Electronically delivered
February 6, 2020

Administrator
St Ottos Care Center
920 Southeast 4th Street
Little Falls, MN 56345

RE: CCN: 245257
Cycle Start Date: January 23, 2020

Dear Administrator:

On January 23, 2020, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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.

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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Kathleen Lucas, Unit Supervisor
St. Cloud B Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: kathleen.lucas@state.mn.us
Phone: (320) 223-7343
Fax: (320) 223-7348

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 the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by April 23, 2020 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by July 23, 2020 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@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
	245257	A. BUILDING _____ B. WING _____	C 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST OTTOS CARE CENTER	**920 SOUTHEAST 4TH STREET LITTLE FALLS, MN 56345**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 1/22/2020 to 1/23/2020 an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be substantiated: H5257014C 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. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	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	F 880		2/24/20

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

Electronically Signed | 02/14/2020

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

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F 880	Continued From page 2 §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 record review the facility failed to develop a comprehensive infection control program that provided education to family and friends that were in contact with residents on contact precautions, that utilized a consistent process for tracking and documenting infections for accurate data analysis of resident infections to reduce the risk of spread of infections to other residents in the facility. This had the potential to affect all 81 residents who resided in the facility. Findings include: R1's Minimum Data Set (MDS) indicated R1 was cognitively intact and needed extensive assistance with activities of daily living (ADL'S). Additionally, R1 was always incontinent of bowel and bladder and was on antibiotics for Clostridium Difficile (C. Diff.) is a bacterium that can cause symptoms ranging from diarrhea to life-threatening inflammation of the colon. Additionally. R1 had a diagnosis of urinary tract infection, and enterocolitis which is an	F 880	F880 Infection Prevention and Control It is our intent to establish and maintain an infection prevention and control program. A. Correction to Resident R1 and R4. a) Resident R1 has since passed away due to unrelated core morbidities. b) Resident R4 not requiring Transmission based isolation precautions at present. Resident R4 receiving proper care using Standard Precautions. c) Education provided at monthly staff meetings regarding hand hygiene, Standard Precautions, and Transmission Based Precautions, (Contact Precautions). B. Correction to Signage a) New signage for Transmission Based Precautions obtained to use for resident rooms, alerting staff, visitors and residents. b) Additional visitor information, general Infection Control Precautions fact sheet, will be given at care conferences to inform	

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F 880	Continued From page 3 inflammation of the digestive tract, involving enteritis of the small intestine and colitis of the colon. It may be caused by various infections, with bacteria, viruses, fungi, parasites, or other causes due to C. Diff. During observation on 1/22/2020, at 9:00 a.m. R1's room had a yellow caddy hanging over the outside of R1's room. A contact precaution sign was noted to be in one of the compartments with a box of bleach wipes covering the lower half of the sign which was 8 by 11.5 inches. Further the contact precautions sign was tilted forward making it difficult to read in that position. During observation on 1/22/2020, at 1:20 p.m. a family friend (FF)-A was observed to be in R1's room wearing street clothes and bare hands rubbing R1's upper right shoulder and leaning in towards R1 in conversation. R1 was covered with a blanket. During interview on 1/22/2020, at 1:25 p.m. FF-A stated the facility staff did not ask her to wear gloves or wash FF-A's hands before leaving R1's room. FF-A stated she visited R1 every few days. Further, FF-A was observed to leave R1's room without washing her hands and proceeded to take an elevator with three other residents and touched the door of a public restroom. During interview on 1/22/2020, at 2:08 p.m. nursing assistant (NA)-A stated in order to see that R1 was on contact precautions the sign "needed to be removed entirely from the caddy to be able to read" outside of R1's door. The contact precautions sign outside R1's door indicated visitor report to nurses station before entering. The contact precaution sign outside R1's room	F 880	them prior to an occurrence, protecting all residents. C. Infection Control personnel to provide education on infection control measures and corrective plan to facility staff. D. Correction to tracking logs a) Infection Control summary will be reviewed and follow up communication provided to staff relating to current status and any emerging trends. b) Surveillance tracking logs will be used on floors via hard copy when gastrointestinal conditions arise and isolation practices are in place to ensure residents are in isolation for correct amount of time. c) Surveillance tracking will be added to EMAR as an order for tracking upper respiratory symptoms and UTI symptoms by lane nurses every shift. This will allow for meeting criteria of an antibiotic if needed, as well as comfort for resident. d) Infection Report-Antibiotic Time Out events will be posted on home page of EHR for daily review. DON/Designee will discuss with staff to ensure all antibiotic starts have been entered as events. E. Auditing plan a) Infection Control personnel/designee will complete audit 5 times per week for 4 weeks, then 2 times per week for 4 weeks and then weekly for 1 month of Tracking log and associated infection events within the EHR. b) Audits will be brought to the quarterly QAPI meeting after 3 months to determine if continued monitoring is	

