DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 4, 2021

Administrator
Edenbrook Of Rochester
1875 19th Street Northwest
Rochester, MN 55901

RE: CCN: 245409
Cycle Start Date: October 2, 2020

Dear Administrator:

On October 15, 2020, we notified you a remedy was imposed. On January 15, 2021 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of January 8, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective November 24, 2020 be discontinued as of January 8, 2021. (42 CFR 488.417 (b))

However, as we notified you in our letter of October 15, 2020, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 24, 2020. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 4, 2021

Administrator
Edenbrook Of Rochester
1875 19th Street Northwest
Rochester, MN 55901

Re: Reinspection Results
Event ID: LMG312

Dear Administrator:

On January 15, 2021 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the surveys completed on October 16, 2020 and December 4, 2020. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

Electronically delivered
December 28, 2020

Administrator
Edenbrook Of Rochester
1875 19th Street Northwest
Rochester, MN 55901

RE: CCN: 245409
Cycle Start Date: October 2, 2020

Dear Administrator:

On October 15, 2020, we informed you of imposed enforcement remedies.

On December 4, 2020, the Minnesota Department(s) of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. {Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted immediate jeopardy to resident health or safety. The most serious deficiencies in your facility were found to be a pattern of deficiencies that constituted immediate jeopardy (Level K), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY

On December 4, 2020, the situation of immediate jeopardy to potential health and safety cited at F880 was removed. However, continued non-compliance remains at the lower scope and severity of G.

As a result of the survey findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective November 24, 2020, will remain in effect.

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

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444).

You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective November 24, 2020. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 24, 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.

As we notified you in our letter of October 15, 2020, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 24, 2020.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), and emergency preparedness deficiencies (those preceded

by an “E” tag), i.e., the plan of correction should be directed to:

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

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

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

APPEAL RIGHTS

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/ INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

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

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

Feel free to contact me if you have questions.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING _____ B. WING _____	C 12/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	**1875 19TH STREET NORTHWEST ROCHESTER, MN 55901**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A COVID-19 Focused Infection Control survey was conducted on 12/2/20, 12/3/20 and 12/4/20 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. Clean survey: Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 12/2/20, 12/3/20 and 12/4/20, an abbreviated survey was completed at your facility to conduct complaint investigations. A COVID-19 Focused Infection Control survey was also conducted on 12/2/20, 12/3/20 and 12/4/20 by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. Edenbrook of Rochester was found NOT to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities and 483.80 for Infection Control. The survey resulted in an Immediate Jeopardy (IJ) at F880 when the facility failed to promptly implement infection control practices to prevent and/or minimize a facility wide outbreak of COVID-19. The IJ began on 11/22/20, when the facility failed to implement cohorting strategies when covid positive residents were not separated from their roommates. The IJ was removed on 12/4/20, when the facility	F 000		

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

Electronically Signed | 01/07/2021

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F 000	Continued From page 1 developed and implemented an appropriate plan of correction. The following complaints were found to be substantiated: H54009077C. Deficiencies issued at F684, F698, F686 H54009078C. Deficiency issued at F880. H54009079C. Deficiency issued at F561. 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 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other	F 561		1/8/21

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F 561	Continued From page 2 applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 3 residents (R18) reviewed was provided assistance to bathe according to her preferences and bath schedule. Findings Include: R18 was interviewed and observed on 12/3/20, at 1:47 p.m. R18 was sitting in recliner chair in her room, her hair was unbrushed and had oily appearing texture. R18 stated, "Very true not getting bathed." R18 stated that yesterday she had a chair bath. R18 stated, "They tell me we cannot do showers and I got a bath in the chair [recliner]. I need to have my hair washed 4 times a week I am lucky if it is done once. Washing hair with wash cloth doesn't do the job." R18 stated she has seborric dermitis, her scalp was very itchy and she had medicated shampoo. R18 stated, "They told me that we aren't allowed to take showers/baths." R18 stated she has yeast	F 561	" R18 had her bathing preferences reviewed, and care planned to include her preference of receiving showers twice a week and hair washed four times per week. " All residents have the potential to be affected if their self-determine of bathing preferences is not followed. Therefore, a whole house review of bathing preferences will be completed to ensure resident preferences are included in their respective plans of care and individual Kardex. " All nursing staff will be educated on importance of resident self-determination as it relates to bathing, and following those preferences in the resident□s plan of care. " Bathing preferences will be reviewed in care conferences to ensure resident preferences are being reviewed and	

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F 561	Continued From page 3 infections, skin issues and the tub was good for her skin, takes pressure off her spine and feels good. R18's quarterly Minimum Data Set (MDS) assessment dated 11/19/20; identified R18 required physical help in part of bathing activity from one staff member providing physical assist and had intact cognition with a brief interview mental score of 15. R18 had clear speech, was understood and understands with clear comprehension. R18's bath schedule indicated she was to be bathed on Wednesday and Sunday mornings. The bath schedule did not indicate two other days of the week to have her hair washed. R18's Visual/Bedside Kardex report utilized by nursing assistants to provide cares, indicated Bathing; assist of 1, bath Sunday and Wednesday AM (morning). R18's hair washing care plan revised 6/27/19 included, "[R18] would like her hair washed T [Tuesday], TH [Thursday], Sat [Saturday] in the beauty shop with her specific shampoo." Intervention included, Staff will offer the beauty salon for specified dates to wash [R18's] hair. R18's bathing care plan revised 11/25/19 included, "Behavior; refusing to bathe. [R18] has a history of refusing to bathe when offered and then complaining to staff that she is allegedly not being bathed. Interventions included, "Resident has a peri-wand to assist with personal hygiene. Staff will continue to offer [R18] her showers at specified requested times. Staff will [did not indicate what they would do] if [R18] refuses her	F 561	updated per resident choice. " Weekly bathing audits will be conducted for four weeks, monthly for two months, and periodically as needed based on audit findings. " Audit results to be reviewed at monthly QAPI to evaluate the effectiveness of resident determination adherence and the need for audit continuation. " DON/Designee is responsible for ensuring compliance.	

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F 561	Continued From page 4	F 561		

shower/bathing."

R18's bathing documentation was reviewed from 11/11/20 to 12/2/20 and revealed R18 had a bath on 11/12/20 and 11/15/20 during the time period reviewed.

R18's progress notes were reviewed from 11/1/20 to 12/3/2020. There was one progress note dated 11/8/2020 that included resident refused shower during the time period reviewed.

During an interview on 12/3/2020, at 4:05 p.m. the director of nursing (DON) stated she had interviewed three nursing assistants on the covid unit and they could not answer questions regarding R18's bathing. The DON stated she interviewed R18 and R18 told her she had a bed bath in her recliner yesterday, but had not had a bath for two weeks before that. The DON stated R18 asked her if they were not able to have showers because of COVID. The DON stated she reassured R18 that she could have a shower. The DON also stated R18 shared she was not getting her hair washed four times a week. The DON stated her expectation was R18 was to have her shower twice a week and her hair washed four times a week. The DON stated about a month ago we created a master shower list so no matter where they (the residents) are moved each wing had the master schedule for bathing for all of the residents. The DON stated R18 not getting showers and hair washed was unacceptable. During a subsequent interview on 12/4/20, at 8:27 a.m. the DON stated she updated the bath schedule to include R18's shampoo days on the bath schedule. The DON stated she would be developing a form to document shampoos, which, will be turned in to

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F 561	Continued From page 5 the DON. The Bath/Shower policy revised 2/26/20 included, "Documentation: Document in Point of Care that shower/bath was complete, and the level of assistance. Reporting: 1. Notify the nurse if resident refuses the shower/tub bath ..."	F 561		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to monitor and assess signs and symptoms of hypo/hyperglycemia (low/high blood sugars) and failed to notify the physician according to physician orders for 2 of 3 residents (R7, R8) reviewed for diabetic management, however the failures had the potential to effect all 15 diabetic residents who resided in the facility. Findings include R7 Admission Record provided by the facility on 12/3/2020, included diagnosis of diabetes type 2 and schizophreniform disorder. R7's quarterly Minimum Data Set (MDS) dated	F 684	" The facility completed a diabetic order review on all residents with a diabetic diagnosis to ensure blood sugar parameter orders were in place. This includes residents R7 and R8. " All licensed nursing staff will be educated on diabetic monitoring and assessing signs and symptoms of hypo/hyperglycemia, including notifying providers if blood sugars are outside of ordered parameters. " Upon admission blood sugar parameter orders will be obtained from the physician and entered into PCC. " Weekly audits for diabetic management and provider notifications will be conducted weekly for four weeks,	1/8/21

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F 684	Continued From page 6 10/13/2020, did not have cognitive impairment and required insulin. R7's diabetic care plan dated 6/11/2019, directed to give R7 diabetes medications as ordered and monitor/document for side effects and effectiveness. The care plan also directed staff to monitor/document/report as needed any signs or symptoms of hypoglycemia and hyperglycemia. R7's physician orders included the following -Lantus (long acting insulin) 70 units daily in the morning (start date 9/7/2020, stop date 10/1/2020) -Lantus 80 units daily in the morning (start date 10/1/2020, stop date 11/15/2020) -Lantus 90 units daily in the morning (start date 10/15/2020 -Novolog (rapid acting insulin) 16 units in the morning, 12 units at lunch, and 12 units (16/12/12) at evening meal (8/24/2020, end date 9/22/2020) -Novolog insulin 20/16/16 (start date 9/22/2020, stop date 10/1/2020) -Novolog insulin 22 units daily with meals (start date 10/2/2020, stop date 11/6/2020) -Novolog insulin 26 units daily with meals (start date 11/6/2020, stop date 12/2/2020) Facility Post-Acute and Long Term Care Standing Orders dated 6/8/18, included the following orders for diabetes: -Notify clinician if 2 consecutive blood glucose readings < 70 and/or >=400. -If finger stick glucose < 70 and asymptomatic, give glucose/carbohydrate orally -If patient becomes symptomatic and glucose is < 70, give glucose/carbohydrate and protein orally. Notify clinician. Continue to monitor finger stick glucose and treat every 15 minutes until glucose	F 684	monthly for two months, and periodically as needed based on audit findings. " Audit results to be reviewed at monthly QAPI to evaluate effectiveness of diabetic management and the need for audit continuation. " DON/Designee is responsible for ensuring compliance.	

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F 684	Continued From page 7 > 100. During an observation and interview on 12/2/2020, at 11:08 a.m. licensed practical nurse (LPN)-A stated R7 received Novolog insulin 26 units at lunch time. LPN-A dialed R7's insulin pen to 26 units, walked to R7's room, took R7's blood sugar which was 194. LPN-A stated Novolog was a short acting insulin and the label on the pen directed to take with meals. LPN-A administered R7's insulin at 11:12 a.m. R7 stated when her blood sugars were low she got the chills, but could not articulate what her blood sugars were when she was symptomatic. LPN-A indicated last week R7 reported symptoms however, her blood sugar was around "125ish" and she had notified the provider. R7 received her lunch tray between approximately 30 minutes after insulin administration between 11:45-11:50 a.m. R7's blood sugar records and nursing progress notes reviewed from 9/1/2020 to 12/2/2020, identified low and high blood sugars without evidence of appropriate interventions, monitoring, and physician notifications. -On 9/23/2020, at 10:09 p.m. nursing progress note included "Residents blood sugar was high this evening and she no longer has scheduled insulin on the MAR [medication administration record. Staff encouraged her to increase water and walk. Resident did this." According to the blood sugar record R7's blood sugar was 412; according to the record R7's blood sugar was not rechecked until the next morning at 7:36 a.m. R7's record lacked evidence of assessment and monitoring for signs/symptoms of hyperglycemia. -R7's blood sugar record identified on 9/28/2020, at 4:09 p.m. blood sugar was 463; record did not identify recheck until the next scheduled check at	F 684		

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F 684	Continued From page 8 9:29 p.m. at which time blood sugar was 445. R7's record lacked physician notification, monitoring and assessment for symptoms of hyperglycemia. -R7's blood sugar record identified on 9/29/2020, at 9:05 p.m. R7's blood sugar was 465; next recorded the next morning at 7:14 a.m. R7's record lacked evidence of physician notification, monitoring and assessment for signs and symptoms of hyperglycemia. -On 10/15/2020, at 11:55 a.m. nursing progress note and blood sugar record identified R7 had a blood sugar of 52. The record identified R7's blood sugar was not rechecked until the next scheduled check at 4:48 p.m. According to R7's medication administration record, R7 was administered 26 units of Novolog insulin despite a blood sugar of 52. The record lacked evidence interventions, assessment, and monitoring for signs and symptoms of hypoglycemia. -On 11/9/2020, at 4:04 p.m. nursing progress note indicated R7's Novolog insulin was held "due to low blood sugar"; recorded blood sugar was at 3:30 p.m. was 80 and was not rechecked until the next ordered check at 9:19 p.m. The record lacked evidence of monitoring, intervention, and assessment for signs and symptoms of hypoglycemia -On 11/19/2020, at 12:12 p.m. nursing progress note indicated R7's Novolog insulin was held because R7 refused lunch; recorded blood sugar at 12:12 p.m. was 109 and blood sugar was not monitored for signs and symptoms of hypoglycemia or if R7 was provided and or offered snacks to maintain safe blood sugar levels between meals. During an interview on 12/3/2020, at 8:19 a.m. director of nursing (DON) reviewed R7's record,	F 684		

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stated the physician should have been notified right away when the blood sugars were over 400 mg/dl for correction orders. DON verified record lacked evidence of monitoring and evaluation of signs/symptom of hypo/hyperglycemia. DON stated documentation should include physician/family notification, interventions used and effectiveness, blood sugar rechecks per protocol, and signs/symptoms of hypo/hyperglycemia.

