STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245471	A. BUILDING _____ B. WING _____	04/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE WATERVIEW SHORES LLC	402 - 13TH AVENUE TWO HARBORS, MN 55616

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** Based on observation, interview, and document review, the facility failed to implement a comprehensive infection control program with current Centers for Medicaid and Medicare Services (CMS) and Centers for Disease Control (CDC) guidelines for COVID-19 to ensure immediate screening and surveillance of staff and visitors for potential COVID-19 symptoms prior to entering the facility and having contact with the residents. In addition, the facility failed to implement consistent daily monitoring of 8 of 9 residents (R1, R2, R3, R4, R5, R6, R7, and R9) for symptoms of COVID-19. In addition, the facility failed to ensure residents who required assistance with dining maintained a distance of at least 6 feet of separation from other residents during socialization and dining to prevent exposure and spread of COVID-19 for 6 of 11 residents (R3, R4, R5, R6, R7, and R8) observed in the dining room prior to and during meal service. These practices had the potential to affect all 38 residents who resided in the facility and staff. Findings include: On 4/8/20, at 11:50 a.m. upon entrance into the facility, a clipboard was on a table with a questionaire regarding symptoms of COVID-19, and recent risk of exposure to COVID-19 to be filled out upon entrance. The director of nursing (DON) directed surveyor to fill it out, and then to go to the West nurse's station to have a temperature taken. The DON then brought the thermometer to the entrance to take temperature to screen for symptoms of COVID-19. The DON stated they usually had visitors and staff report to the West nurses station to have their temperature taken and questionnaire reviewed. On 4/8/20, at 1:27 p.m. a hospice staff entered the building, filled out a questionnaire, came in through the door, was stopped at the desk and told to bring the form down to the West nurses station. Hospice staff walked down the hall in the facility to the west nurse's station, and had her temperature taken by licensed practical nurse (LPN)-A, prior to beginning resident visit. On 4/8/20, at 1:30 p.m. LPN-A was interviewed and stated visitors, such as hospice and therapy, come in the front door, and check in on the West nurses station. LPN-A stated she would review their questionnaires, and take their temperature. LPN-A stated if the temperature was greater than 100 degrees Fahrenheit (F) or if they answered yes to a screening question on the questionnaire, she would call the registered nurse or DON and follow directions, and that person would be sent home. LPN-A stated staff entered the facility opposite the West nurses station, walked past dietary department, and got a mask and came to the nurse's station to fill out a questionnaire and have their temperature taken. LPN-A stated everyone entering the building, even after being at facility, leaving to another setting, and returning would have their temperature taken upon re-entering the facility. A review of staff and visitor screenings indicated there were 33 separate occurrences of staff and visitor screenings without documentation of temperatures between 4/1/20, and 4/8/20. On 4/8/20, at 2:55 p.m. the DON verified staff and visitor screenings prior to beginning work or visiting a resident should include a temperature, and stated it was not good if temperatures were not taken prior to beginning work. The DON stated staff would be sent home if they had a temperature of greater than 100 degrees F or if the displayed symptoms of COVID-19. The DON verified staff and visitors had to walk into the building and down the hall to a resident area to be screened. R1's Weights and Vitals Summary dated between 3/17/20, and 4/8/20, indicated R1's temperature was not monitored on five days, including 4/5/20, and oxygen saturation levels were not monitored on 17 days. R1's progress notes dated 4/6/20, indicated R1's physician was notified of R1's complaints of a sore throat and cough, and temperature that was elevated two degrees above R1's baseline temperature. R1's physician ordered lab tests to assist in identifying the cause of R1's symptoms, including influenza and COVID-19. R2's Weights and Vitals Summary dated between 3/17/20 and 4/8/20, indicated R2's temperature was not monitored on nine days, and oxygen saturation levels were not monitored on 18 days. R3's Weights and Vitals Summary dated between 3/17/20, and 4/8/20, indicated R3's temperature was not monitored on four days, and oxygen saturation levels were not monitored on 12 days. R4's Weights and Vitals Summary dated between 3/17/20, and 4/8/20, indicated R3's temperature was not monitored on seven days, and oxygen saturation levels were not monitored on 18 days. R5's Weights and Vitals Summary dated between 3/17/20, and 4/8/20, indicated R5's temperature was not monitored on seven days, and oxygen saturation levels were not monitored on 18 days. R6's Weights and Vitals Summary dated between 3/17/20, and 4/8/20, indicated R6's temperature was not monitored on eight days, and oxygen saturation levels were not monitored on 19 days. R7's Weights and Vitals Summary dated between 3/17/20, and 4/8/20, indicated R7's temperature was not monitored on eight days, and oxygen saturation levels were not monitored on 18 days. R9's Weights and vitals Summary dated between 3/17/20, and 4/8/20, indicated R9's temperature was not monitored on 7 days, and oxygen saturation levels were not monitored on 19 days. On 4/8/20, at 4:25 p.m. DON verified residents should be monitored for symptoms of COVID-19 at least daily with temperatures, oxygen saturation levels, and respiratory symptoms. The facility policy Coronavirus (COVID-19) revised 4/2/20, directed staff be screened for fever and respiratory symptoms prior to beginning of the shift, and be actively screened with temperature and documentation of symptoms, visitors to be screened and temperature taken prior to further entrance to the facility, and each resident's temperature, oxygen saturations, and respiratory status would be monitored and documented at least twice daily. On 4/8/20, at 12:06 p.m. four residents were observed seated in dining room B either together or at tables that were not six feet apart. A staff member was going around the dining room offering residents who were seated at the dining room tables wipes to clean their hands prior to the noon meal service. The trained medication aide (TMA)-A was interviewed and stated all of the residents in dining room B had to be there because they required assistance or supervision with eating. At 12:18 p.m. the East dining room had five residents in the dining room. Two were seated at a dining room table across from each other. Staff moved one of these residents to the nurse's station where an overbed table had been set up to accommodate his lunch meal, leaving the other four residents at individual tables, approximately six feet apart. At 1:51 p.m. TMA-A stated the facility had provided training on COVID-19, stating the training included keeping residents six feet apart. On 4/9/20, at 3:05 p.m. an interview was conducted with the DON. The DON stated she did not know the measurements of the dining room tables, and verified some residents were seated closer than six feet from one another. The facility policy Coronavirus (COVID-19) revision date 4/2/20, directed group activities and communal dining should be canceled until further guidance is provided. Residents requiring assistance or supervision with eating may continue to be served meals in the dining room or common area, as long as they are without symptoms of a respiratory illness. The facility will make every effort to maintain social distancing of at least six feet between residents.

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