Electronically delivered
August 27, 2020

Administrator
Ecumen Lakeshore
4002 London Road
Duluth, MN 55804

Re: State Nursing Home Licensing Orders
Event ID: E69R11

Dear Administrator:

The above facility was surveyed on August 11, 2020 through August 13, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Teresa Ament, Unit Supervisor
Email: teresa.ament@state.mn.us
Phone: (218) 302-6151
Fax: (218) 723-2359

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245215	A. BUILDING _____ B. WING _____	C 08/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECUMEN LAKESHORE	**4002 LONDON ROAD DULUTH, MN 55804**

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E 000	Initial Comments A COVID-19 Focused Infection Control survey was conducted 8/11/20, through 8/13/20, at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.73(b)(6). The facility was IN full compliance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents	E 000		
F 000	INITIAL COMMENTS On 8/11/20, through 8/13/20, an abbreviated survey and a COVID-19 Focused Infection Control survey were 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 and to determine compliance with §483.80 Infection Control. The survey identified the facility was NOT in compliance. In addition the following complaint was found to be substantiated: H5215043C. However, no deficiencies were cited due to actions implemented by the facility prior to survey. The following complaints were found to be unsubstantiated: H5215044C, H5215045C, H5215046C, H5215047C, H5215048C. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first	F 000		

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

Electronically Signed | 09/05/2020

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F 000	Continued From page 1 page of the CMS-2567 form.	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: §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	F 880		9/21/20

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F 880	Continued From page 2 to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement a comprehensive infection control program to include the Centers for Medicaid and Medicare Services (CMS) COVID-19 recommendations to ensure active screening and surveillance of staff for potential COVID-19 symptoms before entering the facility and having contact with residents. In	F 880	Active Screening: 1) Corrective Action: All staff will be actively screened whenever entering Ecumen Lakeshore. 2) Corrective Action as it applies to other residents: An audit of 100% of all staff's compliance with active screening education including what active screening	

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F 880	Continued From page 3 addition, the facility failed to ensure staff were wearing proper protective equipment (PPE) to prevent the spread of COVID-19 according to Centers for Disease Control (CDC) guidelines for 3 of 4 residents (R7, R9, R11) observed for modified droplet precautions. These practices had the potential to affect all 28 residents who resided at the facility. Findings include: On 8/11/20, at 1:00 .p.m.. the facility main entrance provided signage and information related to COVID-19 to ensure immediate screening and surveillance of staff and visitors for potential COVID-19 symptoms before entering the facility and having contact with residents. In addition, upon entrance signage direction those who entered to please sanitize hands, put on a mask, and be screened at reception desk. On 8/12/20, at 7:05 a.m. Environmental worker (E)-A was observed entering the facility. Upon entering the facility, E-A sanitized his hands, donned a mask, and walked to the reception desk. E-A was observed to screen himself using a 3-ring binder located at the reception desk. E-A then took his own temperature with a forehead scanner, and documented it in the binder. No sanitizing wipes were observed to be at the desk to sanitize the pens or thermometer which staff members used to complete independent screening. On 8/12/20, at 7:29 a.m. housekeeper (H)-A was interviewed, and stated she completed the COVID-19 screening herself. NA-A verified sanitizing wipes were not available at the desk to sanitize the pens or thermometer.	F 880	means, why staff must be actively screened, and demonstration of active screening with each staff entrance into the building will be completed. 3) Date of Completion: September 21, 2020 4) Re-occurrence will be prevented by: All staff including nursing, therapy, EVS, maintenance, culinary, social services, human resources, business office, and administration will be educated at a mandatory training offered multiple times by their manager between 8/27 and 9/14 regarding active screening. Staff unable to attend will be educated individually. 5) The correction plan will be monitored by: DON or designee will complete daily audits X 2 weeks, weekly audits X 4 weeks and monthly audits for 5 months to insure that all staff are actively screened when entering the facility. The QA Committee will review the audit results and provide further direction as needed.	

