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	355031	A. BUILDING _____ B. WING _____	C 09/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINOT HEALTH AND REHAB, LLC	600 S MAIN ST MINOT, ND 58701

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E 000	Initial Comments A COVID-19 Emergency Preparedness Survey was completed by the Centers for Medicare and Medicaid Services (CMS) on 09/01/2020. The facility was found in compliance with 42 CFR §483.73 related to E-0024(b)(6).	E 000		
F 000	INITIAL COMMENTS An unannounced onsite complaint survey was completed on 09/01/20. The sample included 13 residents for focused review. A COVID-19 Focused Infection Control Survey was conducted on 09/01/20. The facility was found to not be in compliance with 42 CFR 483.80 infection control regulations and will be cited at F880. The facility has implemented the Centers for Medicare and Medicaid Services (CMS) and Centers for Disease Control (CDC) recommended practices to prepare for COVID-19. The facility had no COVID-19 positive residents.	F 000		
F 740 SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced	F 740		9/25/20

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

Electronically Signed | 09/25/2020

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F 740	Continued From page 1 by: Based on record review, review of facility policy, and staff interview, the facility failed to adequately assess a resident's intent to harm self, implement appropriate interventions, and/or develop a comprehensive care plan for 1 of 2 sampled residents (Resident #6) with psychosocial concerns. Failure to properly identify and assess Resident #6's potential for self harm placed the resident at risk for further self harm/injury and decreased psychosocial well-being. Findings include: Review of the facility policy titled, "SUICIDE THREATS" occurred on 09/01/20. This undated policy, stated, ". . . When a Resident reports feeling like he/she would be better off dead, threatens to harm themselves or kill themselves or threaten to kill/harm someone else, it is every staff member's responsibility to report to Resident's Charge Nurse and the Charge Nurse's responsibility to report to the facility DON/ADON [Director of Nursing/Assistant Director of Nursing] . . . Immediately assign a staff member to provide one on one supervision of the resident to ensure the Resident's safety . . . Establish a safe environment to reduce the risk of self-harm or danger to the resident by removing items in the resident's immediate environment that could be used by the resident to harm self or others . . . Assess the Resident for intent, plan, means to harm self or other and notify the Director of Nursing of the threat and findings of the assessment . . . The resident must remain on one to one supervision until seen and cleared in writing by a physician . . ."	F 740	Resident #6 received 'one on one' supervision and then was transfer to higher level of care where a physician evaluated and provided treatment on 8/27/20. Resident #6's care plan was reviewed by the Interdisciplinary team and updated with interventions, which were place on 9/1/20. The interdisciplinary team members, including the Executive Director and Social Worker, reviewed and set up resident #6's room environment to be free from potential hazards. Safety checks remain in place at the discretion of the Medical Director and interdisciplinary team based on resident psychosocial status. Resident #6 has continued consultants with psychiatric professionals. Care conferences with resident and /or resident representative(s) scheduled for 10/8/20. The facility's staff educated on 9/3/20 and 9/15/20 via handouts and staff meetings on action to take to protect the resident if resident #6 or other facility residents indicate desire to self-harm, including one on one supervision and transfer to higher level of care for evaluation. The all faculty residents to have PHQ-9 assessments completed with physician notification for assessments indicating depression (1.0) unless depression scoring has improved from previous PHQ-9 on record.	

