Electronically Submitted

October 8, 2020

Administrator
Bywood East Health Care
3427 Central Avenue Northeast
Minneapolis, MN 55418

RE: CCN: 24E185
Cycle Start Date: September 18, 2020

Dear Administrator:

On September 18, 2020, survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted both substandard quality of care and immediate jeopardy to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On September 11, 2020, the situation of immediate jeopardy to potential health and safety cited at F689 was removed.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Octuober 7, 2020.

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

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective Octuober 7, 2020, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective Octuober 7, 2020, (42 CFR 488.417 (b)).

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

NURSE AIDE TRAINING PROHIBITION

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

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective September 18, 2020. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information,

you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Bywood East Health Care is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective September 18, 2020. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

DEPARTMENT CONTACT

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

Susan Frericks, Unit Supervisor
Metro D District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
PO Box 64990
St. Paul MN 55164-0900
Email: susan.frericks@state.mn.us
Mobile: (218) 368-4467

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 18, 2021 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS DENIAL OF PAYMENT

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

Tamika.Brown@cms.hhs.gov

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

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

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

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

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

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly

Health Care Financing Administration) at the following address:

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

DIRECTED PLAN OF CORRECTION

A Directed Plan of Correction (DPOC) is imposed in accordance with 42 CFR § 488.424. Your facility must include the following in their POC for the deficient practice cited at F880:
ps://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/ppe/index.html

PERSONAL PROTECTIVE EQUIPMENT (PPE)

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

POLICIES/PROCEDURES/SYSTEM CHANGES:

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

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

- Review policies and procedures for donning/doffing PPE during COVID-19 with current guidelines to include crisis standard of care, contingency standard of care and standard care.
- Develop and implement a policy and procedure for source control masks.
- Review policies regarding standard and transmission based precautions and revise as needed.

TRAINING/EDUCATION:

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

- The training may be provided by the Director of Nursing, Infection Preventionist, or Medical Director with an attestation statement of completion.
- The training must include competency testing of staff and this must be documented.
- Residents and their representatives should receive education on the facility's Infection Prevention Control Program as it related to them and to the degree possible/consistent with resident's capacity.
- Online infection prevention training courses may be utilized. The CDC and MDH websites have several infection control training modules and materials.

CDC RESOURCES:

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

CDC: Isolation Precautions Guideline:
https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007): https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Personal Protective Equipment: https://www.cdc.gov/niosh/ppe/
Healthcare Infection Prevention and Control FAQs for COVID-19:
https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control-faq.html

MDH RESOURCES:

Personal Protective Equipment (PPE) for Infection Control:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/ppe/index.html
MDH Contingency Standards of Care for COVID-19: Personal Protective Equipment for Congregate Care Settings (PDF): https://www.health.state.mn.us/communities/ep/surge/crisis/ppegrid.pdf
Interim Guidance on Facemasks as a Source Control Measure (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/maskssource.pdf
Interim Guidance on Alternative Facemasks (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/masksalt.pdf
Aerosol-Generating Procedures and Patients with Suspected or Confirmed COVID-19 (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/aerosol.pdf
Droplet Precautions:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html
Airborne Precautions:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html

MONITORING/AUDITING:

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

EQUIPMENT/ENVIRONMENT

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

POLICIES/PROCEDURES/SYSTEM CHANGES:

- The facility's Quality Assurance and Performance Improvement Committee must conduct a root cause analysis (RCA) to identify the problem(s) that resulted in this deficiency and develop intervention or corrective action plan to prevent recurrence.
- The director of housekeeping, director of maintenance, and director of nursing must review policies and procedures regarding disinfecting multiuse/shared equipment/items and/or environmental disinfection to ensure they meet the CDC guidance for disinfection in health care facilities and follow disinfectant product manufacturer directions for use including contact time.

TRAINING/EDUCATION:

- The Director of Housekeeping/Maintenance, and/or Director of Nursing, or Infection Preventionist must train all staff responsible for resident care equipment and environment on the facility policies/practices for proper disinfection, including following manufacturer direction for use. Each staff person must demonstrate competency at the conclusion of the training.

Training and competency testing must be documented. The Minnesota Department of Health (MDH), Center for Disease Control (CDC), and Environmental Protection Agency have education materials that may be used for training.

- CDC: Infection Control Guidelines and Guidance Library. https://www.cdc.gov/infectioncontrol/guidelines/index.html/eic_in_HCF_03.pdf
- MDH COVID-19 Toolkit. https://www.health.state.mn.us/diseases/coronavirus/hcp/ltctoolkit.pdf
- EPA: List N: Disinfectants for Use Against SARS-CoV-2 (COVID-19) https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2-covid-19

CDC RESOURCES:

Infection Control Guidance: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html
CDC: Isolation Precautions Guideline: https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007): https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Personal Protective Equipment: https://www.cdc.gov/niosh/ppe/
Healthcare Infection Prevention and Control FAQs for COVID-19: https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control-faq.html

MDH RESOURCES:

Personal Protective Equipment (PPE) for Infection Control: https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/ppe/index.html
MDH Contingency Standards of Care for COVID-19: Personal Protective Equipment for Congregate Care Settings (PDF): https://www.health.state.mn.us/communities/ep/surge/crisis/ppegrid.pdf
Interim Guidance on Facemasks as a Source Control Measure (PDF): https://www.health.state.mn.us/diseases/coronavirus/hcp/maskssource.pdf
Interim Guidance on Alternative Facemasks (PDF):

https://www.health.state.mn.us/diseases/coronavirus/hcp/masksalt.pdf
Aerosol-Generating Procedures and Patients with Suspected or Confirmed COVID-19 (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/aerosol.pdf
Droplet Precautions:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html
Airborne Precautions:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html

MONITORING/AUDITING:

- The Director of Nursing, the Infection Preventionist, and/or other facility leadership will conduct audits for proper cleaning and disinfection of resident use equipment/environmental cleaning, on all shifts every day for one week, then may decrease frequency as determined by compliance.

ACTIVE SCREENING

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

POLICIES/PROCEDURES/SYSTEM CHANGES:

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

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

- Develop and implement procedures, policies, and forms regarding active screening for temperature and signs and symptoms of COVID-19, in accordance with CDC guidelines to be conducted at the point of entry for every person who enters the facility. The procedures and policy must restrict entrance to anyone who does not meet the criteria as outlined by the CDC. This procedure must include actively measuring and recording staff temperature and assessment of shortness of breath, new or changed cough, and sore throat. The results must be documented. The MDH COVID-19 Toolkithttps://www.health.state.mn.us/diseases/coronavirus/hcp/ltctoolkit.pdf has examples of forms to utilize for staff screening.