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F 880	Continued From page 4 On 8/12/20, at 7:32 a.m. nursing assistant (NA)-D was interviewed, and stated he completed the COVID-19 screening himself. NA-D further stated he would report a temperature of over 99.9 to the registered nurse (RN) on charge via phone, and would not enter further into the facility. NA-D verified sanitizing wipes were not available at the desk to sanitize the pens or thermometer. On 8/12/20, at 7:43 a.m. the front desk receptionist (R)-A was interviewed and stated Monday through Friday from the hours of 8 a.m. and 6 p.m., and Saturdays and Sunday from the hours 9 a.m. and 5 p.m., the front desk had a staff member who screened staff and visitors at the reception desk. R-A stated staff members used to screen themselves when there was not a screener at the desk, including nightshift and dayshift for those that start prior to a screener being at the front desk. On 8/12/20, at 7:45 a.m. business office worker (BW)-A was observed entering the facility. Upon entering the facility, BW-A used hand sanitizer, donned a clean mask, and walked to the reception desk. BW-A picked up a pen and answered questions, then took her temperature. Neither the pen nor thermometer were sanitized before or after use. On 8/13/20, at 10:02 a.m. the director of nursing (DON) verified the facility had not been actively screening staff on night shift, and those that entered early for dayshift. The DON stated this practice could result in possible exposure and spread of COVID-19. The DON stated guidance through CMS and MDH specified active screening, and the facility had not been following	F 880		

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F 880	Continued From page 5	F 880		

guidance. The DON further stated the facility had not been sanitizing items such as thermometer and pens used by staff. The DON stated this facility practice could have led to a breach in infection control and spread of COVID-19.

R7's Face Sheet printed 8/13/20, included diagnosis of mild cognitive impairment, history of falls, and reduced mobility.

R7's Care plan initiated 8/10/20, indicated R8 had activity of daily living (ADL) self-care deficit and was dependent on staff for ambulation, and required minimal assistance of one staff with all ADLs. R7's care plan directed caregivers to personal protective equipment (PPE) at all times when providing care due to facility 14 day quarantine period upon admission.

R7's progress note dated 8/10/20, indicated R7 admitted to the facility from a recent hospital stay.

R9's Face Sheet printed 8/13/20, indicated R8's diagnoses included muscle weakness, history of falls, and reduced mobility.

R9's Care plan initiated 8/7/20, indicated R9 had ADL self-care deficit, and was dependent on staff for ambulation, and required minimal assistance of one staff with all ADLs.

R9's progress note dated 8/7/20, indicated R9 admitted to the facility from a recent hospital stay.

R11's Face Sheet printed 8/13/20, included diagnosis of dementia, history of falls, and reduced mobility.

R11's Care plan initiated 8/5/20, indicated R11

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F 880	Continued From page 6	F 880		

had ADL self-care deficit, and was dependent on staff for ambulation, and required extensive assistance of one staff with all ADLs.

R11's progress note dated 8/5/20, indicated R11 had been admitted to the facility from a recent hospital stay.

On 8/11/20, at 2:49 p.m. R7's room was observed to have a clear bin outside of the room which included alcohol based hand rub (ABHR), signage for modified droplet precautions directing a 14 day quarantine was to be in effect until 8/24/20. Instructions posted include staff was to wear a face mask, eye shield, and gloves when providing cares for R7.

On 8/11/20, at 2:49 p.m. during continuous observation, NA-A was observed outside R7's room donning an isolation gown and gloves. NA-A did not use hand sanitizer prior to donning gloves. NA-A's face mask and eye shield were already in place and being worn properly. NA-A proceeded to enter R7's room, shut off R7's call light, and exit R7's room with water pitcher. NA-A then proceeded to place R7's water pitcher on the isolation bin, removed the soiled gloves, and opened a new box of gloves. Without performing hand hygiene, NA-A donned clean gloves, filled R7's water pitcher from the unit's ice and water machine, and returned to R7's room. NA-A filled R7's drinking glass from the water pitcher. NA-A then removed the soiled gloves, and went into R7'S bathroom. NA-A washed hands, and removed the gown, and exited room.

