STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355069	A. BUILDING _____ B. WING _____	12/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE HEARTLAND	**620 14TH AVE NE DEVILS LAKE, ND 58301**

(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 Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the Centers for Medicare & Medicaid Services (CMS) on 11/30/20 through 12/01/20. The facility was found to be in substantial compliance with 42 CFR 483.73 related to E-0024 (b)(6).	E 000		
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control survey was conducted by Healthcare Management Solutions, LLC on behalf of the Centers for Medicare & Medicaid Services (CMS) on 11/30/20 through 12/01/20. The facility was found not to be in substantial compliance with 42 CFR 483.80 Infection Control requirements. Survey Census: 59 Sample Size: 5 Supplemental: 0	F 000		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F 880		

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

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

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F 880	Continued From page 1 and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions 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	F 880		

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F 880	Continued From page 2 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 observations, staff interviews, and record review, the facility failed to ensure clean gowns were stored in a sanitary manner in the hallway, which had the potential to expose the clean cloth gowns to COVID-19 and other infections. This failure affected all areas of the facility, and all 59 facility residents. Findings include: On 11/30/20 at 11:25 AM, Certified Nurse Aide (CNA) 1 moved several clean cloth gowns from a large plastic tub sitting on the floor outside room 2 to a plastic cart with drawers. There were several cloth gowns left in the tub, and the tub was not covered in any way. CNA1 stated laundry staff brought the clean cloth gowns to the floor and put them in the plastic tubs on the floor. On 11/30/20 at 11:40 AM, a plastic tub full of	F 880		

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F 880	Continued From page 3	F 880		

unfolded and crumpled clean cloth gowns sat on the floor at the entry to the charting room across from the nurses' station. The tub was not covered, and five staff members and two residents were observed in the vicinity, walking past the bin often.

On 11/30/20 at 1:00 PM, two plastic tubs full of clean cloth gowns sat on the floor in the "green," or clean, area at the entrance to the COVID-19 designated unit. The tub was not covered.

On 12/01/20 at 9:10 AM, a two-tiered open cart in front of room 34 held a pile of unfolded and crumpled clean cloth gowns. The cloth gowns were not covered in any way. Several of the cloth gowns were in contact with the wall and handrail behind the cart.

On 12/01/20 at 9:22 AM, a plastic tub full of unfolded and crumpled clean cloth gowns sat on the floor, uncovered, in front of room 2.

On 12/01/20 at 9:27 AM, Laundry Worker (LW) 1 stated she always covered clean laundry when transporting it through the hall to the resident's room. She stated they used a covered cart to ensure the laundry was not exposed to the environment. LW1 stated she laundered the gowns and placed the clean ones in the carts and plastic tubs. She stated she had never considered covering the clean gowns to prevent exposure to the environment.

On 12/01/20 at 9:30 AM, the family room of the Memory Care unit had an open three-tiered rolling cart piled high with crumpled and unfolded clean cloth gowns in front of the entrance. The

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F 880	Continued From page 4	F 880		

cloth gowns were not covered and were accessible to the 14 residents in the Memory Care unit.

On 12/01/20 at 9:35 AM, RN2 stated the residents in the Memory Care unit wandered frequently.

On 12/01/20 at 10:24 AM, the Executive Director stated there was a point when all facility residents required the use of gowns for care, and he thought they were put out on the floor in tubs and carts at that time to ensure they were easily accessible by the staff. He added, "We never even thought just to put the cover over it."

On 12/01/20 at 10:37 AM, the Housekeeping/Laundry Supervisor (HS) stated via telephone interview that the clean gowns were normally stored in the clean linen room or carts with drawers, but because there were so many residents requiring use of gowns, "I think they just started putting them on the floor." The HS stated she felt the gowns should be kept covered while out in the hallway on the floor or open carts. She added there were covers available for the plastic tubs.

On 12/01/20 at 11:20 AM, the Infection Preventionist (IP) stated, "Ideally, when transporting gowns, they should be covered." She stated the clean gowns stored in plastic tubs and carts were not covered when out on the floor. The IP explained there was a time when most residents needed gowns stored outside their rooms, and this is when the tubs and carts were used as there were not enough carts with drawers.

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F 880	Continued From page 5 On 12/01/20 at 11:45 AM, the two-tiered cart piled with clean cloth gowns sat outside of room 34. Several cloth gowns were in contact with the wall and handrail behind the cart. The cloth gowns were not covered. On 12/01/20 at 11:47 AM, the plastic bin full of clean cloth gowns sat outside the charting room, covered with a blanket. Though it was covered, there was a tie to a gown sticking out from under the cover that came in contact with the floor. On 12/01/20 at 11:48 AM, the plastic bin with clean cloth gowns sat on the floor outside room 2. One of the clean cloth gowns had a sleeve sticking out over the side that was in contact with the floor. The facility's "Transporting Linen" policy, revised in April 2017, documented, "Purpose: To ensure all linen is covered. Procedure: Any linen, clean or soiled, needs to be covered when being transported."	F 880		