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F 740	Continued From page 2 Review of Resident #6's medical record occurred on all days of survey. A progress note on the day of admission, dated 08/20/20 at 11:57 p.m. stated, "Resident alert and oriented, refused to eat of [sic] drink . . . refused bedtime medication stated he wants to die . . ." The baseline care plan stated, ". . . . Resident has stopped eating and drinking, can't deal with life. Requests palliative care. Does not qualify for Hospice . . ." The current care plan stated, "Cognitive loss as evidenced by (specify) r/t [related to] resident has a will to die [initiated on care plan 09/01/20] . . . disease process (Statementsby [sic] resident, I can not deal with life and had consult for palliative care, but does not meet qualifications through Hospice) . . . Psych consult and treatment; had Psych consult at [hospital] [initiated on care plan 08/20/20] . . ." Nursing progress notes showed the following: * 08/27/20 at 11:48 a.m. - ". . . admitted to facility on 8/20/2020 for post acute care. Has voiced a desire to die and did have court hearing declaring he is competent to make choices regarding his care. He reports he is tired of living like this . . . Obviously distressed elderly gentleman with five self inflicted lacerations to left inner forearm and several self inflicted puncture wounds near anecdotal area from a ball point pen he used to cut himself. Reports he was attempting to get to a big bleed so he could bleed to death and be done with this. Reports he does not want to live and if he could make himself die he will . . . Response: Removed pen from resident's grasp, removed any items he may consider to use to harm himself, assigned staff to remain one to one	F 740	The facility's residents psychosocial care plans will be reviewed and updated by the Interdisciplinary team based on PHQ-9 Assessments. The psychological status of three residents will be audited weekly for 12 weeks via resident interviews by the Social Worker designee on depressed feelings or indications for self-harm. The Social Worker will report concerns to the charge nurse, Director of Nursing, and the Executive Director. The audit results will be reviewed by the QAPI committee. Monitoring will not be discontinued until the facility completes 3 consecutive rounds of monthly monitoring which demonstrate sustained compliance as approved by the QAPI committee.	

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F 740	Continued From page 3 with him and will reach attending MD [medical doctor] for transfer orders as he cannot safely be managed here . . ." * 08/27/20 at 11:58 a.m. - ". . . Attending physician, [physician name], notified of resident's self inflicted injury with intent to cause significant self harm and "bleed to death". Orders received to transfer to hospital. . . ." * 08/27/20 at 12:15 p.m. - ". . . contacted 911 and requested ambulance service to transfer for self harm and suicidal ideation . . ." * 08/28/20 at 10:50 a.m. - ". . . Requested maintenance manager remove call lights from room due to recent self inflicted injury and ongoing suicidal ideation. Bell will be provided at bedside to ring if assistance is needed. Resident is on one to one at this time" * 08/28/20 at 5:10 p.m. - "Received notification from MD that it is felt ongoing one to one monitoring will increase the resident's level of agitation. Orders were given for 15 minute checks at this time . . ." During an interview on 09/01/20 at 4:30 p.m., an administrative staff member (#5) confirmed the care plan lacked specific interventions in a timely manner. The facility staff failed to assess and implement interventions to prevent Resident #6 from harming self. The care plan also lacked specific intervention such as 15 min checks, removal of call light, and placement of bedside bell.	F 740		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an	F 880		9/25/20

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F 880	Continued From page 4 infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions 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,	F 880		

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F 880	Continued From page 5 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, review of facility policy, and staff interview, the facility failed to follow infection control standards for 3 of 13 sampled residents (Residents #9, #10, and #13). Failure to follow infection control standards of hand hygiene during pressure ulcer dressing changes (Resident #9 and #10) and perineal care (Resident #9, #10 and #13), and failure to properly disinfect bedside tables (Resident #9 and #10), and store reusable gowns (Resident #9 and #13) has the potential to spread infection to	F 880	1. Corrective Action The facility will immediately implement an appropriate infection prevention and intervention plan consist with the requirements of ¿483.80 for the infection control deficient practices identified in the deficiency. The infection preventionist (IP) and director of nursing (DON), in conjunction with the medical director, shall complete the following: (1) Identify and implement standards of practice for reusable PPE consistent with	