On 8/11/20, at 4:15 p.m. NA-A verified she had not perform hand hygiene between glove changes.

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F 880	Continued From page 7 On 8/12/20, at 8:47 a.m. R9's room was observed to have a clear bin outside of the room which included ABHR, signage for modified droplet precautions directing a 14 day quarantine was to be in effect until 8/21/20. Instructions posted included staff were to wear a face mask, eye shield, and gloves when providing cares for R9. On 8/12/20, at 8:47 a.m. during continuous observation, NA-B was observed in R9's room assisting R9 with standing up. NA-B was observed wearing his face mask and eye protection, however, NA-B did not wear gloves while providing cares for R9. NA-B was observed performing hand hygiene when exiting R9's room. On 8/12/20, at 8:56 a.m. R11's room was observed to have a clear bin outside of the room which included ABHR, signage for modified droplet precautions directing a 14 day quarantine was to be in effect until 8/18/20. Instructions posted included staff were to wear a face mask, eye shield and gloves when providing cares for R11. On 8/12/20, at 8:56 a.m. during continuous observation, NA-C was observed in R11's room assisting R11 into bed with the use of mechanical lift. NA-B was observed wearing a face mask and eye protection, however NA-C did not wear gloves while providing cares for R11. NA-C then exited R11's room, sanitized the mechanical lift and performed hand hygiene. On 8/12/20, at 8:58 a.m. NA-C verified she had not been wearing gloves when providing personal cares for R11, which included assisting R11 into her bed.	F 880		

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F 880	Continued From page 8 On 8/12/20, at 11:31 a.m. registered nurse (RN)-A stated all new admissions required a 14 day quarantine period as part of COVID-19 assessment. RN-A stated all staff providing cares for residents on modified droplet precautions were required to wear gloves when entering the room and providing cares. On 8/13/20, at 12:43 p.m. the DON stated staff were to wear the appropriate PPE while providing cares for residents. The DON stated it was important to follow the recommended guidelines which included isolation for 14 days upon admission to prevent the possible spread of COVID-19. The DON stated not all residents have the COIVD-19 test prior to admission, thus following modified droplet precautions needed to be adhered to by all staff providing cares. The DON stated she expected all staff were following the guidelines of wearing face mask, eye protection, and gloves when entering the residents on 14 day isolation precautions. The facility policy 14 Day New Admission Quarantine /Modified Droplet Precautions updated 5/6/20, directed staff to be wearing required PPE while quarantine/modified droplet precautions providing cares for residents to include surgical mask, eye protection, and gloves. The facility policy COVID-19 Policy for New Admission Isolation undated, directed new admissions to be placed on 14 day isolation with precautions. The policy further directed after 14 days have elapsed and the resident has not developed any symptoms of infection, modified precautions can be discontinued and the resident may be moved to a shared room as needed.	F 880		

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F 880	Continued From page 9 The facility policy Ecumen Lakeshore Screening Protocols dated 8/4/20, lacked specific direction and guidance related to active screening, and sanitization of common use items.	F 880		

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:

PERSONAL PROTECTIVE EQUIPMENT (PPE)

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

POLICIES/PROCEDURES/SYSTEM CHANGES:

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

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

- Review policies and procedures for donning/doffing PPE for TBD and during COVID-19 with current guidelines to include crisis standard of care, contingency standard of care and standard care.
- 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.

Electronically delivered
August 27, 2020

Administrator
Ecumen Lakeshore
4002 London Road
Duluth, MN 55804

RE: CCN: 245215
Cycle Start Date: August 13, 2020

Dear Administrator:

On August 13, 2020, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMEDIES

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

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 26, 2020.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 26, 2020. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 26, 2020.