During an interview on 12/4/2020, at 9:16 a.m. certified nurse practitioner (CNP)-A stated nurses were supposed to evaluate for signs/symptoms of hypoglycemia and notify us if residents are symptomatic and follow the facility protocol. CNP-A stated this should be documented in the record.

R8
R8's quarterly Minimum Data Set (MDS) dated 9/3/2020, identified R8 had diagnosis of diabetes, had moderate cognitive impairment and required insulin administration.

R8's diabetic care plan dated 7/28/15, directed of the following "diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness." and to monitor/document/report as needed signs and symptoms of hypo/hyperglycemia.

R8's current physician orders included:
-Novolin NPH insulin 60 units in the morning (give with breakfast) and 10 units in the evening (give with evening meal) hold doses if not eating and blood sugar (BS) under 90 mg/dl.
-Blood glucose checks before meals and at

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bedtime. Notify CNP (certified nurse practitioner) for blood glucose less than 100 or greater than 400 next working day; unless symptomatic, or requires treatment for hypoglycemia per facility protocol notify immediately.

Facility Post-Acute and Long Term Care Standing Orders dated 6/8/18, included the following orders for diabetes:
-Notify clinician if 2 consecutive blood glucose readings < 70 and/or >=400.
-If finger stick glucose < 70 and asymptomatic, give glucose/carbohydrate orally
-If patient becomes symptomatic and glucose is < 70, give glucose/carbohydrate and protein orally. Notify clinician. Continue to monitor finger stick glucose and treat every 15 minutes until glucose > 100.

Physician visit note dated 12/1/2020, included "I note some significantly low blood glucose levels, do not see in record that this has been brought to attention to provider." The physician gave orders, Novolin 70/30 30 units in the morning and 5 units in the evening hold if blood sugar is less than 90 and nursing to notify provider if blood sugar less than 100 or greater than 350 next working day, unless symptomatic or per facility hypoglycemic protocol.

R8's blood sugar record (BSR) in correlation with nursing progress notes from 10/1/2020 to 12/2/2020.??the order above was given 12/2/20? The blood sugar record identified 41 blood glucose readings of under 100 mg/dl (milligrams per deciliter) without evidence of physician notification per physician orders. In addition, the regard lacked evidence appropriate interventions were provided to R8, the lacked evidence of

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monitoring and assessment for signs and symptoms of hypoglycemia. All of the following are some examples (not all inclusive) within the last 30 days where the facility failed to notify the physician, lacked evidence of appropriate interventions and monitoring, and lacked assessment for signs/symptoms of hypoglycemia:
-BSR 11/30/2020
At 8:07 a.m. BS was 82.0 mg/dl
At 9:44 a.m. BS was 97.0 mg/dl
At 12:17 p.m. BS was 69.0 mg/dl
At 4:38 p.m. BS was 62.0 mg/dl
At 8:18 a.m. BS was 131.0 mg/dl
-BSR 11/28/2020
At 11:43 a.m. BS was 88.0 mg/dl
At 4:31 p.m. BS was 85.0 mg/dl-according to medication administration record R7's insulin was not held per order.
At 7:52 p.m. BS was 95.0 mg/dl
-BSR on 11/27/2020, at 7:22 a.m. BS was 92.0 mg/dl
-BSR on 11/25/2020, at 3:30 p.m. BS was 98.0 mg/dl
-BSR on 11/23/2020, at 8:54 p.m. BS was 38.0 mg/dl, next recorded BS check was not recorded until the next morning at 11:29 p.m. BS was 139.0 mg/dl. Corresponding progress note on 11/23/2020, at 8:54 only included, "OJ give due to low BS".
-BSR on 11/21/2020, at 7:52 a.m. BS was 98.0 mg/dl, at 3:13 p.m. BS was 95.0 mg/dl
-BSR on 11/20/2020, at 7:09 a.m. BS was 87, next check at 11:15 a.m. BS was 90.0 mg/dl, next checked at 4:38 p.m. 63.0 mg/dl, next recorded check at 7:18 p.m. 85 mg/dl. Progress note dated 11/20/2020, at 4:39 p.m. only included, "Insulin held due to low blood sugar. OJ given."
-BSR on 11/18/2020, at 6:58 a.m. BS was 86.0 mg/dl

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F 684	Continued From page 12 -BSR on 11/11/2020, at 3:12 p.m. BS was 80 mg/dl. During an interview on 12/3/2020, at 8:19 a.m. director of nursing (DON) reviewed R8's record, stated the physician should have been notified right away when the blood sugars per physicians orders. DON verified record lacked evidence of monitoring and evaluation of signs/symptom of hypo/hypoglycemia. DON stated documentation should include physician/family notification, interventions used and effectiveness, blood sugar rechecks per protocol, and signs/symptoms of hypo/hyperglycemia. During an interview on 12/4/2020, at 9:16 a.m. certified nurse practitioner (CNP)-A stated nurses were supposed to evaluate for signs/symptoms of hypoglycemia and notify us if residents are symptomatic and follow the facility protocol. CNP-A stated this should be documented in the record. During an interview on 12/4/2020, physician assistant (PA)-A reviewed R8's record, stated the record did not identify any communication from the facility that reported blood sugars under 100 mg/dl. PA-A stated an unawareness of the multiple blood sugars under 100 mg/dl; stated the facility should have notified per the ordered parameters. PA-A stated when the blood sugar was low evaluate for signs of hypoglycemia and notify the physician into providing the correct intervention and recheck the blood sugars every 15 minutes until safe level. PA-A stated all the information should be documented in the medical record. Facility policy Hyperglycemic Protocol dated	F 684		

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F 684	Continued From page 13 6/11/20, included the purpose as "To monitor residents for signs and symptoms of hyperglycemia and treat the symptoms as indicated. Diabetic residents presenting with signs/symptoms of hyperglycemia will be further assessed and treated in accordance with the facility protocol as follows: 2. Upon presentation of symptoms, the licensed nurse should check the blood glucose level via an accucheck. a. If an accucheck reveals a blood glucose level above 300 mg/dl or level identified per individual orders, hyperglycemia should be suspected. b. If any signs/symptoms, or other abnormal condition are identified, reprt the diabetic resident's condition to the physician immediately. Hyperglycemic protocol: 1) Administer hypoglycemic agents and/or insulin per individual physician orders. 2) Offer 16-24 ounces of water or sugar free beverage over two hours unless clinically contraindicated. 3) Recheck blood glucose level 4) Report findings to the physician Facility policy Hypoglycemic Procedure dated 6/11/2020, included procedure "To monitor residents for signs and symptoms of hypoglycemia and treat the symptoms as indicated. Diabetic residents presenting with signs/symptoms of hypoglycemia will be further assessed and treated in accordance with the facility protocol as follows: 2) Upon presentation of symptoms, the licensed nurse should check the blood glucose level via an accucheck. A) if an accucheck reveals a blood sugar below 70 mg/dl, hypoglycemia should be suspected. i. Should evidence of severe, or life-threatening signs/symptoms exist contact the	F 684		

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F 684	Continued From page 14 physician immediately or call 911. B. If any symptoms listed or other abnormal condition are identified, report condition the physician immediately. 3) Follow the resident's individual hypoglycemic protocol, if ordered by a physician. If no individual protocol is ordered, update the physician based on clinical assessment and current blood sugar. Hypoglycemic Treatment protocol was inconsistent with physician standing orders. 1) Treat hypoglycemia promptly with 15-20 grams of fast-acting carbohydrates for blood sugar less than 70 mg/dl. B. Glucagon 1 mg is given by licensed nurse if the patient cannot ingest a sugar treatment, per physician orders. 2) Repeat the accucheck and report findings to physician 3) Repeat the protocol only once if the blood glucose level remains less than 70 mg/dl and report findings to the physician.	F 684		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to accurately identify and monitor dialysis access port for signs and symptoms of infection, and complete daily weight monitoring for 1 of 1 resident (R20) reviewed for dialysis services.	F 698	" All residents receiving dialysis services were reviewed to ensure orders are in place for identifying and monitoring dialysis access ports for signs and symptoms of infection, and completing daily weight monitoring. This includes resident R20.	1/8/21

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F 698	Continued From page 15 Findings include R20's Admission Record provided by the facility on 12/4/2020, included diagnoses of end stage renal disease, metabolic encephalopathy, right and left leg below the knee amputation, diabetes type 2, and heart failure. R20's admission Minimum Data Set (MDS) dated 11/12/2020, indicated R20 did not have cognitive impairment, and did not have rejections of care behaviors. MDS identified R20 required extensive assistance from two or more staff members for dressing, one staff extensive assistance for hygiene, and dependent on two or more staff for transfers. The MDS also indicated R20 was frequently incontinent of urine and required dialysis. R20's baseline care plan upon admission identified R20 required dialysis. R20's comprehensive care plan for dialysis dated 11/18/2020, included: facility will have ongoing communication and collaboration with the dialysis center, fluid as ordered, monitor right tunneled dialysis catheter site for bleeding and signs/symptoms of infection, update dialysis center of changes in condition that may affect their overall condition. During an observation and interview on 12/2/2020, at 3:12 p.m. R20 laid in his bed. R20 stated his dialysis access was on his right upper chest and never had anything in his stomach. R20 pulled down his shirt, the central line was secured and covered with a clear dressing that had a dime size amount of blood around the insertion site and light yellow/purplish bruising above the site extending up to the shoulder.	F 698	" All nursing staff will be educated on the importance of identifying and monitoring dialysis access ports for signs and symptoms of infection, and completing daily weight monitoring. " Upon admission orders for identifying and monitoring dialysis ports for signs and symptoms of infection as well as daily weight monitoring will be obtained from the physician and entered into PCC. " Audits for dialysis care will be completed weekly for four weeks, monthly for two months, and periodically as needed based on audit findings. Audits will include identifying and monitoring dialysis access ports for signs and symptoms of infection, notification to provider if infection is noted, and conducting daily weight monitoring. " Audit results will be reviewed monthly at QAPI to evaluate the effectiveness of dialysis care management and the need for audit continuation. " DON/Designee is responsible for ensuring compliance	

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F 698	Continued From page 16 R20's physician orders included the following: -Dialysis shunt monitoring: Check thrill/bruit of shunt in left abdomen. Feel the thrill, strong pulse, or buzzing sensation, by placing your fingers over the fistula/graft. If you can feel the thrill, the blood is flowing through the blood vessel and your fistula is working. Notify MD if weak or no thrill/bruit present every shift. (Start date 11/5/2020 stop date 12/3/2020) -Dialysis, Central Port: Dialysis Unit to complete all dressing changes during dialysis appointment. Nursing to monitor site to assure dressing remains clean/dry/intact. Contact dialysis for further direction of any concerns or needed dressing changes every shift. (Start date 11/5/2020, -Monitor dialysis access site upon return from dialysis for signs/symptoms of complications including bleeding, pain, redness, and edema around the site. Notify provider and dialysis unit of concerns. Schedule on dialysis days and time returned Monday, Wednesday, Friday (start date 11/5/2020, stop date 12/3/2020) -Resident has catheter permanent tunneled implanted, right chest wall (Start date 11/24/2020) -Admission weight procedure: weigh upon admission and for 2 days after admission then weekly for 3 weeks, then monthly for unless otherwise ordered (start date 11/5/2020) -Weigh daily process for weight, every morning before breakfast, perform in same manner, notify MD of weight gain of 2-3 lbs. or more per day over a 2 day period or 5 pounds in a week (Start date 11/25/2020) -Fluid intake every shift four times a day for dialysis (Start date 11/16/2020) -Urine output every shift for dialysis (start date 11/16/2020)	F 698		

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R20's hospital discharge summary dated 11/5/2020, did not identify any fluid restrictions and/or direction on daily fluid intake goals. R20's record lacked evidence the facility completed a dietary assessment to determine adequate fluid intake and/or inquiries with the dialysis providers or primary care provider until 12/1/2020.

