| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245382 | A. BUILDING _____ B. WING _____ | 05/07/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **MADISON HEALTHCARE SERVICES** | **900 SECOND AVENUE MADISON, MN 56256** |

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><br>Based on observation, interview, and document review the facility failed to actively screen employees prior to entry or appropriately train staff on signs and symptoms of COVID-19 in accordance with Centers for Disease Control (CDC) and Centers for Medicare and Medicaid Services (CMS) guidelines for COVID-19. Finding include: Observation on 5/5/20 at 9:25 a.m., of the main entrance to the health care facility identified a table was located in the area immediately inside the first set of double doors. On that table was hand sanitizer, screening forms, and masks. Observation and interview on 5/5/20 at 9:32 a.m.,with maintenance staff (M)-B identified he approached the screening table inside the main entrance of the building, had no mask on and he took his own temperature and documented it on the screening form. He was to check his temperature each day upon arrival to the facility. He was required to wear a source control mask in resident area's. M-B identified contracted workers or visitors were to enter through the main entrance. Staff normally entered the facility from a back staff entrance. The staff entrance required them to enter the facility, walk around a corner where business offices and proceed down the hall to a table inside the front main entrance. Located at this table was a thermometer, binder containing all staff screening forms, and hand sanitizer. Observation and interview on 5/5/20 at 10:00 a.m., with nursing assistant (NA)-A identified staff were to screen themselves when coming into work prior to entering resident areas. She had came on duty at 5:30 a.m. and donned a mask, but was late for shift and had forgotten to screen herself by taking her temperature and complete screening form prior to working with the residents. NA-A identified she had reviewed the information related to symptoms of COVID-19 but could not recall specific information. She had received training on use of personal protective equipment (PPE) and hand washing but could not recall the date. NA-A was informed of COVID-19 symptoms, but had only been aware of the limited information identified on the self-screening form and was unable to identify additional signs or symptoms of COVID-19. Interview on 5/5/20 at 12:50 p.m., with dietary manager (DM) identified that a staff member in her department had tested positive for COVID-19 on 5/1/20, cook (C)-A had worked her full shift on 4/25/20, with no mention of not feeling well. DM identified C-A had not reported any signs or symptoms of illness to anyone in the dietary department that day. She identified C-A had not been scheduled to work on 4/26/20, and 4/27/20. On 4/28/20 at 1:21 a.m., DM received a text message from C-A identifying she could not make her shift. C-A had reported feeling ill, had body aches and had vomited. Further interview on 5/7/20 at 10:24 a.m., with DM identified she came into work on 4/28/20 but did not inform anyone of C-A's symptoms or that she had called in sick. The DM notified the IP at 10:00 a.m., of C-A call-in and symptoms who then contacted the triage nurse at the clinic. The DM identified she had not attended COVID-19 meetings. She received her information for COVID-19 updates via email. The DM was not updated of the new COVID-19 symptoms from CDC, and was unaware C-A's symptoms were associated with COVID-19. Staff received COVID-19 updates in an orange communication binder at the screening table located at the front entrance and via reading material on the computer. The DM was unable to identify who had reviewed the COVID-19 updates because staff were not expected to sign the reviewed information. Her expectation was for staff to review the information provided on the screening table before starting their shift. Interview on 5/5/20 at 1:12 p.m., with dietary aides DA-A and DA-B identified both self-screen. Both said they received no formal training, only emails. For staff who do not read emails they would not know about the training. Neither DA-A nor DA-B were aware of reportable signs or symptoms for COVID-19. Interview on 5/5/20 at 1:18 p.m., with the chief financial officer (CFO), identified she completed a self-screen upon entry to work. She was unaware of the COVID-19 signs and symptoms to identify. The CFO identified it would be helpful if the information was listed on the screening form. Interview on 5/5/20 at 1:20 p.m., with housekeeping supervisor (HK)-A identified the facility protocol was for staff to self screen and if their temperature was above 99.0 degrees Fahrenheit (F) they should not enter the building. Interview on 5/5/20 at 1:27 p.m., with licensed practical nurse (LPN)-A identified if a staff person had a temperature above 100.3 F when they self screened they