STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355041	A. BUILDING _____ B. WING _____	11/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN HOME OF THE GOOD SHEPHERD	1226 1ST AVE N NEW ROCKFORD, ND 58356

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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 November 16-18, 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 November 16-18, 2020. 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 had 13 COVID-19 positive residents.	F 000		
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	F 880		12/18/20

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

Electronically Signed | 12/11/2020

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 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 1 of 4 residents (Resident #1) and 6 supplemental residents (Resident #5, #6, #7, #8, #9 and #10) on isolation precautions related to positive COVID-19 status. Failure to place visible isolation signage, cohort residents, close doors, and properly utilizing personal protective equipment (PPE) for residents on isolation/transmission based precautions has the potential to spread the COVID-19 virus to other residents, personnel, and visitors. During the infection control survey on November 16, 2020, the team determined a potential Immediate Jeopardy (IJ) situation existed. The IJ potential resulted from observations of PPE use and staff interviews. These showed residents were placed in immediate dangerous situations due to improper use of PPE, open doors to positive patient rooms and lack of staff education. These situations failed to protect residents from the potential spread of the COVID-19 virus. * 11/16/20 at 5:30 p.m. - The survey team contacted the management staff at the State Survey Agency (SSA) to report the findings and to discuss a potential IJ situation.	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 identify and implement standards for the following: (1) Ensure doors remain closed and visible signage on the use of specific PPE required for staff before entering an isolation room consistent with nursing facility guidelines from Centers for Disease Control and Prevention (CDC) and Centers for Medicare and Medicaid Services. (2) Ensure staff entering and exiting a room on droplet precautions donned, doffed disposed of personal protective equipment (PPE), in accordance with CDC guidelines. (3) Implement cohort of positive resident to the COVID unit, in accordance with CDC guidelines.	

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F 880	Continued From page 3 * 11/17/20 at 3:45 p.m.- The survey team notified the facility's administration (administrator, director of nursing [DON], and infection preventionist [IP]) of the IJ situation and requested they develop a plan for abatement of the immediate jeopardy. * 11/17/20 at 6:30 p.m. - The SSA notified the regional office of the immediate jeopardy situation. * 11/18/20 at 12:18 p.m. - The facility provided a written plan of correction for the IJ. * 11/18/20 at 1:15 p.m. - The survey team reviewed and accepted the facility's written plan. * 11/18/20 at 3:45 p.m. - The survey team determined the IJ situation at a scope/severity of K was abated and reduced to a scope/severity of E. * 11/18/20 at 5:46 p.m. - The SSA notified the regional office of the removal of the immediate jeopardy situation. Findings Include: Review of the facility policy titled "Novel-Corona Virus Prevention and Response" occurred on 11/17/20. This policy, revised October 2020, stated, ". . . 5. d. Educate staff on proper use of personal protective equipment and application of contact, droplet and airborne precautions, including eye protection. e. Promote easy and correct use of proper personal protective equipment (PPE). . . 6. e. Promote easy and correct use of personal protective equipment (PPE) by: i. Posting signs on the door or wall outside of the resident room that clearly describe the type of precaution needed and required PPE. ii. Make PPE, including face mask, eye protection, gowns, and gloves available immediately outside of the resident's room. . . ."	F 880	(4) Identify and implement new and/or revised facility policy and procedures related to infection control standards and practices. The DON, staff development coordinator (SDC), IP or designee, in conjunction with applicable IDT members, will: (1) Educate on 11/17/20 on doors remaining closed, selecting, donning, doffing and disposing of PPE when entering a room on droplet precaution isolation/quarantine procedures. To verify each of these/this staff understands the procedure, the each will perform a successful return demonstration of selecting, donning, doffing and disposing of PPE for providing cares in a droplet precaution room. (2) Educate on 11/18/20 on guidelines/checklist for newly identified COVID positive residents. 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 12/19/2020 the facility shall complete the following actions: (1) The DON, IP and applicable IDT members will	