TRAINING/EDUCATION:

As part of a corrective action plan, the facility must provide training for Infection Preventionist and all other staff who enter the facility, as well as staff responsible for the screening. The training must cover the need for active screening. The CDC has training videos available for COVID-19 which may be utilized, Training for Healthcare Professionals; https://www.cdc.gov/coronavirus/2019-ncov/hcp/training.html and the MDH COVID-19 Toolkit may be utilized.

- Include documentation of the completed training with a timeline for completion.

- The training may be provided by the Director of Nursing, Infection Preventionist, or Medical Director with an attestation statement of completion.

CDC RESOURCES:
Infection Control Guidance: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html
CDC: Isolation Precautions Guideline:
https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007): https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Personal Protective Equipment: https://www.cdc.gov/niosh/ppe/
Healthcare Infection Prevention and Control FAQs for COVID-19:
https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control-faq.html

MDH RESOURCES:
Personal Protective Equipment (PPE) for Infection Control:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/ppe/index.html
MDH Contingency Standards of Care for COVID-19: Personal Protective Equipment for Congregate Care Settings (PDF): https://www.health.state.mn.us/communities/ep/surge/crisis/ppegrid.pdf
Interim Guidance on Facemasks as a Source Control Measure (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/maskssource.pdf
Interim Guidance on Alternative Facemasks (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/masksalt.pdf
Aerosol-Generating Procedures and Patients with Suspected or Confirmed COVID-19 (PDF):https://www.health.state.mn.us/diseases/coronavirus/hcp/aerosol.pdf
Droplet Precautions:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html
Airborne Precautions:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html

MONITORING/AUDITING:

- The Director of Nursing, the Infection Preventionist, and other facility leadership will conduct audits on all shifts, four times a week for one week, twice weekly for one week and biweekly thereafter, until 100% compliance is achieved to ensure active screening is being completed at the point of entry for all persons who enter the facility.

The Director of Nursing, Infection Preventionist or designee will review the results of audits and monitoring with the Quality Assurance Program Improvement (QAPI) program.

In accordance with 42 CFR § 488.402(f), this remedy is effective 15 calendar days from the date of the enforcement letter. The DPOC may be completed on or after that date. The effective date is not a deadline for completion of the DPOC. However, a revisit will not be approved prior to receipt of documentation confirming the DPOC was completed. To demonstrate that the facility successfully completed the DPOC, the facility must provide all of the following documentation. Documentation

should be uploaded as attachments through ePOC.

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

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

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

Attach all items into ePOC.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E185	A. BUILDING _____ B. WING _____	C 09/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BYWOOD EAST HEALTH CARE	3427 CENTRAL AVENUE NORTHEAST MINNEAPOLIS, MN 55418

(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 A COVID-19 Focused Infection Control survey was conducted 9/15/20, to 9/18/20, at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was determined NOT to be in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, a revisit of your facility will be conducted to validate substantial compliance with the regulations has been attained in accordance with your verification. Additionally, on 9/15/20, to9/18/20, an abbreviated standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The survey resulted in an immediate jeopardy (IJ) to resident health and safety. An IJ at F689 began on 9/10/20, when the wanderguard alarm did not sound in response to a resident (R1) exiting the facility. The facility failed to ensure the wanderguard system was operational or provide enhanced supervision of R1. Subsequently, R1 did elope from the facility. The administrator and	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/09/2020

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

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	24E185	A. BUILDING _____ B. WING _____	C 09/18/2020

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BYWOOD EAST HEALTH CARE	3427 CENTRAL AVENUE NORTHEAST MINNEAPOLIS, MN 55418

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F 000	Continued From page 1 director of nursing (DON) were notified of the IJ for R1 on 9/17/20, at 11:37 a.m. The facility immediately implemented correction action on 9/11/20, and F689 is being issued at past non-compliance. In addition, an extended survey was completed 9/18/20, related to the substandard quality of care findings. Complaint HE185093 was unsubstantiated, and complaint HE185092 was substantiated at F689, for past non-compliance. Although the provider had implemented corrective action prior to survey, harm or immediate jeopardy was sustained prior to the correction. Although no plan of correction is required for a finding of past non-compliance, it is required the facility acknowledge receipt of the electronic documents.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the wanderguard was functioning to prevent an elopment for 1 of 3 residents (R1) reviewed for	F 689	Past noncompliance: no plan of correction required.	10/8/20

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F 689	Continued From page 2	F 689		

elopements. This resulted in an immediate jeopardy (IJ) when R1 eloped out of the building on 9/10/20 and was missing for 3.5 hours and was found by police unharmed. The facility immediately implemented interventions and corrected the deficient practice on 9/11/20. This is issued as past noncomplaince at Immediate Jeopardy (IJ).

The IJ that began on 9/10/20 was corrected on 9/11/20 when the facilty implemented interventions to prevent reoccurance. The administrator and director of nursing (DON) were notified of the IJ past noncomplaince on 9/17/20, at 11:37 a.m., as a result of the immediate corrective action taken by the facility.

Findings include:

R1's admission Minimun Data Set (MDS) dated 7/2/20, indicated R1 had diagnoses that included dementia, bipolar, depression, chronic obstructive pulmonary disorder (COPD), and severe cognitive impairment. The MDS further indicated R1 was independent for ambulation and surface to surface transfers.

A Brief Interview for Mental Status (BIMS) was most recently completed on 8/21/20, that indicated R1 had severe cognitive impairment.

A wander risk assessment completed on 8/19/20, indicated R1 exhibited behaviors of refusals, impaired judgement, impulsive behavior, and had wandered aimlessly within the facility or grounds within the past month. The assessment further indicated R1 was deemed unsafe to leave the facility unescorted.

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R1's care plan, last reviewed 8/18/20, indicated R1 was a wander risk, had a wanderguard alarm in place, and was deemed unsafe to leave the facility unescorted.

A progress note dated 9/10/20, at 9:11 a.m. indicated R1 was persistently asking for cigarettes and would not wait for staff, setting off the door alarm. The progress note further indicated R1 was found walking down the alley, just off campus, and was redirected.

A progress note dated 9/10/20, at 1:23 p.m. indicated R1exited the living room door with a cigarette in hand and the alarm did not sound.

A progress note dated 9/10/20, at 1:41 p.m. indicated the maintenance director (MD)-A was notified via email to check the wanderguard on R1 to see if it was defective.

An email from the food services director (FSD)-B to MD-A sent on 9/10/20, at 1:44 p.m., had a subject that indicated to please check, and further indicated R1 went out the living room door and the alarm did not sound.

A progress note dated 9/10/20, at 8:34 p.m. noted R1 had not been seen by any staff member in or around the facility since 3:00 p.m. and no report was provided by previous shift about R1 leaving the facility. Staff searched for R1 around the vicinity but were unable to find R1. The DON, administrator, case manager, and police were notified.