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

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

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

If you have not achieved substantial compliance by September 26, 2020, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Ecumen Lakeshore will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 26, 2020. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.
However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

DEPARTMENT CONTACT

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

Teresa Ament, Unit Supervisor
Email: teresa.ament@state.mn.us
Phone: (218) 302-6151
Fax: (218) 723-2359

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 13, 2021 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a

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

Tamika.Brown@cms.hhs.gov

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

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

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

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

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period

allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00594	A. BUILDING: _____ B. WING _____	C 08/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECUMEN LAKESHORE	**4002 LONDON ROAD DULUTH, MN 55804**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 8/11/20, through 8/13/20, an abbreviated survey was completed at your facility to conduct a COVID-19 Focused Infection Control survey and complaint investigations. Your facility was found to be not in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECUMEN LAKESHORE	4002 LONDON ROAD DULUTH, MN 55804

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2 000	Continued From page 1 The following complaint was found to be substantiated: H5215043C. However, no deficiencies were cited due to actions implemented by the facility prior to survey. The following complaints were found to be unsubstantiated: H5215044C, H5215045C, H5215046C, H5215047C, H5215048C. Deficiencies were cited under infection control. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be corrected.	2 000		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement a comprehensive infection control program to include the Centers for Medicaid and Medicare Services (CMS) COVID-19 recommendations to ensure active screening and surveillance of staff for potential COVID-19 symptoms before entering the facility and having contact with residents. In addition, the facility failed to ensure staff were wearing proper protective equipment (PPE) to prevent the spread of COVID-19 according to Centers for Disease Control (CDC) guidelines for 3 of 4 residents (R7, R9, R11) observed for modified droplet precautions. These practices had the potential to affect all 28 residents who	21375	Active Screening: 1) Corrective Action: All staff will be actively screened whenever entering Ecumen Lakeshore. 2) Corrective Action as it applies to other residents: An audit of 100% of all staff's compliance with active screening education including what active screening means, why staff must be actively screened, and demonstration of active screening with each staff entrance into the building will be completed. 3) Date of Completion: September 21, 2020 4) Re-occurrence will be prevented by:	9/21/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21375	Continued From page 2 resided at the facility. Findings include: On 8/11/20, at 1:00 .p.m.. the facility main entrance provided signage and information related to COVID-19 to ensure immediate screening and surveillance of staff and visitors for potential COVID-19 symptoms before entering the facility and having contact with residents. In addition, upon entrance signage direction those who entered to please sanitize hands, put on a mask, and be screened at reception desk. On 8/12/20, at 7:05 a.m. Environmental worker (E)-A was observed entering the facility. Upon entering the facility, E-A sanitized his hands, donned a mask, and walked to the reception desk. E-A was observed to screen himself using a 3-ring binder located at the reception desk. E-A then took his own temperature with a forehead scanner, and documented it in the binder. No sanitizing wipes were observed to be at the desk to sanitize the pens or thermometer which staff members used to complete independent screening. On 8/12/20, at 7:29 a.m. housekeeper (H)-A was interviewed, and stated she completed the COVID-19 screening herself. NA-A verified sanitizing wipes were not available at the desk to sanitize the pens or thermometer. On 8/12/20, at 7:32 a.m. nursing assistant (NA)-D was interviewed, and stated he completed the COVID-19 screening himself. NA-D further stated he would report a temperature of over 99.9 to the registered nurse (RN) on charge via phone, and would not enter further into the facility. NA-D verified sanitizing wipes were not available at the	21375	All staff including nursing, therapy, EVS, maintenance, culinary, social services, human resources, business office, and administration will be educated at a mandatory training offered multiple times by their manager between 8/27 and 9/14 regarding active screening. Staff unable to attend will be educated individually. 5) The correction plan will be monitored by: DON or designee will complete daily audits X 2 weeks, weekly audits X 4 weeks and monthly audits for 5 months to insure that all staff are actively screened when entering the facility. The QA Committee will review the audit results and provide further direction as needed. Appropriate Hand Hygiene and Utilization of Personal Protective Equipment (PPE): 1) Corrective Action: All staff will be compliant with precautions for New Admission Isolation patients, including the appropriate use of PPE and hand hygiene. 2) Corrective Action as it applies to other residents: An audit of 100% of all patients on New Admission Isolation will be completed to insure that appropriate PPE is worn and hand hygiene is completed. 3) Date of Completion: September 21, 2020 4) Re-occurrence will be prevented by: All direct care providers will be educated at a mandatory training offered multiple times between 8/27 and 9/14 regarding appropriate PPE utilization and hand hygiene to be correctly performed. Staff unable to attend will be educated individually. 5) The Correction Plan will be monitored by: DON or designee will complete audits	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ECUMEN LAKESHORE	4002 LONDON ROAD DULUTH, MN 55804