R20's weight record did not reflect daily weight monitoring per physician orders; between 11/5/2020 and 12/4/2020 only 4 weights were recorded.
11/5/2020, weight of 246 lbs. (pounds)
11/23/2020, weight of 251 lbs.
12/2/2020, weight of 114 kg.
12/2/2020 weight of 112.3 kg. (dialysis post weight)

According to R20's records, R20 did not have a dialysis shunt in left abdomen, however according to the medication administration records (MAR) between 11/5/2020 to 12/3/2020, the boxes had check marked boxes that indicated nurses found bruit and thrill on a shunt that was not there. The TAR also identified physician order for R20's central port; boxes had check marks indicating the task had been completed, however no other documentation pertaining to the integrity of the site was evident in the record.

R20's progress note dated 11/20/2020 at 10:55 a.m. included, "Received a call from [name of nurse] at dialysis, stating resident is being taken to ED [emergency department] d/t [due to] drainage from his dialysis catheter. R20's DCR dated 11/20, did not identify that the site was assessed or that there was any signs/symptoms of infection. A subsequent note at 10:04 p.m.

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included, "[R20] was transferred from HD [hemodialysis dialysis] to [name of hospital] on 11/20 in the setting of AMS [sic], hypotension. Noted purulence, redness around his catheter site. Resident was admitted to [name of hospital].

R20's hospital After Visit Summary dated 11/24/2020, indicated R20 was admitted to the hospital on 11/20, and discharged back to the facility on 11/24/2020. Reason for hospitalization was infection catheter peripheral insertion central. The AVS included " ... male admitted for purulence at the catheter insertion site with concern for catheter infection post removal, now presenting for replacement of the tunneled hemodialysis catheter." The summary also included he presented with altered mental status and hypotension during hemodialysis session. He was noted to have purulent drainage from the right chest wall tunneled dialysis catheter exit site with surrounding erythema. R20 received two different intravenous antibiotics and transitioned to oral antibiotics. Discharge orders included "weigh patient daily per facility protocol Daily for dialysis."

During an interview on 12/2/2020, at 2:39 p.m. assistant director of nursing (ADON) stated R7's dialysis access was on his right chest wall. DON stated the order abdominal site was entered in error, nurses should not have been documenting. DON stated R20 was admitted to the hospital from dialysis because R7 central line had blood in one of the line ports.

During an interview on 12/2/2020, at 5:40 p.m. licensed practical nurse (LPN)-A stated the dialysis site was supposed to be checked before and after dialysis and if there was any

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abnormalities it would be documented in a progress note. LPN-A stated she looked at R7's site morning; there was a little bit of dried blood around the insertion site. LPN-A stated she had not looked at the site after R7 had returned from dialysis around lunch time and was not aware there was blood under the dressing around the insertion site.

During an interview on 12/3/2020, at 2:49 a.m. dialysis charge nurse (DRN) stated on 11/20/2020 she was the one who observed the central line site. DRN stated prior to the R20 arriving to the clinic the facility had not called or indicated any changes on the communication form. DRN stated when she went to hook R20 up, the line had thick purulent drainage dripping down the catheter line from underneath the clear dressing, more purulent drainage underneath the dressing. DRN stated she took the dressing off, a lot of drainage on it, cleaned the area and noted the insertion site was quite red. DRN stated the drainage was very evident and could not have been missed if someone was looking at it. DRN indicated that could not have happened within a couple of hours. DRN confirmed R20 did not have a fistula in his abdomen. DRN stated most times dialysis patients are on fluid restrictions but since R20 was so new to dialysis they were monitoring how much fluid was removed each dialysis run to determine if a restriction was necessary or if needed to increase fluid. DRN stated another reason she sent him to the hospital on 11/20/20, was because he was hypotensive. DRN stated expectation facility staff weigh residents who are on dialysis daily and communicate weight gains as appropriate, she also expected staff to monitor the appropriate dialysis site for signs and symptoms of infection

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and immediately contact dialysis clinic.

During an interview on 12/3/2020, at 4:16 p.m. RN-A stated he understood the central line was supposed to be checked only before and after dialysis and he did not recall observing the line when he worked prior to R20 going to the hospital on 11/20, stated he usually worked the night shift. RN-A stated dialysis residents are supposed to be weighted daily and confirmed R20 had not been, however R20 got weighed at dialysis three times per week. RN-A stated dialysis patients are supposed be monitored for intake and output, monitored for dehydration and fluid overload.

During an interview on 12/4/2020, at 9:37 a.m. physician assistant (PA)-A checking dialysis access sites are standard of practice and nurses were supposed to be checking the site "Obviously it was not caught." PA-A confirmed R20 did not have an abdominal shunt; stated nurses should be reading and know what they are checking off not just to check it off and was concerning for potential other tasks were just checked off. PA-A reviewed R20's physician notes and discharge summaries and indicated the type of access wasn't clearly identified, the staff should have called either the dialysis clinic or physician. PA-A stated if there was a fluid restriction that was used during the hospital and if it was noted, then she would continue that restriction if there was not a specific order or use the standard 2 liters. PA-A stated it was standard and important to monitor/evaluate fluid intake and output, as well as following daily weight monitoring and expected facility staff to follow the orders and facility protocols.

Facility policy Care of Hemodialysis Resident

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F 698	Continued From page 21	F 698		

dated 1/3/2020, included: Purpose: To ensure the needs of the resident receiving hemodialysis are met by both the facility and the dialysis center. Resident receiving hemodialysis are transported routinely out of the facility. Communication is essential for continuity of care.
-Facility will provide ongoing assessment of the resident's condition and will monitor for complications before and after each dialysis treatment received at a certified dialysis facility. Facility will have ongoing communication and collaboration with the dialysis facility.
-Dialysis center should be made aware of changes in condition that may affect their overall condition, such as increased risk for pressure injury and appropriate interventions.
External Catheters:
-Care should be taken so the external catheter is not pinched poked, bent or pulled.
-A smooth clamp should be kept at the bedside for emergency situations.
-Avoid getting catheter wet during bathing. You may cover with plastic wrap during bathing
-Replace the dressing if it comes off or becomes wet. Cleanse the area with cleanser such as Betadine swab or Hibiclens and apply new sterile dressing.
The coordinated, person-centered care plan will include:
-Monitor for complications
-Frequency of monitoring vital signs, respiratory distress, chest pain, headache, seizure, etc.
-Potential for bleeding
-Care of the access site
-Potential for infection
-Nutritional/fluid management including documentation of weights, resident compliance with food/fluid restrictions and provision of meals before/during and/or after dialysis.

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F 698	Continued From page 22 -Alteration in skin integrity	F 698		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 755	" The facility completed a diabetic order	1/8/21

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F 755	Continued From page 23 review the facility failed to ensure a system of timely implementation of physician orders related to administration of insulin for 1 of 3 (R7) reviewed for medication administration. Finding include: R7 Admission Record provided by the facility on 12/3/2020, included diagnosis of diabetes type 2 and schizophreniform disorder. During an observation on 12/2/2020, at 11:08 a.m. licensed practical nurse (LPN)-A stated R7 received Novolog insulin 26 units at lunch time. LPN-A dialed R7's insulin pen to 26 units, walked to R7's room, took R7's blood sugar which was 194. LPN-A stated Novolog was a short acting insulin and the label on the pen directed to take with meals. LPN-A administered R7's insulin at 11:12 a.m. R7 stated when her blood sugars were low she got the chills, but could not articulate what her blood sugars were when she was symptomatic. LPN-A indicated last week R7 reported symptoms however, her blood sugar was around "125ish" and she had notified the provider. R7's diabetic care plan dated 6/11/2019, directed to give R7 diabetes medications as ordered and monitor/document for side effects and effectiveness. R7's endocrinology visit dated 9/2/2020, included current orders for insulin, "Novolog 16 units for breakfast, 12 units for lunch, 16 units for evening meal (8/24/2020). Lantus 60 units daily." The noted also included, "Numbers are pretty high across the board. Increase Lantus to 70 units. Please update the medication list."	F 755	review on all residents with a diabetic diagnosis to ensure short acting insulin orders included correct directions for used in conjunction with meal times. This includes residents R7. " All licensed nursing staff will be educated on importance of following prescribed orders for short-acting insulins in conjunction with meal times. " Audits for diabetic management will be completed weekly for four weeks, monthly for two months, and periodically as needed based on audit findings. These audits will include monitoring that short-acting insulins are being administered as prescribed in conjunction with meal times. " Audit results will be reviewed monthly at QAPI to evaluate the effectiveness of insulin administration and the need for audit continuation. " DON designee is responsible for ensuring compliance	

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R7's medication administration record (MAR) identified the new order for Lantus 70 units daily was not implemented until 9/5/2020; indicating R7 received the less wrong dose of 60 units on 9/3 and 9/4/2020.
Facility records lacked identification of the medication errors.

R7's endocrinology visit dated 9/17/2020, included "Increase Novolog to 20 with breakfast and 16 lunch. Please update in med list."

R7's Medication Administration Record (MAR), identified the new orders for Novolog 20 units with breakfast and 16 units for lunch was not updated and implemented until 9/22/2020; indicating R7 instead received the lesser wrong dose of 16 units for breakfast and 12 units for lunch from 9/18/2020 to 9/21/2020.

Facility records lacked identification of the medication errors.

R7's endocrinology visit dated 10/1/2020, included, "Patient is noted to have significant hyperglycemia." had a medication list current at the time of the appointment that included: Lantus-70 units daily in the morning, and Novolog 20 units for breakfast, 16 units for lunch, 16 units for dinner. Under the Assessment Plan section new orders included, Novolog 22 units with each meal and Lantus 80 units one time a day.

R7's endocrinology visit dated 10/14/2020, included "Increase Lantus to 90 units. Update in med list."

R7's MAR identified the new order for Lantus 90

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F 755	Continued From page 25	F 755		

units was not updated and implemented until 10/16/2020; indicating R7 received the lesser dose of 80 units on 10/16/2020.

Facility records lacked identification of the medication errors.

R7's endocrinology visit dated 11/6/2020, indicated blood sugars were improving and identified insulin doses from previous appointment and new orders to increase Novolog to 26 units with each meal.

R7's printed SBAR (situation/background/assessment/recommendation is a communication tool to health care providers) note dated 11/17/2020, identified the reason for communication was for medication reconciliation. The note included "EMAR [electronic medication administration record] and medication supply is not matching" Lantus 90 units and Novolog 26 units with meals. Supply Label reads: Novolog Inject 20 units at breakfast and 16 units with lunch and dinner. Recent note in system says 22 units with each meal (10/16/2020). The note requested for current orders to be faxed to the facility.

The printed SBAR had handwritten orders; "Recommended dose of Novolog 26 units at the beginning of each meal." Despite the wrong insulin label according to the MAR R7 received the correct dose of insulin from 11/6/2020 to 11/17/2020.

R7's endocrinology visit dated 11/24/2020, included "Yes, adjustment to euglycemia will take some time especially if patient keeps eating to drive sugars up." and "Always important when

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symptomatic to check patients blood sugar and if above 90 to reassure that symptoms are not due to hypoglycemia"

R7's endocrinology visit dated 11/30/2020, included "blood sugars are improving. Bedtime numbers are still suboptimal most days. Increase Novolog to 30 units with evening meal. Please update the med list."