A progress note dated 9/10/20, at 10:53 p.m., indicated R1 was brought back by police at about 10:30 p.m. and R1 was noted to have no injuries.

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F 689	Continued From page 4 When interviewed on 9/16/20, at 12:09 p.m., FSD-B stated R1 exited through the living room door, and the alarm didn't sound. FSD-B further stated she charted the incident and emailed MD-A, asking him to check the door. FSD-B further stated she did not notify anyone else, but will copy the administrator or the DON in the future. FSD-B confirmed having received disciplinary action and re-education regarding elopement procedures. When interviewed on 9/16/20, at 11:45 a.m., MD-A stated when a wanderguard was not working he should be informed via text or phone call, "anything but an email." MD-A further stated with an urgent issue, an email would be the last resort. When interviewed on 9/15/20, at 4:24 p.m., the facility administrator stated MD-A did not receive the email notification of the wanderguard alarm not sounding because MD-A had left for the day. The administrator further stated FSD-B did not inform anyone else the alarm was not working properly. The administrator contacted MD-A on 9/11/20, at approximately 6:00 a.m., at which time MD-A reported the wanderguard alarm system had already been checked that morning and was working properly. When interviewed on 9/16/20, at 11:45 a.m., MD-A stated there were no issues during an audit of the wanderguard alarm system on 9/11/20. MD-A further stated during an audit he ensures the key pads and unit power sensor works and that the magnet is on. MD-A further stated green lights indicate the door unit was in working order.	F 689		

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F 689	Continued From page 5 On 9/16/20, at 12:07 p.m., licensed practical nurse (LPN)-A was observed to escort R1 from the smoking patio into the facility. When LPN-A and R1 passed through the door, the alarm sounded appropriately. When interviewed on 9/15/20, at 3:24 p.m., R1 stated a staff member goes with him outside to smoke. R1 further stated feeling safe at the facility. When interviewed on 9/15/20, at 3:31 p.m., trained medication aide (TMA)-A stated all residents' wanderguard placement was checked each shift and the evening supervisor tested each night to make sure their wanderguard works. When interviewed on 9/15/20, at 3:33p.m., nursing assistant (NA)-A stated staff recently received training on wanderguard and elopement procedures. NA-A further stated all staff respond to the wanderguard alarm and must locate the resident before deactivating the alarm. When interviewed on 9/16/20, at 10:07 a.m., NA-B stated all staff were recently re-educated regarding elopement procedures, including which residents were at risk and how to respond. When interviewed on 9/16/20, at 12:21 p.m., NA-C stated she recently received education on how to respond if someone with a wanderguard elopes from the facility. NA-C further stated the charge nurse would be immediately informed if a resident could not be located. When interviewed on 9/16/20, at 12:26 p.m., housekeeping staff (H)-A stated he received education on elopement and wanderguards when	F 689		

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F 689	Continued From page 6	F 689		

he first started working at the facility earlier in the year, and had recently read new education related to elopement and how to respond to the wanderguard alarm.

When interviewed on 9/16/20, at 12:29 p.m. LPN-A stated R1 had a wanderguard and was cognitively impaired. LPN-A further stated appropriate interventions were currently followed and worked well for R1 over the past week.

When interviewed on 9/16/20, at 2:49 p.m., the DON stated the facility checked wanderguard placement on residents every shift and wanderguard function every 24 hours for residents with wanderguards. The DON further stated if it were noted the wanderguard system was not working the expectation was to notify the DON, infection preventionist, administrator, or assistant administrator immediately. The DON further stated staff should monitor the door or have increased monitoring of the resident if there was an issue with a residents wanderguard. The DON also stated, in response to R1's elopement on 9/10, staff followed the policy when the wanderguard alarm went off around 3:30 p.m., and staff did not realize R1 had eloped when another resident set off the wanderguard alarm. The DON added when the facility realized R1 was missing they searched rooms, the building grounds, called the police and reported the incident to the State Agency (SA). Finally, the DON stated all staff had been re-educated on the elopement policy.

When interviewed on 9/17/20, at 9:39 a.m., the administrator stated FSD-B should have notified the administrator and DON immediately about the wanderguard alarm not sounding on 9/10/20,

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F 689	Continued From page 7 versus writing an email to MD-A. The policy titled Wandering / Elopement Prevention Plan Policy and Procedure, updated 6/20, indicated it was the policy of the facility to provide a safe environment for all residents. The policy further indicated the safety care plan would be assessed as needed to ascertain appropriate wandering prevention. The policy further indicated staff would inform maintenance of any alarm maintenance or needed repair work. The document titled Wanderguard Protocol Refresher, dated 9/11/20, included images of residents with a wanderguard, and indicated when the wanderguard alarm sounds, staff should check for residents on a wanderguard outside the building and around corners. The protocol refresher further indicated staff should not turn off the wanderguard alarm unless they are 100% certain residents with a wanderguard are safe and accounted for. The immediate jeopardy (IJ) that began on 9/10/20, was removed on 9/11/20, when the facility took the following steps to remove the IJ and correct the deficient practice: On 9/11/20, an audit of the wanderguard system, including all wanderguard bracelets used, was completed to ensure they were in proper working order. On 9/11/20, disciplinary action and re-education regarding equipment malfunction was provided to maintenance staff and staff that observed the wanderguard malfunction. On 9/11/20, the elopement protocol was updated to indicate staff will check the grounds thoroughly and account for residents with a wanderguard in response to the door alarm. All staff were re-educated to the facility elopement policy and protocol beginning	F 689		

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F 689	Continued From page 8 on 9/11/20. Verification of corrective action was confirmed by interview with a variety of nursing and non-nursing staff that verified education was provided and staff will notify maintenance and administrative staff of any possible malfunction of the wanderguard system and ensure the notification is received.	F 689		

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F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control survey was conducted 9/15/20, to 9/18/20, at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was determined NOT to be in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, a revisit of your facility will be conducted to validate substantial compliance with the regulations has been attained in accordance with your verification. Additionally, on 9/15/20, to9/18/20, an abbreviated standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The survey resulted in an immediate jeopardy (IJ) to resident health and safety. An IJ at F689 began on 9/10/20, when the wanderguard alarm did not sound in response to a resident (R1) exiting the facility. The facility failed to ensure the wanderguard system was operational or provide enhanced supervision of R1. Subsequently, R1 did elope from the facility. The administrator and	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 000	Continued From page 1 director of nursing (DON) were notified of the IJ for R1 on 9/17/20, at 11:37 a.m. The facility immediately implemented correction action on 9/11/20, and F689 is being issued at past non-compliance. In addition, an extended survey was completed 9/18/20, related to the substandard quality of care findings. Complaint HE185093 was unsubstantiated, and complaint HE185092 was substantiated at F689, for past non-compliance. Although the provider had implemented corrective action prior to survey, harm or immediate jeopardy was sustained prior to the correction. Although no plan of correction is required for a finding of past non-compliance, it is required the facility acknowledge receipt of the electronic documents.	F 000		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §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:	F 880		10/9/20