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F 880	Continued From page 4 has all black text with a light green background. During interview on 1/22/2020, at 2:10 p.m. registered nurse (RN)-A stated the only interaction with visitors or notification of visitors of a resident who is on contact precautions is the precaution signs posted on R1's room. Further, RN-A stated if visitors did not know what to do she would expect the visitors to ask the facility staff what they needed to do. Additionally, RN-A stated the precautions sign outside R1's door is behind a box of bleach wipes and is not easy to read. RN-A also stated if R1 has regular visitors RN-A would assume the visitors know what to do for contact precautions. During interview on 1/22/2020, at 2:58 p.m. family member (FM)-B stated she visits R1 and had not been told to wash her hands before leaving R1's room. Further, FM-B stated she helped change R1's brief and did not wear a gown or gloves. Additionally, FM-B stated R1 constantly leaks urine and stool and it's "impossible to keep R1 clean all the time". FM-B stated she has never worn gloves and washed FM-B hands frequently when R1 is in isolation. During interview on 1/23/2020, at 8:55 a.m. licensed practical nurse (LPN)-A stated if a visitor asked about the sign outside R1's door LPN-A would direct the visitor to gown and glove before entering R1's room. Further LPN-A stated when the visitor leaves the room the gown and gloves would need to be removed in R1's room and the visitor should wash their hands with soap and water so the visitor "did not spread anything to anyone else". During interview on 1/23/2020, at 9:00 a.m. RN-A	F 880	needed.	

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F 880	Continued From page 5	F 880		

stated the registered nurses would complete the "2020 C. Diff Tracking" log in the infection control tracking book located at the nurse station. The tracking log lists the following information: the lane, room, resident name, symptom onset date, date isolation precautions started, date medical doctor (MD) notified, C. Diff test results positive/negative and the date isolation precautions were discontinued. Further, RN-A stated the nurses would complete an event in the electronic medical record (EMR) which includes details about the infection; was a culture was obtained, was the MD contacted, was the resident put on antibiotics and if the resident was placed in isolation. RN-A stated the event form in the EMR has a list of questions that need to be answered based on the type of infection. Upon review of R1's EMR, RN-A stated R1 did not have an event completed for C. Diff. Further, RN-A stated once an event is filed in R1's EMR the event would be listed on the dashboard report which is the first place that launches when RN-A logs into the EMR.

During record review R1 was not on the 2020 C. Diff Tracking form for January 2020. Additionally, R1 was diagnosed with C. Diff on 12/6/2019, and the C. Diff Tracking form did not have R1 listed.

R4's medical record indicated R4 was diagnosed with C. Diff. on 1/6/2020. R4 and was no longer in isolation for C. Diff. as of 1/19/2020. R4's medical record indicated an event was completed for R4 on 1/6/2020.

During interview on 1/23/2020, at 10:46 a.m. with the Director of Nursing (DON) and the Infection Preventionist (IP)-B stated the facility nursing supervisor completed the infection control logs

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F 880	Continued From page 6	F 880		

located on each floor. The logs are used for tracking infections and are used by both the nursing staff and infection control. Infection control logs are reviewed routinely by infection control. Additionally, IP-B stated the nursing staff need to document an event in the EMR, which displayed on the dashboard screen. Further, IP-B stated the event in the EMR is primarily used for the antibiotic stewardship program. Both the DON and IP-B stated neither R1 and R4 were listed on the infection control logs and that R1 did not have an event completed. In addition, the DON and IP-B observed the posted signage at R1's room to review the contact precaution sign in the caddy sleeve, both stated the information for visitors would be easily missed and the information is not highlighted. The DON and IP-B stated the contact precaution sign should have a red stop sign so visitors would know to go ask the nursing staff what they needed to do.

A policy titled "Clostridium Difficile" dated 3/1/2010 with a revision on 8/7/2019, indicated C. Diff spores can remain in the environment for months if contaminated surface and/or items are not properly cleaned and disinfected. Further the policy indicated gloves and gowns will be worn prior to entering the resident's room and removed prior to exiting the room. The policy also indicated perform hand hygiene before putting on gloves, after removing gloves, and any time hands are visibly soiled.