R7's MAR identified the new order for Novolog 30 units with evening meal was not updated and implemented until 12/3/2020; indicating R7 received the lesser dose of 26 units from 11/30/2020 to 12/2/2020.

Facility records lacked identification of the medication errors.

During an interview on 12/3/2020, 8:19 a.m. regional nurse consultant (RNC)-A and director of nursing (DON) stated Novolog insulin should be given within 15 minutes of meals or should have a substantial snack. DON indicated the facility had not identified the medication errors. Stated the medication errors should have recognized and error report should have been completed, nurses should have identified the discrepancy between the MAR and the label on the pen immediately and clarified with the physician.

During an interview on 12/4/2020, at 9:16 a.m. certified nurse practitioner (CNP)-A indicated R7 was overseen by endocrinology for diabetic management, and was not aware or had been notified of any medication errors involving R7's insulin. CNP-A stated nurses should have identified the wrong discrepancy between the pen and MAR immediately had the nurses been doing

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F 755	Continued From page 27 the three verification checks prior to administration- obviously this was not being done. CNP-A indicated Novolog should be given after meals to prevent hypoglycemia.	F 755		
F 880 SS=K	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §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	F 880		1/8/21

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F 880	Continued From page 28 communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement CDC (Centers for Disease Control) and CMS (Centers for Medicaid and Medicare Services) guidance/recommendations for 4 of 4 residents	F 880	R1 was asymptomatic, with positive Covid test. R1 has recovered and no longer resides in Covid specific room R2 had POC antigen testing which was negative. No longer resides in Covid Unit	

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F 880	Continued From page 29 (R1, R2, R5, R6) when the facility failed to separate and quarantine covid positive residents from negative resident roommates. The facility failed to ensure proper infection control procedures were followed to prevent and/or mitigate the risk of an outbreak of COVID-19. This deficient practice had the potential to affect all 41 residents residing in the facility and staff who were at risk for contracting COVID-19. The immediate jeopardy began on 11/22/20, when the facility failed to implement appropriate infection control practices to mitigate or reduce the spread of COVID-19 in the facility, the IJ was identified on 12/3/20. The administrator, regional nurse consultant (RNC) and the director of nursing (DON) were notified of the immediate jeopardy at 3:19 p.m. on 12/3/20. The immediate jeopardy was removed on 12/4/20, when the facility had developed and implemented an acceptable plan. However, noncompliance remained at the lower scope and severity level of G, isolated scope and severity, which indicated harm that is not immediate jeopardy. Findings Include: The facility did not ensure COVID positive residents were placed in quarantine separate from COVID negative residents. In addition, infection control concerns were observed during observations and the facility lacked evidence of comprehensive risk analysis of potential exposures and/or transmission to other residents, investigation of the illness, and identification of potential causal factors of disease transmission. According to the census reports, R1 and R2 resided in the same room on the COVID unit.	F 880	room. Recovered from Covid in June 2020. R5 had positive results of Covid and was hospitalized on 11/25/20 and remains in the hospital at this time R6 had positive POC results and was placed in Covid Unit room. Has since recovered and no longer resides in a specific Covid room. Residents with COVID-19 exposure and positive COVID-19 test results are at risk for alleged deficient practices. The facility has identified specific rooms to be used for Covid Positive & Presumptive Covid Positive residents. This will include those residents with presumed Covid symptoms/known exposure and positive POC testing results. All recommended PPE will be available in these rooms. These will be for a single resident only. The facility has developed a log of residents who have previously recovered from Covid, what room they reside in and what room they were relocated to. The log will be kept current by facility IDT Team. The log will be audited 3 times a week x 3 Months, then weekly x 3months. Results will be analyzed and reported to QAPI Committee to determine if further action is required. Infection Control policies related to COVID-19 have been reviewed and updated as needed. Education of staff regarding cohorting of residents with like infections was completed by 1/8/2021. Use of designated Infection Rooms for those with presumed/active symptoms and/or positive Covid results. The facility has	

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F 880	Continued From page 30 R1 R1's Admission Record, indicated R1 was admitted to the facility 9/28/20. R1's diagnosis included Non-Hodgkin Lymphoma, unspecified asthma, adult failure to thrive and anemia. R1's admission Minimum Data Set (MDS) assessment dated 10/5/20 indicated R1 had intact cognition. R1's progress note dated 11/17/20 included, "COVID PCR [polymerase chain reaction] test completed as part of house wide testing due to COVID positive status in the building. Will await results." R1's progress note dated 11/22/2020, at 12:59 p.m. included, "11/16/2020 COVID-19 test result confirmed as positive. Droplet Precautions initiated." R1's progress note dated 11/24/2020, at 11:13 p.m. included, "Resident doing well, no c/o [complaints of] pain, dyspnea, cough. VS [vital signs] remain WNL [within normal limits], LS [lung sounds] clear. Good appetite and output. Some diarrhea this evening. Encouraging fluids for replacement." R1's progress note dated 11/25/2020, at 4:31 a.m. included, "ocass [occasional] loose non prod [nonproductive] cough. denies SOB [shortness of breath], denies pain. has been asleep most of the night." R2 R2's Admission Record, indicated R2 was	F 880	used the Minnesota /Principles for Cohorting Covid 19 in Long Term Care Facilities for educating staff. The Interdisciplinary Team will complete audits of Hand Hygiene, Donning and Doffing of PPE 3 times per Week x 1 Month then Weekly x 2 months. Review of resident placement related to COVID-19 symptoms, exposure and testing will be completed daily at the IDT stand-up meeting and by the Nurse on weekends in collaboration with Manager on Duty. Issues will be addressed as they are identified during the audits. Audit results will be analyzed and reported to QAPI Committee to determine if further action is required.	

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admitted to the facility 1/20/20. R1's diagnosis included unspecified dementia without behavioral disturbance and cognitive communication deficit.

R2's quarterly Minimum Data Set (MDS) assessment dated 10/17/20, indicated R2 had long and short-term memory problems and was independent with decision-making skills for daily living.

R2's progress note dated 11/17/2020, at 7:31 p.m. included, "COVID PCR [polymerase chain reaction] test completed as part of house wide testing due to COVID positive status of the building. Will await results."

R2's progress note dated 11/22/2020, at 5:31p.m., included, "[R2]'s roommate tested positive for COVID-19. Although her result came back undetected, [R2] will be treated as COVID-19 positive. Droplet precautions will be instituted ..."

R2's progress note dated 11/23/2020, at 9:02 p.m. included, "COVID POC [point of care] antigen test completed today with negative results. COVID PCR [polymerase chain reaction] test was also completed and sent to lab as part of house wide testing due to COVID positive status of the building. Will await results."

R2's progress note dated 11/30/2020, at 2:47 p.m. included, "Resident noted to have some COVID-like symptoms. Completed point of care antigen test which was negative. Also completed a confirmatory PCR [polymerase chain reaction] test. Will await results from the lab."

R1 was tested for COVID during the facility wide

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EDENBROOK OF ROCHESTER	**1875 19TH STREET NORTHWEST ROCHESTER, MN 55901**

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testing on 11/17/20. The facility received R1's positive COVID lab results on 11/22/20. R1 was asymptomatic. R1 and roommate R2, were moved to the COVID unit on 11/22/20. R2's COVID tests results were negative however, R2 was moved to the COVID unit because the facility considered her to be presumptive positive from sharing a room with R1. R2 had been COVID positive in July 2020. On 11/30/20, R2 started to have symptoms of two medium emesis of undigested food, R2 complained of abdominal discomfort in umbilicus region and headache after emesis. Documentation indicated the facility was waiting for results of R2's PCR testing, and R2 was tested for COVID via the point of care antigen testing on 12/3/20 which was negative. At that time, R2 was moved to a room off the COVID unit and was placed on 14-day droplet precautions.

During an interview on 12/2/20, at 1:40 p.m. the regional nurse consultant (RNC) stated R2 should have been kept in her room, placed on 14-day precautions and the roommate (R1) that was positive should have been moved to the COVID unit to separate them. RNC stated R2 had been previously positive and had recovered from COVID.

According to the census reports, R5 and R6 had resided in the same room on the COVID unit.

R5

R5's Admission Record, indicated R5 was admitted to the facility on 9/14/20. R5's diagnoses included Type 2 diabetes with diabetic neuropathy, end stage renal disease, dependence on renal dialysis and major

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depressive disorder.

R5's quarterly Minimum Data Set (MDS) assessment dated 10/26/20 indicated R5 had intact cognition.

R5's progress note dated 11/23/2020, at 8:57 p.m., included, "COVID POC [point of care] antigen test completed today with positive results.

R5's progress note dated 11/24/2020, at 2:37 a.m., included, "2L [liters] supplemental O2 [oxygen] started due to sats [saturations] below 90% (88%)."

R5's progress note dated 11/25/2020, at 11:22 a.m. included, "Change of condition ...Nursing observations, evaluations and recommendations are: Baseline status but increased. Primary Care Provider Feedback A. Recommendations: Send for admission (Provider ordered R5 to sent to hospital for admission)..."

R6's Admission Record, indicated R6 was admitted to the facility 6/28/2017. R6's diagnosis included chronic pulmonary obstructive disease, dependence on supplemental oxygen, major depressive disorder, recurrent, moderate and anxiety disorder unspecified.

R6's quarterly Minimum Data Set (MDS) assessment dated 8/28/20, indicated R6 had intact cognition.

R6's progress note dated 11/17/2020, at 7:17 p.m. included, "COVID PCR [polymerase chain reaction] test completed as part of house wide testing due to COVID positive status of the building. Will await results."

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R6's progress note dated 11/23/2020, at 9:03 p.m. included, "COVID POC [point of care] antigen test completed today with negative results. COVID PCR [polymerase chain reaction] test was also completed and sent to lab as part of house wide testing due to COVID positive status of the building. Will await results." R6's test results were negative.

R6's progress note dated 11/30/2020, at 2:56 p.m. included, "COVID PCR [polymerase chain reaction] testing completed. Will await results."

R6's progress note dated 12/2/2020, at 2:11 p.m. included, "Resident tested positive for COVID this afternoon. C/O [complaints of] not feeling well, headache, and temp [temperature] of 102.2. Rapid test was done."

R6's progress note dated 12/3/2020, at 6:07 a.m. included, "Vital Signs: BP [blood pressure] 110/58, P [pulse] 77, T [temperature] 96.6, RR [respirations]19, O2 [oxygen saturations] 95% 2LNC [liters nasal cannula]. Active COVID Symptoms (cough, malaise, fatigue, SOB, fever, headache, loss of taste/smell, GI sx [gastrointestinal symptoms]): non-productive cough, fatigue, increased sleepiness ADL[activities of daily living]/functional declines or recent falls noted: no changes- in bed all night. Emotional/Psychosocial Concerns: none. Appetite and Fluid intake: sleeping, water at bedside. Current interventions and effectiveness: rest, encourage fluids."

R5's onset of symptoms was identified as occuring on 11/23/20, when documentation indicated R5 had loose stools. On 11/23/20, the

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facility completed POC testing and results were positive. R5 shared a room with R6. The room shared was on the COVID unit created 11/22/20. R5 and R6 shared a room on the COVID unit until R5 was hospitalized on 11/25/20. R6 remained in the room they shared on the COVID unit until R6 requested to be moved off the unit on 11/28/20. On 12/2/2020, R6 displayed symptoms headache, temperature 102.2 and had complaints of not feeling well. A POC test was completed and results were positive. R6 was moved back to the COVID unit.

During an observation on 12/2/2020, at 11:45 a.m. in the COVID unit, RN-B and resident (who had mask on) entered from the exit door of the building. RN-B had only N95 donned- no other PPE. RN-B walked up the length of hallway thru the plastic barrier into the nurse breakroom (in unit). RN-B came out of the breakroom with face shield on walked through barrier and then donned gown. RN-B stated she did not think the set up was appropriate. There should be a doffing/donning by the exit door.

During an interview on 12/2/20, at 1:56 p.m. the RNC stated R6 had remained in the room with R5 until R5 was hospitalized as he initially had refused to move rooms. The RNC verified the facility did not have documentation of R6's refusal to move rooms.