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

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F 880	Continued From page 3 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 a comprehensive infection control program to include recommended COVID-19 staff health screening procedures, disinfection of shared equipment and wearing of appropriate personal protective equipment (PPE). This had the potential to affect all 77 residents in the facility Findings include: During continuous observations on 9/17/20, from 8:09 a.m until 8:19 a.m., the following was noted: --At 8:09 a.m., an unidentified staff member was observed entering the facility; no staff were present at the COVID-19 symptom screening station. The unidentified staff member took his own temperature twice, filled out a symptom screening sheet and proceeded to enter the building. There was no screener to ensure the unidentified staff member did not enter the faciltiy if they had symptoms. The thermometer was not sanitized after use. --At approximately 8:16 a.m., nursing assistant (NA)-D arrived at the screening desk from another area within the facility, and was observed	F 880	Based on observation, interview and document review, the facility failed to implement a comprehensive infection control program to include recommended COVID-19 staff health screening location procedures and wear appropriate personal protective equipment. This had the potential to affect all 77 residents that resided in the facility Findings include: 9/15/20, at 12:45 p.m. Surveyor- 1 and Surveyor 2 walked into the facility. S1 and S2 signed their names on a form when they entered the facility. A staff member took temperatures of S1 and S2. S1 asked staff member if they had any questions. The staff member asked screening questions related for COVID 19 but did not write the answers provided by S1 and S2 down on their tracking log. S2 asked the staff member if they were going to write down S1 and S2 COVID 19 screening questions. The staff member proceeded and wrote S1 and S2 answers	

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F 880	Continued From page 4 at screening desk when social worker (SW)-A entered the building. SW-A donned a mask, filled out the COVID-19 symptom screening questions on the staff screening form, took her own temperature with the non-disinfected thermometer, sanitized her hands and proceeded into the building. The thermometer was not disinfected after use. --At 8:19 a.m., licensed practical nurse (LPN)-B was observed entering the facility wearing a surgical mask and eye protection, was observed to fill out the staff COVID-19 symptom screening form, took her own temperature using the non-disinfected thermometer, and entered her temperature on the screening form. The thermometer was not disinfected after use. At no time during the continuous observation of the screening process staff was the thermometer disinfected. On 9/17/20, at 8:38 a.m., NA-E was observed to approach the COVID-19 symptom screening station from inside the building wearing sunglasses and no mask on. No screener was initially present at the COVID-19 symptom screening station; NA-E took her own temperature and filled out the COVID-19 screening form; NA-D came to the screening table at this time and NA-E then proceeded to enter the facility. NA-E was able to enter the facility from another entrance without a screening station and walk through the facility to the screening station without a mask or appropriate eye protection. When interviewed on 9/17/20, at 8:40 a.m., NA-E stated she entered the facility near the kitchen, performed hand hygiene, then walked through the dining room and across the hall to the main lobby	F 880	to screening down. 9/16/20, at 8:45 a.m. S1 and S2 walked into the facility and their temperatures were taken by a staff member. S1 and S2 signed into the facility and wrote their temperatures down. No further information was gathered by facility staff. S1 and S2 proceeded to the elevator and went to the 3rd floor. 9/17/20, at 8:15 a.m. S2 walked into the facility. There was a table with different forms, masks, and a thermometer. S2 waited by the table for a staff member to greet her. A staff member (from housekeeping) walked over and told S2 to sign in. Kebeh Zaimah, CNA-4 came to screen S2. Kebeh Zaimah, CNA-4 took S2s temperature and had S2 sign her name on the "Visitor Sign In" form. 9/17/20, at 8:18 a.m. Marissa Hoffman, Social Worker and Julia Vera, Staff Member-1 came in through the front door. Social Worker and Staff member-1 took their own temperatures and wrote down information on the Daily Staff Screening Log in response to symptoms related to COVID-19 without anyone verbally asking them. 9/17/20, at 8:38 a.m. Angeline, Staff Member-2 came from inside the building to the screening area with no mask and sunglasses on. Staff member-2 walked up to the table where staff and visitors are to be screened by the main door. There was no one at the table when Angeline, Staff Member-2 approached. Angeline, Staff Member-2 took her own temperature and filled out questions related to COVID-19	

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F 880	Continued From page 5 for COVID-19 symptom screening. NA-E further stated most staff enter through the kitchen door. NA-E also stated there was no screening station by the kitchen door, which was closest to the employee parking lot; staff that walk in the kitchen door have to walk through the facility to get screened. On 9/17/20, at 10:15 a.m., dietary aide (DA)-A was observed standing near the dishwasher with no face mask or eye protection in place. When interviewed on 9/17/20, at 10:15 a.m., DA-A stated he did not wear a face mask or eye protection in the dish room as the goggles fogged up and the mask made it hard to breath. DA-A further stated he would wear a face mask and eye protection in other areas of the facility. On 9/17/20, at 10:18 a.m. DA-B was observed to enter the kitchen from the resident serving line wearing a face mask positioned below chin level. When interviewed on 9/18/20, at 10:55 a.m., trained medication aid (TMA)-C stated staff entered the facility either through the front door or the back door. TMA-C further stated staff took their own temperature, sanitized their hands, and filled out the staff screening sheet. TMA-C further stated the nurse filled out the screening form if available, otherwise staff do it themselves. TMA-C further stated the thermometer was cleaned every two or three uses with hand sanitizer. When interviewed on 9/18/20, at 2:13 p.m., the infection preventionist (IP) stated it would be her expectation that a nurse or other staff would be present for the staff COVID-19 symptom screening, but staff could fill out the form	F 880	without anyone asking. Kebah Zaimah, CNA-4 approached the table were Staff Member-2 was. During an interview with Angeline Johnson, Staff member-2 on 9/17/20, at 8:40 a.m. Staff Member-2 reported to have come into the facility through a door by the kitchen. Angeline, Staff member-2 said she would put sanitizer on each time entered, walk through the dining room through the hall to the front main lobby to get screened. Angeline, Staff Member-2 reported to always come in through the door by the kitchen and so do most other staff. 9/17/20, at 9:42 a.m. Administrator approached S1 and S2 to discuss the dietary department and not wearing appropriate PPE on 9/16/20. Administrator explained her recent conversation with the dietary department about her observations of dietary staff not wearing appropriate personal protective equipment (PPE). Administrator stated she followed up with the FSD about her observation and FSD provided education to her staff. Administrator said later that day she caught the FSD not wearing eye protection or a mask after she had just educated on the need. Administrator went over the need for appropriate PPE and reeducated the FSD and dietary staff. The FSD was sent home for not wearing appropriate PPE and corrective action was provided to staff. 9/17/20, at 10:15 a.m. Glenn rock, Dietary aide-1 was observed through a window to the dish room. Dietary Aide-1 was	