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21375	Continued From page 3 desk to sanitize the pens or thermometer. On 8/12/20, at 7:43 a.m. the front desk receptionist (R)-A was interviewed and stated Monday through Friday from the hours of 8 a.m. and 6 p.m., and Saturdays and Sunday from the hours 9 a.m. and 5 p.m., the front desk had a staff member who screened staff and visitors at the reception desk. R-A stated staff members used to screen themselves when there was not a screener at the desk, including nightshift and dayshift for those that start prior to a screener being at the front desk. On 8/12/20, at 7:45 a.m. business office worker (BW)-A was observed entering the facility. Upon entering the facility, BW-A used hand sanitizer, donned a clean mask, and walked to the reception desk. BW-A picked up a pen and answered questions, then took her temperature. Neither the pen nor thermometer were sanitized before or after use. On 8/13/20, at 10:02 a.m. the director of nursing (DON) verified the facility had not been actively screening staff on night shift, and those that entered early for dayshift. The DON stated this practice could result in possible exposure and spread of COVID-19. The DON stated guidance through CMS and MDH specified active screening, and the facility had not been following guidance. The DON further stated the facility had not been sanitizing items such as thermometer and pens used by staff. The DON stated this facility practice could have led to a breach in infection control and spread of COVID-19. R7's Face Sheet printed 8/13/20, included diagnosis of mild cognitive impairment, history of falls, and reduced mobility.	21375	of 100% of New Admission Isolation PPE utilization and hand hygiene completion for 2 weeks, weekly audits X 4 weeks, and monthly audits for 5 months to insure that all staff are using PPE correctly and completing appropriate hand hygiene. The QA Committee will review the audit results on a quarterly basis and provide direction as needed.	

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	00594	A. BUILDING: _____ B. WING _____	C 08/13/2020

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21375	Continued From page 4 R7's Care plan initiated 8/10/20, indicated R8 had activity of daily living (ADL) self-care deficit and was dependent on staff for ambulation, and required minimal assistance of one staff with all ADLs. R7's care plan directed caregivers to personal protective equipment (PPE) at all times when providing care due to facility 14 day quarantine period upon admission. R7's progress note dated 8/10/20, indicated R7 admitted to the facility from a recent hospital stay. R9's Face Sheet printed 8/13/20, indicated R8's diagnoses included muscle weakness, history of falls, and reduced mobility. R9's Care plan initiated 8/7/20, indicated R9 had ADL self-care deficit, and was dependent on staff for ambulation, and required minimal assistance of one staff with all ADLs. R9's progress note dated 8/7/20, indicated R9 admitted to the facility from a recent hospital stay. R11's Face Sheet printed 8/13/20, included diagnosis of dementia, history of falls, and reduced mobility. R11's Care plan initiated 8/5/20, indicated R11 had ADL self-care deficit, and was dependent on staff for ambulation, and required extensive assistance of one staff with all ADLs. R11's progress note dated 8/5/20, indicated R11 had been admitted to the facility from a recent hospital stay. On 8/11/20, at 2:49 p.m. R7's room was observed to have a clear bin outside of the room which	21375		

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included alcohol based hand rub (ABHR), signage for modified droplet precautions directing a 14 day quarantine was to be in effect until 8/24/20. Instructions posted include staff was to wear a face mask, eye shield, and gloves when providing cares for R7.