A document titled "Contact Precautions For C. Diff." undated indicated family members need to be provided education to them and offer a gown and gloves (especially gloves!) before entering the resident's room. Please give them a copy of the C. Diff fact sheet and answer any questions

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F 880	Continued From page 7 they may have. Emphasize the importance of hand washing. Encourage them to not visit multiple residents. A policy titled "Categories of Isolation Precautions" dated 3/1/2010, with a revision date of 8/16/2017, indicated gloves should be worn when providing direct care (changing clothing, toileting, bathing, etc.) to residents with multi-drug resistant organisms (MDRO's). Gloves should also be worn when handling items potentially contaminated by MDRO's (bed linens, nightstand, bedside tables etc.). A policy titled "Guideline for management of Antimicrobial Resistant Microbes (ARMS) dated 3/1/2010, with a revision date of 4/10/2019, indicated gloves should also be worn when handling potentially contaminated by ARM's. Potentially contaminated items include bedside tables, over bed tables, bed rails, bathroom fixtures, television and bed controls, intravenous poles, suction and oxygen tubing and electronic equipment, especially control knobs.	F 880		

Electronically delivered
February 6, 2020

Administrator
St Ottos Care Center
920 Southeast 4th Street
Little Falls, MN 56345

Re: State Nursing Home Licensing Orders
Event ID: JUYY11

Dear Administrator:

The above facility was surveyed on January 22, 2020 through January 23, 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:

Kathleen Lucas, Unit Supervisor
St. Cloud B Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: kathleen.lucas@state.mn.us
Phone: (320) 223-7343
Fax: (320) 223-7348

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,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health

Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

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ST OTTOS CARE CENTER	920 SOUTHEAST 4TH STREET LITTLE FALLS, MN 56345

(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 1/22/2020 to 1/23/2020 a survey was completed at your facility to conduct a complaint investigation. As a result the following citations were issued.	2 000		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program	21375		2/24/20

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	00817	A. BUILDING: _____ B. WING _____	C 01/23/2020

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21375	Continued From page 1 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 record review the facility failed to develop a comprehensive infection control program that provided education to family and friends that were in contact with residents on contact precautions, that utilized a consistent process for tracking and documenting infections for accurate data analysis of resident infections to reduce the risk of spread of infections to other residents in the facility. This had the potential to affect all 81 residents who resided in the facility. Findings include: R1's Minimum Data Set (MDS) indicated R1 was cognitively intact and needed extensive assistance with activities of daily living (ADL'S). Additionally, R1 was always incontinent of bowel and bladder and was on antibiotics for Clostridium Difficile (C. Diff.) is a bacterium that can cause symptoms ranging from diarrhea to life-threatening inflammation of the colon. Additionally. R1 had a diagnosis of urinary tract infection, and enterocolitis which is an inflammation of the digestive tract, involving enteritis of the small intestine and colitis of the colon. It may be caused by various infections, with bacteria, viruses, fungi, parasites, or other causes due to C. Diff. During observation on 1/22/2020, at 9:00 a.m.	21375	Corrected	

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21375	Continued From page 2 R1's room had a yellow caddy hanging over the outside of R1's room. A contact precaution sign was noted to be in one of the compartments with a box of bleach wipes covering the lower half of the sign which was 8 by 11.5 inches. Further the contact precautions sign was tilted forward making it difficult to read in that position. During observation on 1/22/2020, at 1:20 p.m. a family friend (FF)-A was observed to be in R1's room wearing street clothes and bare hands rubbing R1's upper right shoulder and leaning in towards R1 in conversation. R1 was covered with a blanket. During interview on 1/22/2020, at 1:25 p.m. FF-A stated the facility staff did not ask her to wear gloves or wash FF-A's hands before leaving R1's room. FF-A stated she visited R1 every few days. Further, FF-A was observed to leave R1's room without washing her hands and proceeded to take an elevator with three other residents and touched the door of a public restroom. During interview on 1/22/2020, at 2:08 p.m. nursing assistant (NA)-A stated in order to see that R1 was on contact precautions the sign "needed to be removed entirely from the caddy to be able to read" outside of R1's door. The contact precautions sign outside R1's door indicated visitor report to nurses station before entering. The contact precaution sign outside R1's room has all black text with a light green background. During interview on 1/22/2020, at 2:10 p.m. registered nurse (RN)-A stated the only interaction with visitors or notification of visitors of a resident who is on contact precautions is the precaution signs posted on R1's room. Further, RN-A stated if visitors did not know what to do	21375		

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she would expect the visitors to ask the facility staff what they needed to do. Additionally, RN-A stated the precautions sign outside R1's door is behind a box of bleach wipes and is not easy to read. RN-A also stated if R1 has regular visitors RN-A would assume the visitors know what to do for contact precautions.

During interview on 1/22/2020, at 2:58 p.m. family member (FM)-B stated she visits R1 and had not been told to wash her hands before leaving R1's room. Further, FM-B stated she helped change R1's brief and did not wear a gown or gloves. Additionally, FM-B stated R1 constantly leaks urine and stool and it's "impossible to keep R1 clean all the time". FM-B stated she has never worn gloves and washed FM-B hands frequently when R1 is in isolation.