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F 880	Continued From page 6 themselves. The IP further stated staff should all be wearing surgical masks and eye protection while in the facility. When interviewed on 9/18/20, at 3:17 p.m., the DON stated it would be her expectation that staff fill out the COVID-19 symptom screening form and take their own temperature, but the information should be verified by another staff member. The DON further stated the staff screening thermometer should be disinfected between uses. The DON further stated it was her expectation that staff follow the required PPE of the day, and verified the current requirement was for staff to wear a surgical mask and eye protection while in the building. A policy titled Resident Admissions and Care During Pandemic - COVID 19, revised 8/20, indicated all staff were to be actively screened for illness upon reporting to work, and all staff were expected to wear a procedure mask and protective eyewear at all times when in the building. The policy further indicated management shall continue to actively follow governmental, MDH, CDC, CMS and other appropriate guidelines. The Center for Disease Control Interim Infection Prevention and Control Recommendations for Healthcare Personnel During Coronavirus Disease 2019 (COVID-19) Pandemic dated July 15, 2020, indicated health care facilities should actively take temperatures and document symptoms consistent with COVID-19 and to implement universal source control measures which included health care personal (HCP) should wear a facemask at all times while they are in the facility and HCP working in facilities	F 880	standing near the dishwasher with no eyewear or no face mask on. Dietary Aide-1 stated understanding of the need to wear goggles and a mask but doesn't in the dish room as the goggles fog up. Dietary Aide-1 said the mask makes it stuffy and hard to breath. When not in the dish room, Dietary Aide-1 said a face covering and goggles are worn. 9/17/20, at 10:18 a.m. Yougal Tseten, Cook-1 was near baked chicken with a mask on, eyes not covered but had goggles on his forehead. Cook-1 was buttering chicken. Dietary Aide-1 walked through the kitchen with no mask or eye protection. Sherry Y, Dietary Aide-2 came in from the tray line area with a mask below her chin. The Interim Infection Prevention and Control Recommendations for Healthcare Personnel During Coronavirus Disease 2019 (COVID-19) Pandemic dated Julye 15, 2020 by the Center for Disease Control /6/2020, indicated health care facilities should actively take temperatures and document symptoms consistent with COVID-19 and to implement universal source control measure which includes health care personal (HCP) should wear a facemask at all times while they are in the facility and HCP working in facilities located in areas with moderate to substantial community transmission should wear eye protection in addition to their facemask. No residents were affected by the	

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F 880	Continued From page 7 located in areas with moderate to substantial community transmission should wear eye protection in addition to their facemask.	F 880	deficient practice. No residents have been diagnosed with COVID since the date of this survey. All residents have a potential to be affected by the deficient practice. We continue to assess residents vital signs and symptoms twice daily to identify potential COVID symptoms. Presently there are none. Some members of the facilities Quality Assurance and Performance Improvement Committee met to conduct a root cause analysis (RCA) to identify the problem(s) that resulted in this deficiency and develop intervention or corrective action plan to prevent recurrence on 10/9/2020. The Director of Nursing and Infection Preventionist met to review, develop and implement procedures, policies, and forms regarding active screening for temperature and signs and symptoms of COVID-19, in accordance with CDC guidelines to be conducted at the point of entry for every person who enters the facility. The procedures and policy must restrict entrance to anyone who does not meet the criteria as outlined by the CDC. This procedure must include actively measuring and recording staff temperature and assessment of shortness of breath, new or changed cough, and sore throat. The results must be documented. The new form to document this screening was implemented on 6/26/20. All staff are screened upon	

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F 880	Continued From page 8	F 880	entering the building at the beginning of their shift including having their temperature taken and questions asked about other signs and symptoms of COVID-19 as identified by the CDC. This is documented on a standard form. Surgical masks and protective eyewear are available to be picked up at this time during screening. The DON and Infection Preventionist reviewed policies and procedures for donning/doffing PPE for TBD and during COVID-19 with current guidelines to include crisis standard of care, contingency standard of care and standard care and to develop and implement a policy and procedure for source control masks and reviewed policies regarding standard and transmission based precautions and revised as needed on 10/9/2020. The Infection Preventionist completed the certification program recommended by CMS on 9/28/19. Training will be presented to all staff on proper masking and donning and doffing personal protective equipment and disinfection on 10/16/2020. Audits are being conducted 5x a week by management staff as designated by the Director of Nursing. The DON audits evenings, nights, and weekends through the facility surveillance system. The Medical Director will be apprised of	

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F 880	Continued From page 9	F 880	the plan at a meeting 10/16/2020. The results of audits and monitoring will be reviewed at the next QAPI meeting October 16, 2020.	

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E 000	Initial Comments A COVID-19 Focused Infection Control survey was conducted 9/15/20, to 9/18/20, at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.73(b)(6). The facility was IN full compliance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control survey was conducted 9/15/20, to 9/18/20, at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was determined NOT to be in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, a revisit of your facility will be conducted to validate substantial compliance with the regulations has been attained in accordance with your verification. Additionally, on 9/15/20, to9/18/20, an abbreviated standard survey was completed at	F 000		

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

Electronically Signed | 10/09/2020

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F 000	Continued From page 1 your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The survey resulted in an immediate jeopardy (IJ) to resident health and safety. An IJ at F689 began on 9/10/20, when the wanderguard alarm did not sound in response to a resident (R1) exiting the facility. The facility failed to ensure the wanderguard system was operational or provide enhanced supervision of R1. Subsequently, R1 did elope from the facility. The administrator and director of nursing (DON) were notified of the IJ for R1 on 9/17/20, at 11:37 a.m. The facility immediately implemented correction action on 9/11/20, and F689 is being issued at past non-compliance. In addition, an extended survey was completed 9/18/20, related to the substandard quality of care findings. Complaint HE185093 was unsubstantiated, and complaint HE185092 was substantiated at F689, for past non-compliance. Although the provider had implemented corrective action prior to survey, harm or immediate jeopardy was sustained prior to the correction. Although no plan of correction is required for a finding of past non-compliance, it is required the facility acknowledge receipt of the electronic documents.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		10/8/20

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F 689	Continued From page 2 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the wanderguard was functioning to prevent an elopment for 1 of 3 residents (R1) reviewed for elopements. This resulted in an immediate jeopardy (IJ) when R1 eloped out of the building on 9/10/20 and was missing for 3.5 hours and was found by police unharmed. The facility immediately implemented interventions and corrected the deficient practice on 9/11/20. This is issued as past noncomplaince at Immediate Jeopardy (IJ). The IJ that began on 9/10/20 was corrected on 9/11/20 when the facilty implemented interventions to prevent reoccurance. The administrator and director of nursing (DON) were notified of the IJ past noncomplaince on 9/17/20, at 11:37 a.m., as a result of the immediate corrective action taken by the facility. Findings include: R1's admission Minimun Data Set (MDS) dated 7/2/20, indicated R1 had diagnoses that included dementia, bipolar, depression, chronic obstructive pulmonary disorder (COPD), and severe cognitive impairment. The MDS further indicated R1 was independent for ambulation and surface	F 689	Past noncompliance: no plan of correction required.	

