| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245636 | A. BUILDING _____ B. WING _____ | 05/13/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| MN VETERANS HOME FERGUS FALLS | 1821 NORTH PARK FERGUS FALLS, MN 56537 |

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) |
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| F 0880<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Many | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and document review, the facility failed to cease communal dining practices per the Centers for Medicare & Medicaid Services (CMS) QSO-20-14-NH directive dated 3/13/20, in order to control and prevent the transmission of COVID-19. This practice had the potential to affect 94 of 95 residents who resided in the facility and ate in three facility dining rooms. Findings include: During a tour of the East wing on 5/12/20, at 11:54 a.m. staff were observed wheeling and assisting residents off the unit. At this time, licensed practical nurse (LPN)-A stated all the residents were being assisted to the main dining room. When asked what alternatives to communal dining had been implemented, LPN-A stated the facility had never ceased communal dining rather, expanded the space in the dining room into the attached chapel and breezeway and added more tables to allow for distancing when in the dining room. LPN-A stated all facility residents ate their meals in the dining room. LPN-A stated the tables had been spread out as much as they could be and for the most part, were set up in a way to ensure six foot distancing was maintained when dining. LPN-A also stated only one to two residents were seated at each table and that each resident and staff member knew to be mindful about maintaining appropriate distancing when entering and exiting the dining room. LPN-A stated in the event of a COVID-19 positive resident, the facility had a plan in place to halt communal dining and have the residents eat in their rooms, however, this would not be implemented until a COVID-19 positive resident or community member was identified. LPN-A stated at no time were the staff or residents told that they had to eat in their rooms or halt communal dining. At 11:55 a.m. nursing assistant (NA)-A verified all the East and West unit residents ate their meals in the same dining room unless a resident requested to eat in their room, which occasionally occurred. NA-A stated a curtain had initially been placed in the main dining room so that each unit was separated in order to prevent any potential spread of the COVID-19 virus between the units. However, NA-A stated the curtain had been taken down and replaced with hazard/caution tape. NA-A stated two to three residents sat at each table and that the level of assistance a resident required determined the number of residents at each table. NA-A verified since the start of the COVID-19 pandemic, there had been no changes to the facility's dining practices and at no time had communal dining been halted rather, the focus was to keep each resident on their respective unit. During tour of the West wing on 5/12/20, at 12:01 p.m. staff were observed wheeling and assisting residents off the unit. At 12:09 p.m. registered nurse (RN)-A verified all of the residents on the West unit were out of their rooms for the lunch meal. RN-A indicated they separated the East and West unit residents in the dining room and spread the residents throughout the room to maintain six foot social distancing however, had not discontinued communal dining at this time. At 12:15 p.m. upon entry to the dining room, the room was noted to be divided into two sections. Hazard/caution tape was used to cordon off an area in the center of the room, between the two sections. One section was designated for West unit residents and consisted of 15 tables with 32 residents seated 2-3 to a table. Additionally, five staff members were seated at several of the tables. The tables were round and approximately five feet in diameter and not all tables were spaced six feet apart. One table was noted to have three residents and two staff seated next to the residents while assisting them to eat. At this time, a male resident, seated in a wheelchair at a table with two other residents was observed to cough with audible secretions heard without covering his mouth or performing hand hygiene. No staff had approached the resident to encourage covering the mouth or offer and assist him with hand hygiene following the cough. Shortly thereafter, another resident was heard to cough without staff response. On the other side of the hazard/caution tape was an area designated for East unit residents and consisted of 10 tables with 21 residents and six staff members seated 2-4 to a table. A breezeway area, set up outside the main dining area, contained four tables with eight residents seated two to a table in a single row. The tables were arranged so that the wheels of the wheelchairs of two residents at adjacent tables and seated back to back were approximately 1 foot apart. At 12:31 p.m. the dining services supervisor (DSS) indicated they had spaced out the dining area and expanded into the chapel area as well as divided the dining room into specified sections for the East unit and West unit residents and tried to maintain social distancing. The DSS stated the facility had considered having the residents eat in their rooms and stagger meal times, but had not implemented either option. DSS indicated he could not say when or if such a plan would be implemented as it was up to leadership. DSS indicated the breakfast meal was an open style breakfast which occurred from 7:30 a.m. to 9:00 a.m. so the dining area was less crowded however, stated the evening meal was very similar to the noon meal. At 12:31 p.m. upon entrance to the Village unit, two dining rooms were noted to be separated by an open door/walkway. Each dining room held six tables, with two to four residents seated at each table eating their meals. The North dining room was noted to have one table with four residents eating with two staff seated next to them assisting the residents to eat. In the South dining room, staff were noted to be seated at a table with two residents while assisting the residents to eat. At 12:34 p.m. dietary aide (DA)-A stated 11 residents ate in the North dining room and nine in the South dining room. DA-A stated none of the Village unit residents ate in their rooms and when asked, denied any changes to the dining practices having been implemented since the start of the COVID-19 pandemic. DA-A stated other than having daily health screenings performed upon arrival to work and having to wear masks and face shields when working, nothing else had changed with his daily work details or dining practices. At 12:39 p.m. NA-B verified the facility continued communal dining and stated none of the residents ate in their rooms. NA-B stated during dining, the staff try to keep the residents socially distanced, but added, the residents do congregate. NA-B stated the dining tables were approximately five feet in diameter but not six feet apart from each other. At 12:43 p.m. licensed practical nurse (LPN)-B stated there had been not a whole lot of changes made to dining practices and as of yet, there were no residents who ate their meals in their rooms. LPN-B stated when all the residents were in the dining room, the staff do the best they can to maintain the appropriate six foot distancing. NA-B also stated that the residents would continue to participate in communal dining until the facility had a few positive cases of COVID-19 at which time, the residents would be directed to eat in their rooms. NA-B verified no plan had been implemented to halt communal dining and added, the staff would hate to see the residents confined to their rooms. At 1:32 p.m. the director of nursing (DON) and administrator indicated they were aware of the CMS directive however, verified the facility had not ceased communal dining and indicated the plan was to implement residents eating in their rooms once a positive COVID-19 case was identified in the facility or transmission was present in the community. Centers for Medicare & Medicaid Services (CMS) QSO-20-14-NH dated 3/13/20, directed facilities to cancel all communal dining and all group activities, such as internal and external group activities. The direction was effective immediately. CMS QSO-20-28-NH dated 4/24/20, provided updated guidance directing residents may eat in dining rooms, however nursing homes should adhere to social distancing, such as being seated at separate tables at least six feet apart. It was further noted eating in dining areas with appropriate social distancing only applied to residents without signs or symptoms of a respiratory infection and without a confirmed [DIAGNOSES REDACTED]. |

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.