During an interview on 12/3/2020, at 10:21 a.m. RNC stated the facility had nothing documented for contact tracing at this time for residents, but had a plan to complete an analysis once the outbreak had concluded. RN-C stated going forward the facility planned to review residents that were newly positive to identify if there are any

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common denominators between staff and residents that could be a potential link to possible spread. She stated for positive staff, the facility was completing the staff risk assessments however, going forward the facility was going to be expanding the analysis to include any potential exposure to residents they had cared for and other staff they had worked with and any potential exposures out of work.

During an interview on 12/4/2020, at 9:16 a.m. certified nurse practitioner (CNP)-A stated was not aware the facility had not been aware residents were being inappropriately cohorted. CNP-A stated the symptomatic and/or COVID positive residents should absolutely not be in the same rooms as residents that are negative and/or do not have symptoms.

The facility's COVID-19 policy revised 10/19/20 included, "Policy: The facility will conduct education, surveillance and infection control and prevention strategies to reduce the risk of transmission of COVID-19. Due to the constantly changing and fluid nature of the virus; the facility will monitor, follow, and implement recommendations and guidance in accordance with the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO), CMS [Centers for Medicare & Medicaid], and the State Department of Health to include identification and isolation of any suspected cases".

The immediate jeopardy that began on 11/22/2020, was removed on 12/4/2020, at 2:37 p.m., when it could be verified the facility had reviewed their policies, had appropriately implemented cohorting and transmission based

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F 880	Continued From page 37 precautions strategies, had initiated risk assessments for residents, and had provided staff education.	F 880		

Electronically delivered
December 28, 2020

Administrator
Edenbrook Of Rochester
1875 19th Street Northwest
Rochester, MN 55901

Re: State Nursing Home Licensing Orders
Event ID: LMG311

Dear Administrator:

The above facility was surveyed on December 2, 2020 through December 4, 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:

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

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.

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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 12/2/20, 12/3/20 and 12/4/20, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H54009077C with licensing orders issed at S4658.0520 Subp. 1 and S4658.1320 Subp.1545 H54009078C with a licensing order issued at S4658.0800 Subp. 4 H54009079C with a licensing order issued at S144.651 Subd. 10 The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to monitor and assess signs and symptoms of hypo/hyperglycemia (low/high blood sugars) and failed to notify the physician according to physician orders for 2 of 3 residents (R7, R8) reviewed for diabetic	2 830	Acknowledged	1/8/21

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management, however the failures had the potential to effect all 15 diabetic residents who resided in the facility.

Findings include

R7 Admission Record provided by the facility on 12/3/2020, included diagnosis of diabetes type 2 and schizophreniform disorder.

R7's quarterly Minimum Data Set (MDS) dated 10/13/2020, did not have cognitive impairment and required insulin.

R7's diabetic care plan dated 6/11/2019, directed to give R7 diabetes medications as ordered and monitor/document for side effects and effectiveness. The care plan also directed staff to monitor/document/report as needed any signs or symptoms of hypoglycemia and hyperglycemia.
R7's physician orders included the following
-Lantus (long acting insulin) 70 units daily in the morning (start date 9/7/2020, stop date 10/1/2020)
-Lantus 80 units daily in the morning (start date 10/1/2020, stop date 11/15/2020)
-Lantus 90 units daily in the morning (start date 10/15/2020
-Novolog (rapid acting insulin) 16 units in the morning, 12 units at lunch, and 12 units (16/12/12) at evening meal (8/24/2020, end date 9/22/2020)
-Novolog insulin 20/16/16 (start date 9/22/2020, stop date 10/1/2020)
-Novolog insulin 22 units daily with meals (start date 10/2/2020, stop date 11/6/2020)
-Novolog insulin 26 units daily with meals (start date 11/6/2020, stop date 12/2/2020)

Facility Post-Acute and Long Term Care Standing

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2 830	Continued From page 3 Orders dated 6/8/18, included the following orders for diabetes: -Notify clinician if 2 consecutive blood glucose readings < 70 and/or >=400. -If finger stick glucose < 70 and asymptomatic, give glucose/carbohydrate orally -If patient becomes symptomatic and glucose is < 70, give glucose/carbohydrate and protein orally. Notify clinician. Continue to monitor finger stick glucose and treat every 15 minutes until glucose > 100. During an observation and interview on 12/2/2020, at 11:08 a.m. licensed practical nurse (LPN)-A stated R7 received Novolog insulin 26 units at lunch time. LPN-A dialed R7's insulin pen to 26 units, walked to R7's room, took R7's blood sugar which was 194. LPN-A stated Novolog was a short acting insulin and the label on the pen directed to take with meals. LPN-A administered R7's insulin at 11:12 a.m. R7 stated when her blood sugars were low she got the chills, but could not articulate what her blood sugars were when she was symptomatic. LPN-A indicated last week R7 reported symptoms however, her blood sugar was around "125ish" and she had notified the provider. R7 received her lunch tray between approximately 30 minutes after insulin administration between 11:45-11:50 a.m. R7's blood sugar records and nursing progress notes reviewed from 9/1/2020 to 12/2/2020, identified low and high blood sugars without evidence of appropriate interventions, monitoring, and physician notifications. -On 9/23/2020, at 10:09 p.m. nursing progress note included "Residents blood sugar was high this evening and she no longer has scheduled insulin on the MAR [medication administration record. Staff encouraged her to increase water	2 830		

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2 830	Continued From page 4 and walk. Resident did this." According to the blood sugar record R7's blood sugar was 412; according to the record R7's blood sugar was not rechecked until the next morning at 7:36 a.m. R7's record lacked evidence of assessment and monitoring for signs/symptoms of hyperglycemia. -R7's blood sugar record identified on 9/28/2020, at 4:09 p.m. blood sugar was 463; record did not identify recheck until the next scheduled check at 9:29 p.m. at which time blood sugar was 445. R7's record lacked physician notification, monitoring and assessment for symptoms of hyperglycemia. -R7's blood sugar record identified on 9/29/2020, at 9:05 p.m. R7's blood sugar was 465; next recorded the next morning at 7:14 a.m. R7's record lacked evidence of physician notification, monitoring and assessment for signs and symptoms of hyperglycemia. -On 10/15/2020, at 11:55 a.m. nursing progress note and blood sugar record identified R7 had a blood sugar of 52. The record identified R7's blood sugar was not rechecked until the next scheduled check at 4:48 p.m. According to R7's medication administration record, R7 was administered 26 units of Novolog insulin despite a blood sugar of 52. The record lacked evidence interventions, assessment, and monitoring for signs and symptoms of hypoglycemia. -On 11/9/2020, at 4:04 p.m. nursing progress note indicated R7's Novolog insulin was held "due to low blood sugar"; recorded blood sugar was at 3:30 p.m. was 80 and was not rechecked until the next ordered check at 9:19 p.m. The record lacked evidence of monitoring, intervention, and assessment for signs and symptoms of hypoglycemia -On 11/19/2020, at 12:12 p.m. nursing progress note indicated R7's Novolog insulin was held because R7 refused lunch; recorded blood sugar	2 830		

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2 830	Continued From page 5 at 12:12 p.m. was 109 and blood sugar was not monitored for signs and symptoms of hypoglycemia or if R7 was provided and or offered snacks to maintain safe blood sugar levels between meals. During an interview on 12/3/2020, at 8:19 a.m. director of nursing (DON) reviewed R7's record, stated the physician should have been notified right away when the blood sugars were over 400 mg/dl for correction orders. DON verified record lacked evidence of monitoring and evaluation of signs/symptom of hypo/hyperglycemia. DON stated documentation should include physician/family notification, interventions used and effectiveness, blood sugar rechecks per protocol, and signs/symptoms of hypo/hyperglycemia. During an interview on 12/4/2020, at 9:16 a.m. certified nurse practitioner (CNP)-A stated nurses were supposed to evaluate for signs/symptoms of hypoglycemia and notify us if residents are symptomatic and follow the facility protocol. CNP-A stated this should be documented in the record. R8 R8's quarterly Minimum Data Set (MDS) dated 9/3/2020, identified R8 had diagnosis of diabetes, had moderate cognitive impairment and required insulin administration. R8's diabetic care plan dated 7/28/15, directed of the following "diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness." and to monitor/document/report as needed signs and symptoms of hypo/hyperglycemia.	2 830		

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2 830	Continued From page 6 R8's current physician orders included: -Novolin NPH insulin 60 units in the morning (give with breakfast) and 10 units in the evening (give with evening meal) hold doses if not eating and blood sugar (BS) under 90 mg/dl. -Blood glucose checks before meals and at bedtime. Notify CNP (certified nurse practitioner) for blood glucose less than 100 or greater than 400 next working day; unless symptomatic, or requires treatment for hypoglycemia per facility protocol notify immediately. Facility Post-Acute and Long Term Care Standing Orders dated 6/8/18, included the following orders for diabetes: -Notify clinician if 2 consecutive blood glucose readings < 70 and/or >=400. -If finger stick glucose < 70 and asymptomatic, give glucose/carbohydrate orally -If patient becomes symptomatic and glucose is < 70, give glucose/carbohydrate and protein orally. Notify clinician. Continue to monitor finger stick glucose and treat every 15 minutes until glucose > 100. Physician visit note dated 12/1/2020, included "I note some significantly low blood glucose levels, do not see in record that this has been brought to attention to provider." The physician gave orders, Novolin 70/30 30 units in the morning and 5 units in the evening hold if blood sugar is less than 90 and nursing to notify provider if blood sugar less than 100 or greater than 350 next working day, unless symptomatic or per facility hypoglycemic protocol. R8's blood sugar record (BSR) in correlation with nursing progress notes from 10/1/2020 to 12/2/2020.??the order above was given 12/2/20?	2 830		

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2 830	Continued From page 7 The blood sugar record identified 41 blood glucose readings of under 100 mg/dl (milligrams per deciliter) without evidence of physician notification per physician orders. In addition, the regard lacked evidence appropriate interventions were provided to R8, the lacked evidence of monitoring and assessment for signs and symptoms of hypoglycemia. All of the following are some examples (not all inclusive) within the last 30 days where the facility failed to notify the physician, lacked evidence of appropriate interventions and monitoring, and lacked assessment for signs/symptoms of hypoglycemia: -BSR 11/30/2020 At 8:07 a.m. BS was 82.0 mg/dl At 9:44 a.m. BS was 97.0 mg/dl At 12:17 p.m. BS was 69.0 mg/dl At 4:38 p.m. BS was 62.0 mg/dl At 8:18 a.m. BS was 131.0 mg/dl -BSR 11/28/2020 At 11:43 a.m. BS was 88.0 mg/dl At 4:31 p.m. BS was 85.0 mg/dl-according to medication administration record R7's insulin was not held per order. At 7:52 p.m. BS was 95.0 mg/dl -BSR on 11/27/2020, at 7:22 a.m. BS was 92.0 mg/dl -BSR on 11/25/2020, at 3:30 p.m. BS was 98.0 mg/dl -BSR on 11/23/2020, at 8:54 p.m. BS was 38.0 mg/dl, next recorded BS check was not recorded until the next morning at 11:29 p.m. BS was 139.0 mg/dl. Corresponding progress note on 11/23/2020, at 8:54 only included, "OJ give due to low BS". -BSR on 11/21/2020, at 7:52 a.m. BS was 98.0 mg/dl, at 3:13 p.m. BS was 95.0 mg/dl -BSR on 11/20/2020, at 7:09 a.m. BS was 87, next check at 11:15 a.m. BS was 90.0 mg/dl, next checked at 4:38 p.m. 63.0 mg/dl, next recorded	2 830		

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2 830	Continued From page 8	2 830		

check at 7:18 p.m. 85 mg/dl. Progress note dated 11/20/2020, at 4:39 p.m. only included, "Insulin held due to low blood sugar. OJ given."
-BSR on 11/18/2020, at 6:58 a.m. BS was 86.0 mg/dl
-BSR on 11/11/2020, at 3:12 p.m. BS was 80 mg/dl.

During an interview on 12/3/2020, at 8:19 a.m. director of nursing (DON) reviewed R8's record, stated the physician should have been notified right away when the blood sugars per physicians orders. DON verified record lacked evidence of monitoring and evaluation of signs/symptom of hypo/hypoglycemia. DON stated documentation should include physician/family notification, interventions used and effectiveness, blood sugar rechecks per protocol, and signs/symptoms of hypo/hyperglycemia.