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to surface transfers.

A Brief Interview for Mental Status (BIMS) was most recently completed on 8/21/20, that indicated R1 had severe cognitive impairment.

A wander risk assessment completed on 8/19/20, indicated R1 exhibited behaviors of refusals, impaired judgement, impulsive behavior, and had wandered aimlessly within the facility or grounds within the past month. The assessment further indicated R1 was deemed unsafe to leave the facility unescorted.

R1's care plan, last reviewed 8/18/20, indicated R1 was a wander risk, had a wanderguard alarm in place, and was deemed unsafe to leave the facility unescorted.

A progress note dated 9/10/20, at 9:11 a.m. indicated R1 was persistently asking for cigarettes and would not wait for staff, setting off the door alarm. The progress note further indicated R1 was found walking down the alley, just off campus, and was redirected.

A progress note dated 9/10/20, at 1:23 p.m. indicated R1exited the living room door with a cigarette in hand and the alarm did not sound.

A progress note dated 9/10/20, at 1:41 p.m. indicated the maintenance director (MD)-A was notified via email to check the wanderguard on R1 to see if it was defective.

An email from the food services director (FSD)-B to MD-A sent on 9/10/20, at 1:44 p.m., had a subject that indicated to please check, and further indicated R1 went out the living room door and

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the alarm did not sound.

A progress note dated 9/10/20, at 8:34 p.m. noted R1 had not been seen by any staff member in or around the facility since 3:00 p.m. and no report was provided by previous shift about R1 leaving the facility. Staff searched for R1 around the vicinity but were unable to find R1. The DON, administrator, case manager, and police were notified.

A progress note dated 9/10/20, at 10:53 p.m., indicated R1 was brought back by police at about 10:30 p.m. and R1 was noted to have no injuries.

When interviewed on 9/16/20, at 12:09 p.m., FSD-B stated R1 exited through the living room door, and the alarm didn't sound. FSD-B further stated she charted the incident and emailed MD-A, asking him to check the door. FSD-B further stated she did not notify anyone else, but will copy the administrator or the DON in the future. FSD-B confirmed having received disciplinary action and re-education regarding elopement procedures.

When interviewed on 9/16/20, at 11:45 a.m., MD-A stated when a wanderguard was not working he should be informed via text or phone call, "anything but an email." MD-A further stated with an urgent issue, an email would be the last resort.

When interviewed on 9/15/20, at 4:24 p.m., the facility administrator stated MD-A did not receive the email notification of the wanderguard alarm not sounding because MD-A had left for the day. The administrator further stated FSD-B did not inform anyone else the alarm was not working

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properly. The administrator contacted MD-A on 9/11/20, at approximately 6:00 a.m., at which time MD-A reported the wanderguard alarm system had already been checked that morning and was working properly.

When interviewed on 9/16/20, at 11:45 a.m., MD-A stated there were no issues during an audit of the wanderguard alarm system on 9/11/20. MD-A further stated during an audit he ensures the key pads and unit power sensor works and that the magnet is on. MD-A further stated green lights indicate the door unit was in working order.

On 9/16/20, at 12:07 p.m., licensed practical nurse (LPN)-A was observed to escort R1 from the smoking patio into the facility. When LPN-A and R1 passed through the door, the alarm sounded appropriately.

When interviewed on 9/15/20, at 3:24 p.m., R1 stated a staff member goes with him outside to smoke. R1 further stated feeling safe at the facility.

When interviewed on 9/15/20, at 3:31 p.m., trained medication aide (TMA)-A stated all residents' wanderguard placement was checked each shift and the evening supervisor tested each night to make sure their wanderguard works.

When interviewed on 9/15/20, at 3:33p.m., nursing assistant (NA)-A stated staff recently received training on wanderguard and elopement procedures. NA-A further stated all staff respond to the wanderguard alarm and must locate the resident before deactivating the alarm.

When interviewed on 9/16/20, at 10:07 a.m.,

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F 689	Continued From page 6 NA-B stated all staff were recently re-educated regarding elopement procedures, including which residents were at risk and how to respond. When interviewed on 9/16/20, at 12:21 p.m., NA-C stated she recently received education on how to respond if someone with a wanderguard elopes from the facility. NA-C further stated the charge nurse would be immediately informed if a resident could not be located. When interviewed on 9/16/20, at 12:26 p.m., housekeeping staff (H)-A stated he received education on elopement and wanderguards when he first started working at the facility earlier in the year, and had recently read new education related to elopement and how to respond to the wanderguard alarm. When interviewed on 9/16/20, at 12:29 p.m. LPN-A stated R1 had a wanderguard and was cognitively impaired. LPN-A further stated appropriate interventions were currently followed and worked well for R1 over the past week. When interviewed on 9/16/20, at 2:49 p.m., the DON stated the facility checked wanderguard placement on residents every shift and wanderguard function every 24 hours for residents with wanderguards. The DON further stated if it were noted the wanderguard system was not working the expectation was to notify the DON, infection preventionist, administrator, or assistant administrator immediately. The DON further stated staff should monitor the door or have increased monitoring of the resident if there was an issue with a residents wanderguard. The DON also stated, in response to R1's elopement on 9/10, staff followed the policy when the	F 689		

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F 689	Continued From page 7	F 689		

wanderguard alarm went off around 3:30 p.m., and staff did not realize R1 had eloped when another resident set off the wanderguard alarm. The DON added when the facility realized R1 was missing they searched rooms, the building grounds, called the police and reported the incident to the State Agency (SA). Finally, the DON stated all staff had been re-educated on the elopement policy.

When interviewed on 9/17/20, at 9:39 a.m., the administrator stated FSD-B should have notified the administrator and DON immediately about the wanderguard alarm not sounding on 9/10/20, versus writing an email to MD-A.

The policy titled Wandering / Elopement Prevention Plan Policy and Procedure, updated 6/20, indicated it was the policy of the facility to provide a safe environment for all residents. The policy further indicated the safety care plan would be assessed as needed to ascertain appropriate wandering prevention. The policy further indicated staff would inform maintenance of any alarm maintenance or needed repair work.