During interview on 1/23/2020, at 8:55 a.m. licensed practical nurse (LPN)-A stated if a visitor asked about the sign outside R1's door LPN-A would direct the visitor to gown and glove before entering R1's room. Further LPN-A stated when the visitor leaves the room the gown and gloves would need to be removed in R1's room and the visitor should wash their hands with soap and water so the visitor "did not spread anything to anyone else".

During interview on 1/23/2020, at 9:00 a.m. RN-A stated the registered nurses would complete the "2020 C. Diff Tracking" log in the infection control tracking book located at the nurse station. The tracking log lists the following information: the lane, room, resident name, symptom onset date, date isolation precautions started, date medical doctor (MD) notified, C. Diff test results positive/negative and the date isolation precautions were discontinued. Further, RN-A

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stated the nurses would complete an event in the electronic medical record (EMR) which includes details about the infection; was a culture was obtained, was the MD contacted, was the resident put on antibiotics and if the resident was placed in isolation. RN-A stated the event form in the EMR has a list of questions that need to be answered based on the type of infection. Upon review of R1's EMR, RN-A stated R1 did not have an event completed for C. Diff. Further, RN-A stated once an event is filed in R1's EMR the event would be listed on the dashboard report which is the first place that launches when RN-A logs into the EMR.

During record review R1 was not on the 2020 C. Diff Tracking form for January 2020. Additionally, R1 was diagnosed with C. Diff on 12/6/2019, and the C. Diff Tracking form did not have R1 listed.

R4's medical record indicated R4 was diagnosed with C. Diff. on 1/6/2020. R4 and was no longer in isolation for C. Diff. as of 1/19/2020. R4's medical record indicated an event was completed for R4 on 1/6/2020.

During interview on 1/23/2020, at 10:46 a.m. with the Director of Nursing (DON) and the Infection Preventionist (IP)-B stated the facility nursing supervisor completed the infection control logs located on each floor. The logs are used for tracking infections and are used by both the nursing staff and infection control. Infection control logs are reviewed routinely by infection control. Additionally, IP-B stated the nursing staff need to document an event in the EMR, which displayed on the dashboard screen. Further, IP-B stated the event in the EMR is primarily used for the antibiotic stewardship program. Both the DON and IP-B stated neither R1 and R4 were listed on

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the infection control logs and that R1 did not have an event completed. In addition, the DON and IP-B observed the posted signage at R1's room to review the contact precaution sign in the caddy sleeve, both stated the information for visitors would be easily missed and the information is not highlighted. The DON and IP-B stated the contact precaution sign should have a red stop sign so visitors would know to go ask the nursing staff what they needed to do.

A policy titled "Clostridium Difficile" dated 3/1/2010 with a revision on 8/7/2019, indicated C. Diff spores can remain in the environment for months if contaminated surface and/or items are not properly cleaned and disinfected. Further the policy indicated gloves and gowns will be worn prior to entering the resident's room and removed prior to exiting the room. The policy also indicated perform hand hygiene before putting on gloves, after removing gloves, and any time hands are visibly soiled.

A document titled "Contact Precautions For C. Diff." undated indicated family members need to be provided education to them and offer a gown and gloves (especially gloves!) before entering the resident's room. Please give them a copy of the C. Diff fact sheet and answer any questions they may have. Emphasize the importance of hand washing. Encourage them to not visit multiple residents.

A policy titled "Categories of Isolation Precautions" dated 3/1/2010, with a revision date of 8/16/2017, indicated gloves should be worn when providing direct care (changing clothing, toileting, bathing, etc.) to residents with multi-drug resistant organisms (MDRO's). Gloves should also be worn when handling items

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21375	Continued From page 6 potentially contaminated by MDRO's (bed linens, nightstand, bedside tables etc.). A policy titled "Guideline for management of Antimicrobial Resistant Microbes (ARMS) dated 3/1/2010, with a revision date of 4/10/2019, indicated gloves should also be worn when handling potentially contaminated by ARM's. Potentially contaminated items include bedside tables, over bed tables, bed rails, bathroom fixtures, television and bed controls, intravenous poles, suction and oxygen tubing and electronic equipment, especially control knobs. Suggested Method of Correction The DON (Director of Nursing) or designee could review/revise facility policies to ensure they contain all components of an infection control program, including tracking/trending of all illnesses in the facility. The DON or designee could educate staff and perform audits to ensure the policies are being followed. Time Period for Correction: Twenty-one (21) days.	21375		