During an interview on 12/4/2020, at 9:16 a.m. certified nurse practitioner (CNP)-A stated nurses were supposed to evaluate for signs/symptoms of hypoglycemia and notify us if residents are symptomatic and follow the facility protocol. CNP-A stated this should be documented in the record.

During an interview on 12/4/2020, physician assistant (PA)-A reviewed R8's record, stated the record did not identify any communication from the facility that reported blood sugars under 100 mg/dl. PA-A stated an unawareness of the multiple blood sugars under 100 mg/dl; stated the facility should have notified per the ordered parameters. PA-A stated when the blood sugar was low evaluate for signs of hypoglycemia and notify the physician into providing the correct intervention and recheck the blood sugars every 15 minutes until safe level. PA-A stated all the

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2 830	Continued From page 9 information should be documented in the medical record. Facility policy Hyperglycemic Protocol dated 6/11/20, included the purpose as "To monitor residents for signs and symptoms of hyperglycemia and treat the symptoms as indicated. Diabetic residents presenting with signs/symptoms of hyperglycemia will be further assessed and treated in accordance with the facility protocol as follows: 2. Upon presentation of symptoms, the licensed nurse should check the blood glucose level via an accucheck. a. If an accucheck reveals a blood glucose level above 300 mg/dl or level identified per individual orders, hyperglycemia should be suspected. b. If any signs/symptoms, or other abnormal condition are identified, reprt the diabetic resident's condition to the physician immediately. Hyperglycemic protocol: 1) Administer hypoglycemic agents and/or insulin per individual physician orders. 2) Offer 16-24 ounces of water or sugar free beverage over two hours unless clinically contraindicated. 3) Recheck blood glucose level 4) Report findings to the physician Facility policy Hypoglycemic Procedure dated 6/11/2020, included procedure "To monitor residents for signs and symptoms of hypoglycemia and treat the symptoms as indicated. Diabetic residents presenting with signs/symptoms of hypoglycemia will be further assessed and treated in accordance with the facility protocol as follows: 2) Upon presentation of symptoms, the licensed nurse should check the blood glucose level via an accucheck. A) if an accucheck reveals a blood	2 830		

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2 830	Continued From page 10 sugar below 70 mg/dl, hypoglycemia should be suspected. i. Should evidence of severe, or life-threatening signs/symptoms exist contact the physician immediately or call 911. B. If any symptoms listed or other abnormal condition are identified, report condition the physician immediately. 3) Follow the resident's individual hypoglycemic protocol, if ordered by a physician. If no individual protocol is ordered, update the physician based on clinical assessment and current blood sugar. Hypoglycemic Treatment protocol was inconsistent with physician standing orders. 1) Treat hypoglycemia promptly with 15-20 grams of fast-acting carbohydrates for blood sugar less than 70 mg/dl. B. Glucagon 1 mg is given by licensed nurse if the patient cannot ingest a sugar treatment, per physician orders. 2) Repeat the accucheck and report findings to physician 3) Repeat the protocol only once if the blood glucose level remains less than 70 mg/dl and report findings to the physician. Based on observation, interview, and document review the facility failed to accurately identify and monitor dialysis access port for signs and symptoms of infection, and complete daily weight monitoring for 1 of 1 resident (R20) reviewed for dialysis services. Findings include R20's Admission Record provided by the facility on 12/4/2020, included diagnoses of end stage renal disease, metabolic encephalopathy, right and left leg below the knee amputation, diabetes type 2, and heart failure. R20's admission Minimum Data Set (MDS) dated 11/12/2020, indicated R20 did not have cognitive	2 830		

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2 830	Continued From page 11 impairment, and did not have rejections of care behaviors. MDS identified R20 required extensive assistance from two or more staff members for dressing, one staff extensive assistance for hygiene, and dependent on two or more staff for transfers. The MDS also indicated R20 was frequently incontinent of urine and required dialysis. R20's baseline care plan upon admission identified R20 required dialysis. R20's comprehensive care plan for dialysis dated 11/18/2020, included: facility will have ongoing communication and collaboration with the dialysis center, fluid as ordered, monitor right tunneled dialysis catheter site for bleeding and signs/symptoms of infection, update dialysis center of changes in condition that may affect their overall condition. During an observation and interview on 12/2/2020, at 3:12 p.m. R20 laid in his bed. R20 stated his dialysis access was on his right upper chest and never had anything in his stomach. R20 pulled down his shirt, the central line was secured and covered with a clear dressing that had a dime size amount of blood around the insertion site and light yellow/purplish bruising above the site extending up to the shoulder. R20's physician orders included the following: -Dialysis shunt monitoring: Check thrill/bruit of shunt in left abdomen. Feel the thrill, strong pulse, or buzzing sensation, by placing your fingers over the fistula/graft. If you can feel the thrill, the blood is flowing through the blood vessel and your fistula is working. Notify MD if weak or no thrill/bruit present every shift. (Start date 11/5/2020 stop date 12/3/2020) -Dialysis, Central Port: Dialysis Unit to complete	2 830		

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2 830	Continued From page 12 all dressing changes during dialysis appointment. Nursing to monitor site to assure dressing remains clean/dry/intact. Contact dialysis for further direction of any concerns or needed dressing changes every shift. (Start date 11/5/2020, -Monitor dialysis access site upon return from dialysis for signs/symptoms of complications including bleeding, pain, redness, and edema around the site. Notify provider and dialysis unit of concerns. Schedule on dialysis days and time returned Monday, Wednesday, Friday (start date 11/5/2020, stop date 12/3/2020) -Resident has catheter permanent tunneled implanted, right chest wall (Start date 11/24/2020) -Admission weight procedure: weigh upon admission and for 2 days after admission then weekly for 3 weeks, then monthly for unless otherwise ordered (start date 11/5/2020) -Weigh daily process for weight, every morning before breakfast, perform in same manner, notify MD of weight gain of 2-3 lbs. or more per day over a 2 day period or 5 pounds in a week (Start date 11/25/2020) -Fluid intake every shift four times a day for dialysis (Start date 11/16/2020) -Urine output every shift for dialysis (start date 11/16/2020) R20's hospital discharge summary dated 11/5/2020, did not identify any fluid restrictions and/or direction on daily fluid intake goals. R20's record lacked evidence the facility completed a dietary assessment to determine adequate fluid intake and/or inquiries with the dialysis providers or primary care provider until 12/1/2020. R20's weight record did not reflect daily weight monitoring per physician orders; between 11/5/2020 and 12/4/2020 only 4 weights were	2 830		

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2 830	Continued From page 13 recorded. 11/5/2020, weight of 246 lbs. (pounds) 11/23/2020, weight of 251 lbs. 12/2/2020, weight of 114 kg. 12/2/2020 weight of 112.3 kg. (dialysis post weight) According to R20's records, R20 did not have a dialysis shunt in left abdomen, however according to the medication administration records (MAR) between 11/5/2020 to 12/3/2020, the boxes had check marked boxes that indicated nurses found bruit and thrill on a shunt that was not there. The TAR also identified physician order for R20's central port; boxes had check marks indicating the task had been completed, however no other documentation pertaining to the integrity of the site was evident in the record. R20's progress note dated 11/20/2020 at 10:55 a.m. included, "Received a call from [name of nurse] at dialysis, stating resident is being taken to ED [emergency department] d/t [due to] drainage from his dialysis catheter. R20's DCR dated 11/20, did not identify that the site was assessed or that there was any signs/symptoms of infection. A subsequent note at 10:04 p.m. included, "[R20] was transferred from HD [hemodialysis dialysis] to [name of hospital] on 11/20 in the setting of AMS [sic], hypotension. Noted purulence, redness around his catheter site. Resident was admitted to [name of hospital]. R20's hospital After Visit Summary dated 11/24/2020, indicated R20 was admitted to the hospital on 11/20, and discharged back to the facility on 11/24/2020. Reason for hospitalization was infection catheter peripheral insertion central. The AVS included " ... male admitted for purulence at the catheter insertion site with	2 830		

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2 830	Continued From page 14	2 830		

concern for catheter infection post removal, now presenting for replacement of the tunneled hemodialysis catheter." The summary also included he presented with altered mental status and hypotension during hemodialysis session. He was noted to have purulent drainage from the right chest wall tunneled dialysis catheter exit site with surrounding erythema. R20 received two different intravenous antibiotics and transitioned to oral antibiotics. Discharge orders included "weigh patient daily per facility protocol Daily for dialysis."

During an interview on 12/2/2020, at 2:39 p.m. assistant director of nursing (ADON) stated R7's dialysis access was on his right chest wall. DON stated the order abdominal site was entered in error, nurses should not have been documenting. DON stated R20 was admitted to the hospital from dialysis because R7 central line had blood in one of the line ports.

During an interview on 12/2/2020, at 5:40 p.m. licensed practical nurse (LPN)-A stated the dialysis site was supposed to be checked before and after dialysis and if there was any abnormalities it would be documented in a progress note. LPN-A stated she looked at R7's site morning; there was a little bit of dried blood around the insertion site. LPN-A stated she had not looked at the site after R7 had returned from dialysis around lunch time and was not aware there was blood under the dressing around the insertion site.

During an interview on 12/3/2020, at 2:49 a.m. dialysis charge nurse (DRN) stated on 11/20/2020 she was the one who observed the central line site. DRN stated prior to the R20 arriving to the clinic the facility had not called or

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2 830	Continued From page 15 indicated any changes on the communication form. DRN stated when she went to hook R20 up, the line had thick purulent drainage dripping down the catheter line from underneath the clear dressing, more purulent drainage underneath the dressing. DRN stated she took the dressing off, a lot of drainage on it, cleaned the area and noted the insertion site was quite red. DRN stated the drainage was very evident and could not have been missed if someone was looking at it. DRN indicated that could not have happened within a couple of hours. DRN confirmed R20 did not have a fistula in his abdomen. DRN stated most times dialysis patients are on fluid restrictions but since R20 was so new to dialysis they were monitoring how much fluid was removed each dialysis run to determine if a restriction was necessary or if needed to increase fluid. DRN stated another reason she sent him to the hospital on 11/20/20, was because he was hypotensive. DRN stated expectation facility staff weigh residents who are on dialysis daily and communicate weight gains as appropriate, she also expected staff to monitor the appropriate dialysis site for signs and symptoms of infection and immediately contact dialysis clinic. During an interview on 12/3/2020, at 4:16 p.m. RN-A stated he understood the central line was supposed to be checked only before and after dialysis and he did not recall observing the line when he worked prior to R20 going to the hospital on 11/20, stated he usually worked the night shift. RN-A stated dialysis residents are supposed to be weighted daily and confirmed R20 had not been, however R20 got weighed at dialysis three times per week. RN-A stated dialysis patients are supposed be monitored for intake and output, monitored for dehydration and fluid overload.	2 830		

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2 830	Continued From page 16 During an interview on 12/4/2020, at 9:37 a.m. physician assistant (PA)-A checking dialysis access sites are standard of practice and nurses were supposed to be checking the site "Obviously it was not caught." PA-A confirmed R20 did not have an abdominal shunt; stated nurses should be reading and know what they are checking off not just to check it off and was concerning for potential other tasks were just checked off. PA-A reviewed R20's physician notes and discharge summaries and indicated the type of access wasn't clearly identified, the staff should have called either the dialysis clinic or physician. PA-A stated if there was a fluid restriction that was used during the hospital and if it was noted, then she would continue that restriction if there was not a specific order or use the standard 2 liters. PA-A stated it was standard and important to monitor/evaluate fluid intake and output, as well as following daily weight monitoring and expected facility staff to follow the orders and facility protocols. Facility policy Care of Hemodialysis Resident dated 1/3/2020, included: Purpose: To ensure the needs of the resident receiving hemodialysis are met by both the facility and the dialysis center. Resident receiving hemodialysis are transported routinely out of the facility. Communication is essential for continuity of care. -Facility will provide ongoing assessment of the resident's condition and will monitor for complications before and after each dialysis treatment received at a certified dialysis facility. Facility will have ongoing communication and collaboration with the dialysis facility. -Dialysis center should be made aware of changes in condition that may affect their overall condition, such as increased risk for pressure injury and appropriate interventions.	2 830		

