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	355031	A. BUILDING _____ B. WING _____	09/23/2020

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 09/23/2020. The facility was found in 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 on 09/23/20. The facility was found to not be in compliance with 42 CFR 483.80 infection control regulations and will be cited at F880 and F886. The facility had 15 COVID-19 positive residents.	F 000		
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 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	F 880		10/14/20

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

Electronically Signed | 10/14/2020

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F 880	Continued From page 1 facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §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.	F 880		

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F 880	Continued From page 2 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 one of one days (09/23/20) of observation. Failure to store and label reusable face shields, properly store surgical masks, and provide isolation signage for residents on isolation, has the potential to spread infection to other residents, personnel, and visitors. Findings include: Review of the facility policy titled "Pandemic Preparedness and Response Policy", occurred on 9/23/20. This policy, dated 03/23/20, stated, ". . . Standard and Droplet Precautions: Post signs on the door or wall outside of the resident room that clearly describe the type of precautions needed and required PPE. . . ." Review of the facility policy titled "Strategies for Optimizing PPE During a COVID -19 Outbreak occurred on 09/23/20. This policy dated 03/23/20, stated, " . . . Facemasks should be carefully folded so that the outer surface is held inward and against itself to reduce contact with the outer surface during storage. The folded mask can be stored between uses in a clean sealable paper bag or breathable container. ... If	F 880	1. Corrective Action The facility will immediately implement an appropriate infection prevention and intervention plan consistent 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 nursing facility guidelines from Centers for Disease Control and Prevention (CDC) and Centers for Medicare and Medicaid Services and follow facility policy regarding signage for isolation and reusable PPE. 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 20, 2020 the facility shall	

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F 880	Continued From page 3 a disposable face shield is reprocessed, it should be dedicated to one HCP [health care provider] and reprocessed whenever it is visibly soiled or removed (e.g., when leaving the isolation area) prior to putting it back on. . . ." Observation on the afternoon of 09/23/20 showed the faces shields stored on the handrail inside the closed doors of the COVID unit. The face shields lacked staff names or other forms of identification. During an interview the afternoon of 09/23/20, a staff nurse (#5) prepare to enter the COVID unit stated she had no further information regarding the storage of the face shields and was unsure if they were clean or dirty. During an interview the afternoon of 09/23/20, an administrative staff member (#2) agreed the face shields lacked staff names or other identification. The afternoon of 09/23/20 observation of the facility's second floor identified two residents (Resident #1 and #2) with isolation carts outside their rooms. A certified nurse assistant (CNA) (#3) stated Resident #1 was on isolation related to her roommate having a positive COVID test. Resident #2 stated she was on isolation for a hospital return. The facility failed to place isolation signs outside resident's rooms indicating the type of precautions needed and required PPE. During an interview the afternoon of 09/23/20, a dietary staff member (#4) stated she received 4 masks in a paper bag at the beginning of the month. At the end of her shift, she folds it and	F 880	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 related to: Failure to store and label reusable face shields, properly store surgical masks, and provide isolation signage for residents on isolation. 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 use and storage of reusable PPE. b. All staff are educated on all new and/or revised policy/procedures as related to infection control including use of isolation signs and PPE. c. Utilize the teaching method of skills demonstration, as applicable. 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 cleaning and storing of all PPE used by staff throughout the facility. b. Compliance with isolation signage in place and available to staff for any resident on isolation. After twelve weeks of monitoring, provided that such monitoring demonstrates expectations are met, monitoring may be reduced to	

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F 880	Continued From page 4 returns it to the same paper bag containing the remaining clean masks potentially contaminating the clean masks. Observation of the facility second floor the afternoon of 09/23/20 showed multiple white paper bags hung on a bulletin board located behind the nurses' station. On the outside of each paper bag was written a staff members name and the month of September. Each bag contained 3-4 surgical masks. During an interview the afternoon of 09/23/20, a CNA (#3) stated she receives 3-4 masks at the beginning of the month. The CNA (#3) stated she wears one mask for an entire week and places it in her locker at the end of each shift. The CNA (#3) confirmed she did not place the mask in a paper bag when stored in her locker. The facility failed to store, label, and use signage for isolation in attempt to prevent the spread of the COVID-19 virus.	F 880	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 20, 2020 F 880 It is the policy of Minot Health and Rehabilitation to 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. 1. On 10/7/20 the infection Preventionist (IP) and director of nursing (DON), in conjunction with the medical director, met to review facility policy on PPE and completed the following: (1) Identify and implement standards of practice for reusable PPE consistent with nursing facility guidelines from Centers for Disease Control and Prevention (CDC) and Centers for Medicare and Medicaid Services and follow facility policy regarding signage for isolation and reusable PPE. On 10/7/20, isolation signage was placed on residents #1 and #2 room as appropriate. By 10/10/2020,	