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F 880	Continued From page 6 other residents, personnel, and visitors. Findings include: Review of the facility policy titled "Handwashing/Hand Hygiene" occurred on 9/01/20. This undated policy stated, ". . . Employees must wash their hands for at least twenty (20) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: . . . before and after resident contact; . . . before and after assisting resident with toileting; . . . after removing gloves or aprons; . . . In most situations, the preferred method of hand hygiene is with an alcohol-based rub. If hands are not visibly soiled, use an alcohol-based hand rub containing 60-95% ethanol or isopropanol for the following situations: before and after direct contact with residents; . . . before handling clean or soiled dressings, gauze pads, etc,; before moving from a contaminated body site to a clean body site during resident care; after contact with resident's intact skin; after handling used dressings, contaminated equipment, etc,; . . . after removing gloves. Hand hygiene is always the final step after removing and disposing of personal protective equipment. . . ." - Observation on the morning of 09/01/20 showed an open door to Resident #13's room, the door contained instructions for contact isolation. Inside the room showed a reusable cloth gown located on top of a linen cart cover and another gown located on top of a dresser. The facility staff failed to maintain a closed door for a resident in contact isolation and failed to	F 880	nursing facility guidelines from Centers for Disease Control and Prevention (CDC) and Centers for Medicare and Medicaid Services. (2) Identify and implement hand hygiene procedures for staff during resident care including, but not limited to, incontinence care, wound care/dressing changes, and transmission-based precautions. (3) Ensure hand hygiene and disinfecting supplies are available, accessible, and used by staff consistent with nursing facility guidelines from the CDC and CMS. (4) Identify and implement a respiratory protection plan (fit testing for N95 filtering facepiece respirator) for the healthcare workers who are expected to interact with patients with infectious respiratory diseases. (5) Identify and implement new and/or revised facility policy and procedures related to infection control standards and practices. 2. Identification of Others: The IP and DON, in conjunction with the interdisciplinary team (IDT) will review current COVID-19 nursing facility guidelines from CDC and CMS. The IP, DON and applicable IDT members will evaluate the facility's compliance with the guidelines. The facility will develop action plans to address any newly identified non-compliance. 3. System Changes: On or before October 2, 2020 the facility shall complete the following actions: (1) The DON, IP and applicable IDT members will conduct root-cause analysis to identify and address the reasons for non-compliance	

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F 880	Continued From page 7 hang reusable gowns to avoid cross contamination to other surfaces. - Observation on the afternoon of 09/01/20 showed two certified nurse assistants (CNAs) (#2 and #3) donned a gown and gloves and provided bowel incontinence care for Resident #13. The CNA (#2) changed gloves, and without performing hand hygiene, applied a clean brief and repositioned the resident in bed. - Observation on 09/01/20 at 2:00 p.m. showed a staff nurse (#1) and a CNA (#4) donned cloth reusable gowns and gloves, removed Resident #9's brief, provided incontinence care, and the nurse then removed a wound dressing. The staff nurse (#1) removed her gloves, hung her gown on top of another gown and exited the room without performing hand hygiene.. A short while later, the staff nurse (#1) entered the room, donned the same cloth gown and, without performing hand hygiene, applied gloves. The nurse placed a paper wound measuring ruler over the wound area, then placed the paper ruler on the overbed table. The nurse completed the wound care and dressing change, assisted the CNA (#4) to apply a clean brief and placed the bed sheet over the resident. The nurse removed the gloves, removed the cloth gown and hung the gown on top of another gown, and retrieved the paper ruler off the overbed table without sanitizing the overbed table, the nurse left the room. The nurse used the hand sanitizer located in the hallway then proceeded to the nurse's station. While at the nurse's station, the nurse recorded the measurements, discarded the paper ruler, then proceeded to another resident room.	F 880	related to: a. Failure to ensure hand hygiene was consistently done by staff members during resident care tasks to include, but not limited to wound care, dressing change, incontinence care, during resident contact, and when handling PPE. b. Failure to ensure clean/disinfected surfaces was consistently done by staff members before and after resident care procedures. Information about root cause analysis can be found at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/GuidanceforRCA.pdf (2) The DON and IP will ensure education is provided for the following: a. All staff are educated on transmission-based precautions, appropriate PPE use, N95 respirator use, disposable and reusable PPE supplies, performing hand hygiene, disinfecting procedures to reduce and control the spread of infections. Training on hand hygiene is available from the CDC at https://youtu.be/xmYMUly7qiE. b. All staff are educated on all new and/or revised policy/procedures as related to infection control. c. Utilize the teaching method of skills demonstration, as applicable. (3) The DON and IP will ensure implementation and training of healthcare workers on a plan for fit testing. (3) The facility leadership will contact the North Dakota Quality Improvement Organization (QIO) to inquire about the assistance and services available from the QIO in improving infection prevention and control within the facility.	