The document titled Wanderguard Protocol Refresher, dated 9/11/20, included images of residents with a wanderguard, and indicated when the wanderguard alarm sounds, staff should check for residents on a wanderguard outside the building and around corners. The protocol refresher further indicated staff should not turn off the wanderguard alarm unless they are 100% certain residents with a wanderguard are safe and accounted for.

The immediate jeopardy (IJ) that began on 9/10/20, was removed on 9/11/20, when the

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F 689	Continued From page 8 facility took the following steps to remove the IJ and correct the deficient practice: On 9/11/20, an audit of the wanderguard system, including all wanderguard bracelets used, was completed to ensure they were in proper working order. On 9/11/20, disciplinary action and re-education regarding equipment malfunction was provided to maintenance staff and staff that observed the wanderguard malfunction. On 9/11/20, the elopement protocol was updated to indicate staff will check the grounds thoroughly and account for residents with a wanderguard in response to the door alarm. All staff were re-educated to the facility elopement policy and protocol beginning on 9/11/20. Verification of corrective action was confirmed by interview with a variety of nursing and non-nursing staff that verified education was provided and staff will notify maintenance and administrative staff of any possible malfunction of the wanderguard system and ensure the notification is received.	F 689		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §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:	F 880		10/9/20

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F 880	Continued From page 9 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct 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	F 880		

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F 880	Continued From page 10 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 a comprehensive infection control program to include recommended COVID-19 staff health screening procedures, disinfection of shared equipment and wearing of appropriate personal protective equipment (PPE). This had the potential to affect all 77 residents in the facility Findings include: During continuous observations on 9/17/20, from 8:09 a.m until 8:19 a.m., the following was noted: --At 8:09 a.m., an unidentified staff member was observed entering the facility; no staff were present at the COVID-19 symptom screening station. The unidentified staff member took his own temperature twice, filled out a symptom screening sheet and proceded to enter the building. There was no screener to ensure the unidentified staff member did not enter the faciltiy if they had symptoms. The thermometer was not sanitized after use. --At approximately 8:16 a.m., nursing assistant (NA)-D arrived at the screening desk from another area within the facility, and was observed	F 880	Based on observation, interview and document review, the facility failed to implement a comprehensive infection control program to include recommended COVID-19 staff health screening location procedures and wear appropriate personal protective equipment. This had the potential to affect all 77 residents that resided in the facility Findings include: 9/15/20, at 12:45 p.m. Surveyor- 1 and Surveyor 2 walked into the facility. S1 and S2 signed their names on a form when they entered the facility. A staff member took temperatures of S1 and S2. S1 asked staff member if they had any questions. The staff member asked screening questions related for COVID 19 but did not write the answers provided by S1 and S2 down on their tracking log. S2 asked the staff member if they were going to write down S1 and S2 COVID 19 screening questions. The staff member proceeded and wrote S1 and S2 answers	

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F 880	Continued From page 11 at screening desk when social worker (SW)-A entered the building. SW-A donned a mask, filled out the COVID-19 symptom screening questions on the staff screening form, took her own temperature with the non-disinfected thermometer, sanitized her hands and proceeded into the building. The thermometer was not disinfected after use. --At 8:19 a.m., licensed practical nurse (LPN)-B was observed entering the facility wearing a surgical mask and eye protection, was observed to fill out the staff COVID-19 symptom screening form, took her own temperature using the non-disinfected thermometer, and entered her temperature on the screening form. The thermometer was not disinfected after use. At no time during the continuous observation of the screening process staff was the thermometer disinfected. On 9/17/20, at 8:38 a.m., NA-E was observed to approach the COVID-19 symptom screening station from inside the building wearing sunglasses and no mask on. No screener was initially present at the COVID-19 symptom screening station; NA-E took her own temperature and filled out the COVID-19 screening form; NA-D came to the screening table at this time and NA-E then proceeded to enter the facility. NA-E was able to enter the facility from another entrance without a screening station and walk through the facility to the screening station without a mask or appropriate eye protection. When interviewed on 9/17/20, at 8:40 a.m., NA-E stated she entered the facility near the kitchen, performed hand hygiene, then walked through the dining room and across the hall to the main lobby	F 880	to screening down. 9/16/20, at 8:45 a.m. S1 and S2 walked into the facility and their temperatures were taken by a staff member. S1 and S2 signed into the facility and wrote their temperatures down. No further information was gathered by facility staff. S1 and S2 proceeded to the elevator and went to the 3rd floor. 9/17/20, at 8:15 a.m. S2 walked into the facility. There was a table with different forms, masks, and a thermometer. S2 waited by the table for a staff member to greet her. A staff member (from housekeeping) walked over and told S2 to sign in. Kebeh Zaimah, CNA-4 came to screen S2. Kebeh Zaimah, CNA-4 took S2s temperature and had S2 sign her name on the "Visitor Sign In" form. 9/17/20, at 8:18 a.m. Marissa Hoffman, Social Worker and Julia Vera, Staff Member-1 came in through the front door. Social Worker and Staff member-1 took their own temperatures and wrote down information on the Daily Staff Screening Log in response to symptoms related to COVID-19 without anyone verbally asking them. 9/17/20, at 8:38 a.m. Angeline, Staff Member-2 came from inside the building to the screening area with no mask and sunglasses on. Staff member-2 walked up to the table where staff and visitors are to be screened by the main door. There was no one at the table when Angeline, Staff Member-2 approached. Angeline, Staff Member-2 took her own temperature and filled out questions related to COVID-19	