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F 880	Continued From page 4 Observations on 11/16/20 of resident's testing positive for COVID-19 showed the following: * 12:20 p.m. - Resident #5's room door wide open with plastic sheet hanging on the side of alcove entrance to resident's door. * 12:25 p.m. - Resident #6's room door wide open with plastic sheet hanging on the side of alcove entrance to resident's door. * 12:15 p.m. - Resident #7, #8 and #9's room doors wide open with plastic sheets hanging across the alcove with multiple vertical strips cut for openings. * 12:35 p.m. - Resident #1's room door wide open and no visible sign for droplet precautions. * 3:55 p.m. - Resident #7, #8, and #9's room doors remain wide open with plastic sheets hanging across the alcove with multiple vertical strips cut for openings. During an interview on 11/16/20 at 12:31 p.m., a certified nursing assistant (CNA) (#7) stated staff received instructions to wear the same N95 (respirator mask) for their entire shift (between negative and positive rooms). During an interview on 11/16/20 at 1:15 p.m., a CNA (#9) stated she does not wipe off her face shield when going from a positive resident's room to a negative resident's room. The CNA (#9) also stated staff received instructions to wear a N95 mask with a surgical mask over it and to remove the surgical mask prior to going into the negative resident's room. During an interview on 11/16/20 at 3:50 p.m., a CNA (#10) stated she does not wipe/disinfect her face shield between positive and negative	F 880	conduct root-cause analysis to identify and address the reasons for non-compliance related to: (1) Failure to ensure visible signage is posted on the specific use of PPE for staff members before entering an isolation room, doors remained closed for COVID positive residents, donning/doffing of PPE, and cohort of positive residents. (2) Education is provided for the use of the visible signage posted required for an isolation room, doors remained closed, donning/doffing PPE, and cohort of positive residents. (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. 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 the facility is complying with requirements for posted signage. 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	

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F 880	Continued From page 5 resident's rooms and she does not recall receiving staff education to do that. During an interview on 11/16/20 at 4:00 p.m., a CNA (#8) stated staff have not been provided education regarding changing N95 or surgical masks when leaving a positive residents room and entering a negative residents room. The CNA (#8) also stated the resident across the hall (Resident #10) was currently on isolation. Observation showed no droplet precautions sign and/or PPE available outside Resident #10's room. The facility failed to prevent the potential transmission of COVID-19 by the lack of placing visible signs outside the residents' rooms indicating the type of precautions required, close resident's room doors, and educate/monitor staff on the appropriate PPE use and/or disinfecting face shields.	F 880	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. Corrective Date: 12/19/2020 1. Staff were immediately educated on the proper use of PPE when entering a confirmed or suspected COVID-19 resident's room. They were also educated on assuring isolation signage, indicating specific PPE required when entering a room, was placed in a location that was visible for all those caring for the resident. Education was provided on assuring doors remain closed when residents required isolation precautions and a reminder was added to the signage to assure doors are closed during the isolation period. Staff were required to demonstrate donning/doffing of PPE and educated on proper use, disposal, and disinfecting when required. All residents confirmed with COVID-19 will be moved immediately to the COVID wing and be required to isolate for 10 days. 2. The facility has identified that all residents diagnosed with COVID-19 or suspected of COVID-19 requiring isolation have the potential to be affected by this practice. 3. Facility staff were educated on	

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F 880	Continued From page 6	F 880	11/18/20 regarding the results of the Infection Control Survey which occurred on 11/16/20. Education was again provided on 12/9/20 on proper use, disposal, and disinfecting of PPE. They were reeducated on assuring isolation signage, indicating what type of PPE should be used, is located in an area that is visible to those that care for the resident as well as assuring doors remain closed when a resident is on isolation. PPE donning/doffing observations were immediately started on 11/19/20 and will continue weekly. Nursing staff will be required to complete an initial PPE return demonstration on hire and continue PPE demonstrations per facility requirement. The facility has prepared the COVID wing with necessary items as to minimize the transfer of unnecessary items when a resident has to be immediately relocated to the COVID area. The IDT team has completed a root cause analysis of possible reasons why the infection control standards were not followed appropriately. Interventions have been put into place and monitoring will be completed weekly until full compliance is achieved. 4. The facility has determined that all residents requiring isolation due to COVID-19 will be immediately relocated to the COVID unit. The IP or designee will complete weekly audits X 12 weeks on assuring isolation signage is properly and visibly placed and doors are closed during a resident's isolation period. The IP or	

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F 880	Continued From page 7	F 880	designee will complete PPE observations on nursing staff twice a week. Nursing staff will be required to properly demonstrate donning/doffing of PPE. This will be completed weekly X 12 weeks, monthly X 3, and quarterly X 3. Monitoring and further interventions will be put into place if evidence that further education or interventions are needed. 5. Corrective Date: 12/18/2020	