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F 880	Continued From page 8 - Observation on 09/01/20 at 2:20 p.m. showed a staff nurse (#1) donned gloves, removed a wound dressing and provided bowel incontinence care for Resident #10. The staff nurse (#1) changed gloves and, without performing hand hygiene, cleansed the wound, placed a paper wound measuring ruler over the wound area, then placed the paper ruler on the overbed table. Using a cotton tip applicator the nurse inserted the cotton tip in four different areas/directions of the wound. The staff nurse (#1) touched the cotton tip to the paper ruler and documented the measurement on the paper ruler. The staff nurse (#1) completed the wound care and dressing change. Resident #10 was incontinent of bowel movement again, the nurse provided incontinence care, applied a clean brief and pulled the resident's pants up, then removed the gloves and, without performing hand hygiene, the nurse placed the paper ruler into his/her pant pocket. The nurse used a disposable peri-wipe to cleanse the overbed table. While at the nurse's station, the nurse removed the paper ruler from his/her pant pocket and recorded the measurements on another document, then discarded the paper ruler. During an interview on 09/01/20 at 5:25 p.m., an administrative nurse (#5) stated he/she expected reusable cloth gowns to be hung on individual hooks and not over the top of another gown, expected hand hygiene between glove changes, before and after wound care, after perineal cleansing, and changing an incontinent brief. When asked about infection control procedure for use of an overbed table during a dressing change, the administrative nurse (#5) stated he/she would expect staff to place a barrier such	F 880	4. Monitoring: Monitoring of approaches to ensure infection control and prevention are effective will include: (1) Weekly for no less than 12 weeks, the IP, DON and applicable IDT members will conduct on-going monitoring via observation to ensure staff are complying with requirements for:. a. Compliance with proper hand hygiene during resident cares to include, but not limited to, incontinence cares, wound care/dressing changes, N95 respirator use, don/doff and store PPE. b. Compliance with surface disinfecting procedure requirements. c. compliance and adherence to new and/or revised policy and procedures. After twelve weeks of monitoring, provided that such monitoring demonstrates expectations are met, monitoring may be reduced to monthly. Monthly monitoring will continue for no less than three months. All monitoring will be reported to the quality assurance process improvement (QAPI) committee as part of QAPI activities. Monitoring will not be discontinued until the facility completes three consecutive rounds of monthly monitoring which demonstrate sustained compliance as approved by the QAPI committee and medical director. 5. Correction Date: October 2, 2020 Resident #9 and #13's rooms have been equipped with hooks for hanging reusable gowns on 9/1/20. On 9/1/20, the facility residents placed in contact and/or droplet precautions have	

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F 880	Continued From page 9 as a towel on the table and disinfect the table after use. The facility staff failed to follow hand hygiene practices before and after glove changes, before and after gown usage, before and after a dressing change, after handling a contaminated paper wound measuring ruler, and failed to properly disinfect contaminated surfaces.	F 880	hooks placed inside of their rooms for staff to hang reusable gowns. Rooms designated as requiring isolation precautions will be determined by the charge nurse. Infection Preventionist, Director of Nursing, and Medical Director. Isolation rooms are indicated via signage on the door and isolation bins/equipment at the room entrance. Staff nurse #1 was educated on 9/3/20 by the infection Preventionist on hanging reusable gowns on hooks inside rooms under isolation precautions, performing hand hygiene before/after glove changes, creating and using a clean barrier during wound care and disinfecting surfaces post-procedure. Certified Nursing Assistant #2 was educated 9/30/20 on performing hand hygiene before and after donning gloves during continence cares. Faculty staff were educated via handouts and staff meetings from the infection preventionist on 9/3/20 and 9/15/20 on infection control practices related to hand hygiene before and after glove changes during incontinence care and wound care, storage of gowns being reused in contingency or crisis capacity, creating and using a clean barrier during wound care and disinfecting surfaces post-procedure. Weekly staff performance/competency audits to be complete by designees of the	

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F 880	Continued From page 10	F 880	interdisciplinary team for 12 weeks. and then monthly for a duration of 3 months on hand hygiene before and after glove changes during incontinence care and or wound care, storage of gowns being reused in contingency capacity , creating and using a clean barrier during wound care and disinfecting surfaces post – procedure. In collaboration with members of QAPI Committee, including the Director of Nursing, Infection Preventionist, and Medical Director. The Executive Director will be responsible for overseeing completion of audits and will determine if deficient practice has been identified to determine the need for additional education or increased auditing. The facility will identify a local provider to assist the facility staff in be fit-tested for N95s, in addition to being educated on the use and disinfection process for N95s. Audits results will be reviewed by the QAPI committee. Monitoring will not be discontinued until the facility completes three consecutive rounds of monthly monitoring which demonstrate sustained compliance as approved the QAPI committee.	