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F 880	Continued From page 12 for COVID-19 symptom screening. NA-E further stated most staff enter through the kitchen door. NA-E also stated there was no screening station by the kitchen door, which was closest to the employee parking lot; staff that walk in the kitchen door have to walk through the facility to get screened. On 9/17/20, at 10:15 a.m., dietary aide (DA)-A was observed standing near the dishwasher with no face mask or eye protection in place. When interviewed on 9/17/20, at 10:15 a.m., DA-A stated he did not wear a face mask or eye protection in the dish room as the goggles fogged up and the mask made it hard to breath. DA-A further stated he would wear a face mask and eye protection in other areas of the facility. On 9/17/20, at 10:18 a.m. DA-B was observed to enter the kitchen from the resident serving line wearing a face mask positioned below chin level. When interviewed on 9/18/20, at 10:55 a.m., trained medication aid (TMA)-C stated staff entered the facility either through the front door or the back door. TMA-C further stated staff took their own temperature, sanitized their hands, and filled out the staff screening sheet. TMA-C further stated the nurse filled out the screening form if available, otherwise staff do it themselves. TMA-C further stated the thermometer was cleaned every two or three uses with hand sanitizer. When interviewed on 9/18/20, at 2:13 p.m., the infection preventionist (IP) stated it would be her expectation that a nurse or other staff would be present for the staff COVID-19 symptom screening, but staff could fill out the form	F 880	without anyone asking. Kebah Zaimah, CNA-4 approached the table were Staff Member-2 was. During an interview with Angeline Johnson, Staff member-2 on 9/17/20, at 8:40 a.m. Staff Member-2 reported to have come into the facility through a door by the kitchen. Angeline, Staff member-2 said she would put sanitizer on each time entered, walk through the dining room through the hall to the front main lobby to get screened. Angeline, Staff Member-2 reported to always come in through the door by the kitchen and so do most other staff. 9/17/20, at 9:42 a.m. Administrator approached S1 and S2 to discuss the dietary department and not wearing appropriate PPE on 9/16/20. Administrator explained her recent conversation with the dietary department about her observations of dietary staff not wearing appropriate personal protective equipment (PPE). Administrator stated she followed up with the FSD about her observation and FSD provided education to her staff. Administrator said later that day she caught the FSD not wearing eye protection or a mask after she had just educated on the need. Administrator went over the need for appropriate PPE and reeducated the FSD and dietary staff. The FSD was sent home for not wearing appropriate PPE and corrective action was provided to staff. 9/17/20, at 10:15 a.m. Glenn rock, Dietary aide-1 was observed through a window to the dish room. Dietary Aide-1 was	

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F 880	Continued From page 13 themselves. The IP further stated staff should all be wearing surgical masks and eye protection while in the facility. When interviewed on 9/18/20, at 3:17 p.m., the DON stated it would be her expectation that staff fill out the COVID-19 symptom screening form and take their own temperature, but the information should be verified by another staff member. The DON further stated the staff screening thermometer should be disinfected between uses. The DON further stated it was her expectation that staff follow the required PPE of the day, and verified the current requirement was for staff to wear a surgical mask and eye protection while in the building. A policy titled Resident Admissions and Care During Pandemic - COVID 19, revised 8/20, indicated all staff were to be actively screened for illness upon reporting to work, and all staff were expected to wear a procedure mask and protective eyewear at all times when in the building. The policy further indicated management shall continue to actively follow governmental, MDH, CDC, CMS and other appropriate guidelines. The Center for Disease Control Interim Infection Prevention and Control Recommendations for Healthcare Personnel During Coronavirus Disease 2019 (COVID-19) Pandemic dated July 15, 2020, indicated health care facilities should actively take temperatures and document symptoms consistent with COVID-19 and to implement universal source control measures which included health care personal (HCP) should wear a facemask at all times while they are in the facility and HCP working in facilities	F 880	standing near the dishwasher with no eyewear or no face mask on. Dietary Aide-1 stated understanding of the need to wear goggles and a mask but doesn't in the dish room as the goggles fog up. Dietary Aide-1 said the mask makes it stuffy and hard to breath. When not in the dish room, Dietary Aide-1 said a face covering and goggles are worn. 9/17/20, at 10:18 a.m. Yougal Tseten, Cook-1 was near baked chicken with a mask on, eyes not covered but had goggles on his forehead. Cook-1 was buttering chicken. Dietary Aide-1 walked through the kitchen with no mask or eye protection. Sherry Y, Dietary Aide-2 came in from the tray line area with a mask below her chin. The Interim Infection Prevention and Control Recommendations for Healthcare Personnel During Coronavirus Disease 2019 (COVID-19) Pandemic dated Julye 15, 2020 by the Center for Disease Control /6/2020, indicated health care facilities should actively take temperatures and document symptoms consistent with COVID-19 and to implement universal source control measure which includes health care personal (HCP) should wear a facemask at all times while they are in the facility and HCP working in facilities located in areas with moderate to substantial community transmission should wear eye protection in addition to their facemask. No residents were affected by the	

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F 880	Continued From page 14 located in areas with moderate to substantial community transmission should wear eye protection in addition to their facemask.	F 880	deficient practice. No residents have been diagnosed with COVID since the date of this survey. All residents have a potential to be affected by the deficient practice. We continue to assess residents vital signs and symptoms twice daily to identify potential COVID symptoms. Presently there are none. Some members of the facilities Quality Assurance and Performance Improvement Committee met to conduct a root cause analysis (RCA) to identify the problem(s) that resulted in this deficiency and develop intervention or corrective action plan to prevent recurrence on 10/9/2020. The Director of Nursing and Infection Preventionist met to review, develop and implement procedures, policies, and forms regarding active screening for temperature and signs and symptoms of COVID-19, in accordance with CDC guidelines to be conducted at the point of entry for every person who enters the facility. The procedures and policy must restrict entrance to anyone who does not meet the criteria as outlined by the CDC. This procedure must include actively measuring and recording staff temperature and assessment of shortness of breath, new or changed cough, and sore throat. The results must be documented. The new form to document this screening was implemented on 6/26/20. All staff are screened upon	

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F 880	Continued From page 15	F 880	entering the building at the beginning of their shift including having their temperature taken and questions asked about other signs and symptoms of COVID-19 as identified by the CDC. This is documented on a standard form. Surgical masks and protective eyewear are available to be picked up at this time during screening. The DON and Infection Preventionist reviewed policies and procedures for donning/doffing PPE for TBD and during COVID-19 with current guidelines to include crisis standard of care, contingency standard of care and standard care and to develop and implement a policy and procedure for source control masks and reviewed policies regarding standard and transmission based precautions and revised as needed on 10/9/2020. The Infection Preventionist completed the certification program recommended by CMS on 9/28/19. Training will be presented to all staff on proper masking and donning and doffing personal protective equipment and disinfection on 10/16/2020. Audits are being conducted 5x a week by management staff as designated by the Director of Nursing. The DON audits evenings, nights, and weekends through the facility surveillance system. The Medical Director will be apprised of	

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F 880	Continued From page 16	F 880	the plan at a meeting 10/16/2020. The results of audits and monitoring will be reviewed at the next QAPI meeting October 16, 2020.	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 8, 2020

Administrator
Bywood East Health Care
3427 Central Avenue Northeast
Minneapolis, MN 55418

Re: Event ID: JQ6X11

Dear Administrator:

The above facility survey was completed on September 18, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

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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 9/15/20, to 9/18/20, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be IN compliance with the MN State Licensure. The following complaint was found to be UNSUBSTANTIATED: HE185093. NO licensing	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00176	A. BUILDING: _____ B. WING _____	C 09/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BYWOOD EAST HEALTH CARE	**3427 CENTRAL AVENUE NORTHEAST MINNEAPOLIS, MN 55418**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 orders were issued. The following complaint was found to be SUBSTANTIATED: HE185092, however NO licensing orders were issued. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		