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2 830	Continued From page 17 External Catheters: -Care should be taken so the external catheter is not pinched poked, bent or pulled. -A smooth clamp should be kept at the bedside for emergency situations. -Avoid getting catheter wet during bathing. You may cover with plastic wrap during bathing -Replace the dressing if it comes off or becomes wet. Cleanse the area with cleanser such as Betadine swab or Hibiclens and apply new sterile dressing. The coordinated, person-centered care plan will include: -Monitor for complications -Frequency of monitoring vital signs, respiratory distress, chest pain, headache, seizure, etc. -Potential for bleeding -Care of the access site -Potential for infection -Nutritional/fluid management including documentation of weights, resident compliance with food/fluid restrictions and provision of meals before/during and/or after dialysis. -Alteration in skin integrity SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review policies and procedures for diabetic and dialysis management. The DON/designee then could develop and provide education to licensed staff pertaining to standards of practice for interventions/monitroing/evaluating and care of diabetic and dialysis residents. The DON/designee could then develop and implement an auditing system as part of facility's quality assurance program to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		

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2 845	MN Rule 4658.0520 Subp. 2 C Adequate and Proper Nursing Care; Shampoo Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: C. A shampoo at least weekly and assistance with daily hair grooming as needed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 3 residents (R18) reviewed was provided assistance to bathe according to her preferences and bath schedule. Findings Include: R18 was interviewed and observed on 12/3/20, at 1:47 p.m. R18 was sitting in recliner chair in her room, her hair was unbrushed and had oily appearing texture. R18 stated, "Very true not getting bathed." R18 stated that yesterday she had a chair bath. R18 stated, "They tell me we cannot do showers and I got a bath in the chair [recliner]. I need to have my hair washed 4 times a week I am lucky if it is done once. Washing hair with wash cloth doesn't do the job." R18 stated she has seborric dermitis, her scalp was very itchy and she had medicated shampoo. R18 stated, "They told me that we aren't allowed to take showers/baths." R18 stated she has yeast infections, skin issues and the tub was good for her skin, takes pressure off her spine and feels good. R18's quarterly Minimum Data Set (MDS) assessment dated 11/19/20; identified R18 required physical help in part of bathing activity from one staff member providing physical assist and had intact cognition with a brief interview mental score of 15. R18 had clear speech, was understood and understands with clear	2 845	Acknowledged	1/8/21

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2 845	Continued From page 19	2 845		

comprehension.
R18's bath schedule indicated she was to be bathed on Wednesday and Sunday mornings. The bath schedule did not indicate two other days of the week to have her hair washed.
R18's Visual/Bedside Kardex report utilized by nursing assistants to provide cares, indicated Bathing; assist of 1, bath Sunday and Wednesday AM (morning).
R18's hair washing care plan revised 6/27/19 included, "[R18] would like her hair washed T [Tuesday], TH [Thursday], Sat [Saturday] in the beauty shop with her specific shampoo." Intervention included, Staff will offer the beauty salon for specified dates to wash [R18's] hair.
R18's bathing care plan revised 11/25/19 included, "Behavior; refusing to bathe. [R18] has a history of refusing to bathe when offered and then complaining to staff that she is allegedly not being bathed. Interventions included, "Resident has a peri-wand to assist with personal hygiene. Staff will continue to offer [R18] her showers at specified requested times. Staff will [did not indicate what they would do] if [R18] refuses her shower/bathing."
R18's bathing documentation was reviewed from 11/11/20 to 12/2/20 and revealed R18 had a bath on 11/12/20 and 11/15/20 during the time period reviewed.
R18's progress notes were reviewed from 11/1/20 to 12/3/2020. There was one progress note dated 11/8/2020 that included resident refused shower during the time period reviewed.
During an interview on 12/3/2020, at 4:05 p.m. the director of nursing (DON) stated she had interviewed three nursing assistants on the covid unit and they could not answer questions regarding R18's bathing. The DON stated she interviewed R18 and R18 told her she had a bed bath in her recliner yesterday, but had not had a

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2 845	Continued From page 20 bath for two weeks before that. The DON stated R18 asked her if they were not able to have showers because of COVID. The DON stated she reassured R18 that she could have a shower. The DON also stated R18 shared she was not getting her hair washed four times a week. The DON stated her expectation was R18 was to have her shower twice a week and her hair washed four times a week. The DON stated about a month ago we created a master shower list so no matter where they (the residents) are moved each wing had the master schedule for bathing for all of the residents. The DON stated R18 not getting showers and hair washed was unacceptable. During a subsequent interview on 12/4/20, at 8:27 a.m. the DON stated she updated the bath schedule to include R18's shampoo days on the bath schedule. The DON stated she would be developing a form to document shampoos, which, will be turned in to the DON. The Bath/Shower policy revised 2/26/20 included, "Documentation: Document in Point of Care that shower/bath was complete, and the level of assistance. Reporting: 1. Notify the nurse if resident refuses the shower/tub bath ..." SUGGESTED METHOD OF CORRECTION: The director of nursing or social services could in-service staff on the need to follow physician orders for resident's hair to be shampooed. Also monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 845		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection	21390		1/8/21

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21390	Continued From page 21 control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement CDC (Centers for Disease Control) and CMS (Centers for Medicaid and Medicare Services) guidance/recommendations for 4 of 4 residents (R1, R2, R5, R6) when the facility failed to separate and quarantine covid positive residents from negative resident roommates. The facility failed to ensure proper infection control	21390	Acknowledged	

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procedures were followed to prevent and/or mitigate the risk of an outbreak of COVID-19. This deficient practice had the potential to affect all 41 residents residing in the facility and staff who were at risk for contracting COVID-19.

The immediate jeopardy began on 11/22/20, when the facility failed to implement appropriate infection control practices to mitigate or reduce the spread of COVID-19 in the facility, the IJ was identified on 12/3/20. The administrator, regional nurse consultant (RNC) and the director of nursing (DON) were notified of the immediate jeopardy at 3:19 p.m. on 12/3/20. The immediate jeopardy was removed on 12/4/20, when the facility had developed and implemented an acceptable plan. However, noncompliance remained at the lower scope and severity level of G, isolated scope and severity, which indicated harm that is not immediate jeopardy.

Findings Include:

The facility did not ensure COVID positive residents were placed in quarantine separate from COVID negative residents. In addition, infection control concerns were observed during observations and the facility lacked evidence of comprehensive risk analysis of potential exposures and/or transmission to other residents, investigation of the illness, and identification of potential causal factors of disease transmission.

According to the census reports, R1 and R2 resided in the same room on the COVID unit.

R1
R1's Admission Record, indicated R1 was admitted to the facility 9/28/20. R1's diagnosis included Non-Hodgkin Lymphoma, unspecified

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21390	Continued From page 23 asthma, adult failure to thrive and anemia. R1's admission Minimum Data Set (MDS) assessment dated 10/5/20 indicated R1 had intact cognition. R1's progress note dated 11/17/20 included, "COVID PCR [polymerase chain reaction] test completed as part of house wide testing due to COVID positive status in the building. Will await results." R1's progress note dated 11/22/2020, at 12:59 p.m. included, "11/16/2020 COVID-19 test result confirmed as positive. Droplet Precautions initiated." R1's progress note dated 11/24/2020, at 11:13 p.m. included, "Resident doing well, no c/o [complaints of] pain, dyspnea, cough. VS [vital signs] remain WNL [within normal limits], LS [lung sounds] clear. Good appetite and output. Some diarrhea this evening. Encouraging fluids for replacement." R1's progress note dated 11/25/2020, at 4:31 a.m. included, "ocass [occasional] loose non prod [nonproductive] cough. denies SOB [shortness of breath], denies pain. has been asleep most of the night." R2 R2's Admission Record, indicated R2 was admitted to the facility 1/20/20. R1's diagnosis included unspecified dementia without behavioral disturbance and cognitive communication deficit. R2's quarterly Minimum Data Set (MDS) assessment dated 10/17/20, indicated R2	21390		

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had long and short-term memory problems and was independent with decision-making skills for daily living.

R2's progress note dated 11/17/2020, at 7:31 p.m. included, "COVID PCR [polymerase chain reaction] test completed as part of house wide testing due to COVID positive status of the building. Will await results."

R2's progress note dated 11/22/2020, at 5:31p.m., included, "[R2]'s roommate tested positive for COVID-19. Although her result came back undetected, [R2] will be treated as COVID-19 positive. Droplet precautions will be instituted ..."

R2's progress note dated 11/23/2020, at 9:02 p.m. included, "COVID POC [point of care] antigen test completed today with negative results. COVID PCR [polymerase chain reaction] test was also completed and sent to lab as part of house wide testing due to COVID positive status of the building. Will await results."

R2's progress note dated 11/30/2020, at 2:47 p.m. included, "Resident noted to have some COVID-like symptoms. Completed point of care antigen test which was negative. Also completed a confirmatory PCR [polymerase chain reaction] test. Will await results from the lab."

R1 was tested for COVID during the facility wide testing on 11/17/20. The facility received R1's positive COVID lab results on 11/22/20. R1 was asymptomatic. R1 and roommate R2, were moved to the COVID unit on 11/22/20. R2's COVID tests results were negative however, R2 was moved to the COVID unit because the facility considered her to be presumptive positive from

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sharing a room with R1. R2 had been COVID positive in July 2020. On 11/30/20, R2 started to have symptoms of two medium emesis of undigested food, R2 complained of abdominal discomfort in umbilicus region and headache after emesis. Documentation indicated the facility was waiting for results of R2's PCR testing, and R2 was tested for COVID via the point of care antigen testing on 12/3/20 which was negative. At that time, R2 was moved to a room off the COVID unit and was placed on 14-day droplet precautions.

During an interview on 12/2/20, at 1:40 p.m. the regional nurse consultant (RNC) stated R2 should have been kept in her room, placed on 14-day precautions and the roommate (R1) that was positive should have been moved to the COVID unit to separate them. RNC stated R2 had been previously positive and had recovered from COVID.

According to the census reports, R5 and R6 had resided in the same room on the COVID unit.

R5

R5's Admission Record, indicated R5 was admitted to the facility on 9/14/20. R5's diagnoses included Type 2 diabetes with diabetic neuropathy, end stage renal disease, dependence on renal dialysis and major depressive disorder.

R5's quarterly Minimum Data Set (MDS) assessment dated 10/26/20 indicated R5 had intact cognition.

R5's progress note dated 11/23/2020, at 8:57 p.m., included, "COVID POC [point of care]

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21390	Continued From page 26 antigen test completed today with positive results. R5's progress note dated 11/24/2020, at 2:37 a.m., included, "2L [liters] supplemental O2 [oxygen] started due to sats [saturations] below 90% (88%)." R5's progress note dated 11/25/2020, at 11:22 a.m. included, "Change of condition ...Nursing observations, evaluations and recommendations are: Baseline status but increased. Primary Care Provider Feedback A. Recommendations: Send for admission (Provider ordered R5 to sent to hospital for admission)..." R6's Admission Record, indicated R6 was admitted to the facility 6/28/2017. R6's diagnosis included chronic pulmonary obstructive disease, dependence on supplemental oxygen, major depressive disorder, recurrent, moderate and anxiety disorder unspecified. R6's quarterly Minimum Data Set (MDS) assessment dated 8/28/20, indicated R6 had intact cognition. R6's progress note dated 11/17/2020, at 7:17 p.m. included, "COVID PCR [polymerase chain reaction] test completed as part of house wide testing due to COVID positive status of the building. Will await results." R6's progress note dated 11/23/2020, at 9:03 p.m. included, "COVID POC [point of care] antigen test completed today with negative results. COVID PCR [polymerase chain reaction] test was also completed and sent to lab as part of house wide testing due to COVID positive status of the building. Will await results." R6's test results were negative.	21390		

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21390	Continued From page 27 R6's progress note dated 11/30/2020, at 2:56 p.m. included, "COVID PCR [polymerase chain reaction] testing completed. Will await results." R6's progress note dated 12/2/2020, at 2:11 p.m. included, "Resident tested positive for COVID this afternoon. C/O [complaints of] not feeling well, headache, and temp [temperature] of 102.2. Rapid test was done." R6's progress note dated 12/3/2020, at 6:07 a.m. included, "Vital Signs: BP [blood pressure] 110/58, P [pulse] 77, T [temperature] 96.6, RR [respirations]19, O2 [oxygen saturations] 95% 2LNC [liters nasal cannula]. Active COVID Symptoms (cough, malaise, fatigue, SOB, fever, headache, loss of taste/smell, GI sx [gastrointestinal symptoms]): non-productive cough, fatigue, increased sleepiness ADL[activities of daily living]/functional declines or recent falls noted: no changes- in bed all night. Emotional/Psychosocial Concerns: none. Appetite and Fluid intake: sleeping, water at bedside. Current interventions and effectiveness: rest, encourage fluids." R5's onset of symptoms was identified as occuring on 11/23/20, when documentation indicated R5 had loose stools. On 11/23/20, the facility completed POC testing and results were positive. R5 shared a room with R6. The room shared was on the COVID unit created 11/22/20. R5 and R6 shared a room on the COVID unit until R5 was hospitalized on 11/25/20. R6 remained in the room they shared on the COVID unit until R6 requested to be moved off the unit on 11/28/20. On 12/2/2020, R6 displayed symptoms headache, temperature 102.2 and had complaints of not feeling well. A POC test was	21390		

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completed and results were positive. R6 was moved back to the COVID unit.