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F 880	Continued From page 5	F 880	facility residents requiring isolation were identified and Director of Nursing or designee verified that signage was posted. 2. The IP and DON, in conjunction with the interdisciplinary team (IDT) met on 10/8/20 and reviewed current COVID-19 nursing facility guidelines from CDC and CMS. The IP, DON or designee started re-education on COVID 19 infection control practices including ensuring notification of transmission-based precautions and PPE optimization practices including PPE competencies on 10/8/20. DON, Executive Director or Designee will conduct audits no less than 5 times a week of PPE application, storage and use, and signage of transmission-based precautions for 12 weeks or until substantial compliance is maintained. Results of Audits will be brought to QAPI for review and further recommendations. 3. On 10/8/20 the facility completed the following actions: (1) The DON, IP, and Executive Director along with IDT members conducted root cause analysis to identify and address the reasons for alleged non-compliance related to: Storage and labeling of reusable face shields, proper storage of surgical masks, and provision/posting of isolation signage for residents on transmission-based precautions. (2) The DON and/or IP will ensure re-education is provided for the following:	

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F 880	Continued From page 6	F 880	• Proper use and storage of reusable PPE. • Transmission-Based Precautions policy as related to infection control including use of signage and PPE. • Utilize the teaching method of PPE competency. 4. DON, Executive Director or Designee will conduct audits no less than 4 times a week of PPE application, storage and use, PPE cleaning and signage of transmission-based precautions for 12 weeks. Thereafter, monthly for 3 months or until consistent adherence is verified. Results of Audits will be presented to QAPI for review and further recommendations, as applicable. 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 17, 2020.	
F 886 SS=E	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including	F 886		10/14/20

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F 886	Continued From page 7 but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19.	F 886		

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F 886	Continued From page 8 §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to document required COVID-19 test documentation for 5 of 5 sampled residents (#1, #2, #3, #4 and #5) and 2 of 3 sampled staff (#6 and #7). Failure to document COVID 19 testing and results may lead to lack of further interventions required. Findings include: Review of medical records occurred on 09/23/20, and showed Resident #1, #2, #3, #4 and #5 records failed to contain documentation of a COVID 19 test and test results. The facility failed to provide a policy/procedure for refusal of testing for staff and residents when requested. During an interview on 09/23/20 at 3:45 p.m., an administrative staff member (#1) confirmed medical and staff records lacked COVID testing information.	F 886	F 886 It is the policy of Minot Health and Rehabilitation facility to test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. 1) On (October 14, 2020) Nursing COVID 19 SKILLED NURSING CENTER COVID-19 TESTING REQUIREMENTS Policy was brought to QAPI by IDT team and implementation was reinforced. 2) By (October 17, 2020) education on Nursing COVID 19 SKILLED NURSING CENTER COVID-19 TESTING REQUIREMENTS policy was completed with IDT Team by Director of Nursing or Designee. Director of Nursing or designee started education on October 15th of documentation of COVID testing consent and results with licensed nursing staff. 3) Effective 10/5/2020 facility nursing staff-initiated documentation in resident medical record of COVID test including	

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F 886	Continued From page 9	F 886	testing and results. Effective 10/7/2020 Staff, volunteer and/or vendor COVID testing documentation will be compiled and maintained consistent with policy and CMS regulations. 4) DON, Executive Director or Designee will conduct audits of COVID testing documentation for both residents and staff/volunteer records following any round of testing to confirm proper documentation of testing results. 5 audits of either residents or staff/volunteer records, will start by October 17, 2020 and will be completed weekly for 12 weeks, then monthly for 3 months or until substantial compliance is maintained. Results of audits will be brought to QAPI for review and further recommendations. 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. 6) Correction Date: October 17, 2020.	