect data to help determine the effectiveness of such measures. The facility Isolation-Categories of Transmission-Based Precautions revised September 2022, identified transmission-based precautions are initiated when a resident develops signs and symptoms of transmissible infection; arrives for admission with symptoms of an infections; or has a laboratory confirmed infections; and is at risk of transmitting the infection to other residents. The facility Handwashing/Hand Hygiene policy, revised August 2019, identified hand hygiene as the primary means to prevent the spread of infections: The IJ that began on 12/26/24 was removed on 1/15/25 when it was verified the facility implemented the following: 1. The isolation categories Transmission Based Precautions Policy and Procedure was reviewed by IDT and no changes warranted on 1/14/25. 2. Facility clinical leadership would in-service all staff on Transmission Based Precaution Categories with emphasis on item #5 that when a resident is suspected of having an infection, they are placed in transmission-based precaution and the proper signage will be placed to indicate the need for the proper precautions. Facility staff will also be in-serviced on hand hygiene policy with	21375		

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21375	Continued From page 35 emphasis on item #7 which lists when hand hygiene must take place. 3. The clinical IDT was in-serviced on the Isolation-Initiating Transmission based precautions policy and procedure with emphasis on item #4 that precautions remain until the attending physician discontinues them. 4. The facility nurses will continue to use the Respiratory Infection Screening Tool Assessment for residents every shift and for residents who are confirmed, the Nurse Advantage Respiratory Evaluation will be utilized daily until the MD has discontinued isolation precautions after IDT assesses that resident symptoms have resolved. Any resident who is suspected of infection, the physician will be notified, and his/her response will be recorded in the resident record. 5. Current residents will not partake in communal activities or dining unless feeding assistance is needed until the outbreak has been resolved. Any positive or suspected resident will remain in room and receive feeding assistance in rooms. Non-symptomatic residents will be allowed to eat in dining room. 6. Facility staff will be in-serviced on the Employee Illness Policy with emphasis on item #1 that instructs any employee who suspects that them may be ill, must don a mask and will be instructed not to return to work until 24 hours after symptoms have resolved. 7. Facility clinical staff who missed the above in-service education and hand hygiene competency will be in-serviced prior to the beginning of their shift. A mass message was sent to all employees, posting was placed at door and clinical leadership will be present prior to beginning of the shift for in-service education. 8. For residents who are in a room with suspected/positive roommate, staff will use clean PPE for non-symptomatic resident, keep curtain	21375		

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21375	Continued From page 36 closed, encourage mask use if ambulating in the room, educate on hand hygiene and cough etiquette and offer hand sanitizer frequently. Suggested Method of Correction The DON (Director of Nursing) or designee could review/revise facility policies to ensure they contain all components of an infection control program, including tracking/trending of all illnesses in the facility as well as an antibiotic stewardship program and that a facility assessment and plan are written for water borne pathogens. Then the DON or designee could educate staff and perform audits to ensure the policies are being followed. Time Period for Correction: Twenty-one (21) days.	21375		