During an observation on 12/2/2020, at 11:45 a.m. in the COVID unit, RN-B and resident (who had mask on) entered from the exit door of the building. RN-B had only N95 donned- no other PPE. RN-B walked up the length of hallway thru the plastic barrier into the nurse breakroom (in unit). RN-B came out of the breakroom with face shield on walked through barrier and then donned gown. RN-B stated she did not think the set up was appropriate. There should be a doffing/donning by the exit door.

During an interview on 12/2/20, at 1:56 p.m. the RNC stated R6 had remained in the room with R5 until R5 was hospitalized as he initially had refused to move rooms. The RNC verified the facility did not have documentation of R6's refusal to move rooms.

During an interview on 12/3/2020, at 10:21 a.m. RNC stated the facility had nothing documented for contact tracing at this time for residents, but had a plan to complete an analysis once the outbreak had concluded. RN-C stated going forward the facility planned to review residents that were newly positive to identify if there are any common denominators between staff and residents that could be a potential link to possible spread. She stated for positive staff, the facility was completing the staff risk assessments however, going forward the facility was going to be expanding the analysis to include any potential exposure to residents they had cared for and other staff they had worked with and any potential exposures out of work.

During an interview on 12/4/2020, at 9:16 a.m.

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21390	Continued From page 29 certified nurse practitioner (CNP)-A stated was not aware the facility had not been aware residents were being inappropriately cohorted. CNP-A stated the symptomatic and/or COVID positive residents should absolutely not be in the same rooms as residents that are negative and/or do not have symptoms. The facility's COVID-19 policy revised 10/19/20 included, "Policy: The facility will conduct education, surveillance and infection control and prevention strategies to reduce the risk of transmission of COVID-19. Due to the constantly changing and fluid nature of the virus; the facility will monitor, follow, and implement recommendations and guidance in accordance with the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO), CMS [Centers for Medicare & Medicaid], and the State Department of Health to include identification and isolation of any suspected cases". The immediate jeopardy that began on 11/22/2020, was removed on 12/4/2020, at 2:37 p.m., when it could be verified the facility had reviewed their policies, had appropriately implemented cohorting and transmission based precautions strategies, had initiated risk assessments for residents, and had provided staff education. Suggested Method of Correction: The administrator or designee could review policies and procedures to ensure proper infection control practices to mitigate or reduce the spread of COVID-19 in the facility. Facility staff could be reeducated and an auditing system developed to ensure compliance.	21390		

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21390	Continued From page 30 Time Period for Correction: Twenty one (14) days.	21390		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has	21830		1/8/21

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21830	Continued From page 31	21830		

executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include:

(1) examining the personal effects of the resident;

(2) examining the medical records of the resident in the possession of the facility;

(3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and

(4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.

(c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00916	A. BUILDING: _____ B. WING _____	C 12/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901

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21830	Continued From page 32 county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 3 residents (R18) reviewed was provided assistance to bathe according to her preferences and bath schedule. Findings Include: R18 was interviewed and observed on 12/3/20, at 1:47 p.m. R18 was sitting in recliner chair in her room, her hair was unbrushed and had oily appearing texture. R18 stated, "Very true not getting bathed." R18 stated that yesterday she had a chair bath. R18 stated, "They tell me we cannot do showers and I got a bath in the chair [recliner]. I need to have my hair washed 4 times a week I am lucky if it is done once. Washing hair with wash cloth doesn't do the job." R18 stated she has seborric dermitis, her scalp was very itchy and she had medicated shampoo. R18 stated, "They told me that we aren't allowed to take showers/baths." R18 stated she has yeast infections, skin issues and the tub was good for her skin, takes pressure off her spine and feels good.	21830	Acknowledged	

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21830	Continued From page 33 R18's quarterly Minimum Data Set (MDS) assessment dated 11/19/20; identified R18 required physical help in part of bathing activity from one staff member providing physical assist and had intact cognition with a brief interview mental score of 15. R18 had clear speech, was understood and understands with clear comprehension. R18's bath schedule indicated she was to be bathed on Wednesday and Sunday mornings. The bath schedule did not indicate two other days of the week to have her hair washed. R18's Visual/Bedside Kardex report utilized by nursing assistants to provide cares, indicated Bathing; assist of 1, bath Sunday and Wednesday AM (morning). R18's hair washing care plan revised 6/27/19 included, "[R18] would like her hair washed T [Tuesday], TH [Thursday], Sat [Saturday] in the beauty shop with her specific shampoo." Intervention included, Staff will offer the beauty salon for specified dates to wash [R18's] hair. R18's bathing care plan revised 11/25/19 included, "Behavior; refusing to bathe. [R18] has a history of refusing to bathe when offered and then complaining to staff that she is allegedly not being bathed. Interventions included, "Resident has a peri-wand to assist with personal hygiene. Staff will continue to offer [R18] her showers at specified requested times. Staff will [did not indicate what they would do] if [R18] refuses her shower/bathing." R18's bathing documentation was reviewed from 11/11/20 to 12/2/20 and revealed R18 had a bath	21830		

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21830	Continued From page 34 on 11/12/20 and 11/15/20 during the time period reviewed. R18's progress notes were reviewed from 11/1/20 to 12/3/2020. There was one progress note dated 11/8/2020 that included resident refused shower during the time period reviewed. During an interview on 12/3/2020, at 4:05 p.m. the director of nursing (DON) stated she had interviewed three nursing assistants on the covid unit and they could not answer questions regarding R18's bathing. The DON stated she interviewed R18 and R18 told her she had a bed bath in her recliner yesterday, but had not had a bath for two weeks before that. The DON stated R18 asked her if they were not able to have showers because of COVID. The DON stated she reassured R18 that she could have a shower. The DON also stated R18 shared she was not getting her hair washed four times a week. The DON stated her expectation was R18 was to have her shower twice a week and her hair washed four times a week. The DON stated about a month ago we created a master shower list so no matter where they (the residents) are moved each wing had the master schedule for bathing for all of the residents. The DON stated R18 not getting showers and hair washed was unacceptable. During a subsequent interview on 12/4/20, at 8:27 a.m. the DON stated she updated the bath schedule to include R18's shampoo days on the bath schedule. The DON stated she would be developing a form to document shampoos, which, will be turned in to the DON. The Bath/Shower policy revised 2/26/20 included, "Documentation: Document in Point of Care that shower/bath was complete, and the level of	21830		

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21830	Continued From page 35 assistance. Reporting: 1. Notify the nurse if resident refuses the shower/tub bath ..." SUGGESTED METHOD OF CORRECTION: The director of nursing or social services could in-service staff on the need to honor resident requests especially for choice in bathing frequency. Also monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21830		

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:

In order to assist with identifying appropriate corrective actions and implementing systemic changes, the facility must contract with an infection control consultant to provide consultation and oversight for infection prevention and control within the facility.

- The consultant shall exercise independent judgement in the performance of all duties under the consultant contract. The consultant shall meet the independent judgement requirement if the consultant is not presently and has not within a five (5) year period immediately preceding June 1, 2020 directly or indirectly affiliated with the facility, facility's owner(s), agent(s), or employee(s).

- The consultant shall have completed infection prevention and control training from a recognized source, such as the Centers for Disease Control and Prevention or American Health Care Association.

- The consultant will be contracted to work with the facility for a minimum of two (2) months.

- The consultant will assist the facility in completing the CMS infection control self-assessment. If this assessment was completed prior to the June 4, 2020 survey, the assessment should be reviewed to determine if it is an accurate reflection of the facility's infection control program. The self-assessment can be found in the CMS publication QSO-20-20-All, Prioritization of Survey Activity.

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

- Work with the facility to conduct a Root Cause Analysis (RCA) to identify and address the reasons for noncompliance identified in the CMS-2567.
- The facility's Infection Preventionist, Quality Assurance and Performance Improvement (QAPI) committee, must participate in the completion of the RCA. Information regarding RCAs can be found in the CMS publication Guidance for Performing Root Cause Analysis (RCA) with Performance Improvement Projects (PIPs).
- Take immediate action to implement an infection prevention plan consistent with the requirements at 42 CFR § 483.80 for the affected residents impacted by the noncompliance identified in the CMS-2567 to include identification of other residents that may have been impacted by the noncompliant practices. This plan must include but is not limited to implementation of procedures to ensure:

Cohorting Residents/Transmission Based Precaution "Isolation"

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

POLICIES/PROCEDURES/SYSTEM CHANGES:

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

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

- Grouping of residents, or "cohorting," should be done when possible to separate residents with an infectious disease (positive residents) from residents who are not affected. Plans to cohort should be carefully established in advance and should be centered on implementation of infection control practices.
- Dedicate a unit or part of a unit as the care location for residents with disease, including those with or without current symptoms of illness. Anticipate ways to close off units to prevent spread of illness from ill residents to non-ill residents (e.g., for symptomatic COVID-19, recovered COVID-19 residents, non-COVID-19 suspected residents).
- Confine symptomatic residents and exposed roommates to their rooms. If they must leave their room, ensure the resident is wearing a mask.
- Provide dedicated equipment for areas, as able.

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

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

TRAINING/EDUCATION:

- Provide education to residents (to the degree possible/consistent with the resident's capacity) and their representatives or visitors on the use of transmission-based precautions.

- Refer to CDC Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings. https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
- Refer to MDH COVID-19 Infection Prevention and Control and Cohorting in Long-term Care. https://www.health.state.mn.us/diseases/coronavirus/hcp/ltcipchohort.pdf
- MDH: Interim Guidance for Hospital Discharge to Home or Admission to Congregate Living Settings and Discontinuing Transmission-Based Precautions. https://www.health.state.mn.us/diseases/coronavirus/hcp/hospdischarge.pdf

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 verify the placement of each new admission and location and audit for transmission based precautions are being appropriately implemented.
- Conduct a Root Cause Analysis (RCA) which will be done with assistance from the Infection Preventionist, Quality Assurance and Performance Improvement (QAPI) committee and Governing Body. The RCA should be incorporated into the intervention plan. Information regarding RCAs can be found in the document: Guidance for Performing Root Cause Analysis (RCA)with Performance Improvement Projects (PIPs)

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

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

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

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

Use this for IJ

Item	Checklist: Documents Required for Successful Completion of the Directed Plan
1	Consultant name and credentials meeting the criteria outlined above
2	Executed contract with the consultant
3	Documentation demonstrating that the RCA was completed as described above
4	List of facility policies and procedures reviewed by the consultant.
5	Infection control self-assessment
6	Summary of all changes as a result of the RCA and consultant review – to include a summary of how staff were notified and trained on the changes
7	Content of the trainings provided to staff to include a Syllabus, outline, or agenda as well as any training materials used and provided to staff during the training
8	Names and positions of all staff to be trained
9	Staff training sign-in sheets
10	Summary of staff training post-test results, to include facility actions in response to any failed post-tests
11	Summary of follow-up employee supervision and work performance appraisal to include when employees were observed, what actions were observed, and an evaluation of the effectiveness of any new policies and procedures.

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