On 8/11/20, at 2:49 p.m. during continuous observation, NA-A was observed outside R7's room donning an isolation gown and gloves. NA-A did not use hand sanitizer prior to donning gloves. NA-A's face mask and eye shield were already in place and being worn properly. NA-A proceeded to enter R7's room, shut off R7's call light, and exit R7's room with water pitcher. NA-A then proceeded to place R7's water pitcher on the isolation bin, removed the soiled gloves, and opened a new box of gloves. Without performing hand hygiene, NA-A donned clean gloves, filled R7's water pitcher from the unit's ice and water machine, and returned to R7's room. NA-A filled R7's drinking glass from the water pitcher. NA-A then removed the soiled gloves, and went into R7'S bathroom. NA-A washed hands, and removed the gown, and exited room.

On 8/11/20, at 4:15 p.m. NA-A verified she had not perform hand hygiene between glove changes.

On 8/12/20, at 8:47 a.m. R9's room was observed to have a clear bin outside of the room which included ABHR, signage for modified droplet precautions directing a 14 day quarantine was to be in effect until 8/21/20. Instructions posted included staff were to wear a face mask, eye shield, and gloves when providing cares for R9.

On 8/12/20, at 8:47 a.m. during continuous observation, NA-B was observed in R9's room

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assisting R9 with standing up. NA-B was observed wearing his face mask and eye protection, however, NA-B did not wear gloves while providing cares for R9. NA-B was observed performing hand hygiene when exiting R9's room.

On 8/12/20, at 8:56 a.m. R11's room was observed to have a clear bin outside of the room which included ABHR, signage for modified droplet precautions directing a 14 day quarantine was to be in effect until 8/18/20. Instructions posted included staff were to wear a face mask, eye shield and gloves when providing cares for R11.

On 8/12/20, at 8:56 a.m. during continuous observation, NA-C was observed in R11's room assisting R11 into bed with the use of mechanical lift. NA-B was observed wearing a face mask and eye protection, however NA-C did not wear gloves while providing cares for R11. NA-C then exited R11's room, sanitized the mechanical lift and performed hand hygiene.

On 8/12/20, at 8:58 a.m. NA-C verified she had not been wearing gloves when providing personal cares for R11, which included assisting R11 into her bed.

On 8/12/20, at 11:31 a.m. registered nurse (RN)-A stated all new admissions required a 14 day quarantine period as part of COVID-19 assessment. RN-A stated all staff providing cares for residents on modified droplet precautions were required to wear gloves when entering the room and providing cares.

On 8/13/20, at 12:43 p.m. the DON stated staff were to wear the appropriate PPE while providing cares for residents. The DON stated it was

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important to follow the recommended guidelines which included isolation for 14 days upon admission to prevent the possible spread of COVID-19. The DON stated not all residents have the COIVD-19 test prior to admission, thus following modified droplet precautions needed to be adhered to by all staff providing cares. The DON stated she expected all staff were following the guidelines of wearing face mask, eye protection, and gloves when entering the residents on 14 day isolation precautions.

The facility policy 14 Day New Admission Quarantine /Modified Droplet Precautions updated 5/6/20, directed staff to be wearing required PPE while quarantine/modified droplet precautions providing cares for residents to include surgical mask, eye protection, and gloves.

The facility policy COVID-19 Policy for New Admission Isolation undated, directed new admissions to be placed on 14 day isolation with precautions. The policy further directed after 14 days have elapsed and the resident has not developed any symptoms of infection, modified precautions can be discontinued and the resident may be moved to a shared room as needed.

The facility policy Ecumen Lakeshore Screening Protocols dated 8/4/20, lacked specific direction and guidance related to active screening, and sanitization of common use items.

SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could develop systems to ensure active screening is completed for all employees entering the facility. The director of nursing or designee and could educate all appropriate staff on the policies and procedures. The director of nursing or designee

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21375	Continued From page 8 could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21375		