were to notify the DON, contact the doctor and probably receive a virtual visit. Interview on 5/5/20 at 3:23 p.m., with the director of nursing (DON) identified anyone with a fever above 100.0 F, a cough, or who had been around someone with COVID-19 would not enter the building but would go to their car and call their supervisor. DON identified staff were to find communication or updates in the orange binder or on point click care (PCC) under communication. DON identified training on use of the thermometer was located in the orange binder or on PCC. The DON identified she and the administrator had investigated the need to meet and greet staff when they entered the facility and their findings were, it was not necessary and staff were permitted to self screen. Her expectation was that staff were self-screening upon entering the facility for their shift. Interview on 5/5/20 at 3:57 p.m., with administrator identified his expectation was for all employees to self screen upon entering the facility. He sought consultation regarding staff screening, and determined self-screening was adequate. Interview on 5/6/20 at 1:15 p.m., with cook (C)-A identified on 4/25/20, she arrived at work, screened herself and began her shift. C-A identified she had felt tired on 4/25/20, had a loss of appetite, and had general nausea. She felt those were her usual symptoms for her menstrual cycle. She was able to work her full shift on 4/25/20 despite not feeling well. On 4/28/20 at 1:21 a.m., her symptoms worsened and she developed body aches and vomited. The triage nurse (RN) contacted her the afternoon of 4/28/20, to review symptoms and informed her she would need to go in for a COVID-19 test and scheduled a time. On 5/1/20, she received the positive COVID-19 test results. C-A identified she had not been educated in regards to the signs and symptoms of COVID-19 other than what was listed on the screening form. She had not received training on the screening process. She only knew what she learned on the television and what signs and symptoms were on the screening form for COVID-19 symptoms. C-A identified she had followed directions for taking her temperature and answered the four questions on the form. She was unaware she needed to report the occurrence of symptoms on 4/25/20, consisting of headache, nausea, tiredness, and loss of appetite as she was not aware these could be symptoms of COVID. Review of COVID-19 screening book identified C-A's 4/25/20, self-screening form identified: her temperature was 97.4 degrees Ferenheiht (F). C-A checked no to identify she had no contact with anyone confirmed with and/or suspected COVID-19, or anyone with respiratory illness. C-A denied respiratory infection (cough, shortness of breath, sore throat). C-A checked she had not traveled out of the country, or resided in a community with known cases of COVID-19. At the bottom of the form was a notation If you are self-monitoring, notify your manager of any of the signs and symptoms above. If you are at work with symptoms present, notify your manager. No additional symptoms of COVID-19 were included on the form. Interview on 5/6/20 at 1:24 p.m., with nursing assistant (NA)-B identified she had received training on wearing a mask and protective gear. NA-B further identified she was unaware of what would happen if she became ill during work. Interview on 5/6/20 at 5:15 p.m., with the DON identified she had only provided training to the nursing department. Other departments were expected to provide their own training or arrange it with the IP. The DON identified it was each staff's responsibility to review the list of symptoms on the outside of the screening binder and review the orange binder for updates. The DON further explained the department supervisor was responsible to ensure staff knew what the signs and symptoms of COVID-19 were, and when they were restricted from work. The DON had not overseen the process for training or ensuring staff were actively screened. There was no documentation to support the DON or |

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.

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| F 0880<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Many | (continued... from page 1)<br>administrator had performed any oversight to ensure compliance. Interview on 5/7/20 at 9:14 a.m., with the Infection Preventionist (IP) identified she was aware that staff were expected to screen themselves prior to entering the building and caring for residents. Staff were to take their own temperature and complete a four question form. The forms were located in an binder on a table inside front entrance door. IP identified she had not provided the training to staff on how to screen themselves or on the signs and symptoms of COVID-19. The IP was unaware of who or how often staff screening sheets were reviewed. She identified employee screening questions were not current and she had not been involved in the creation of the form. She identified COVID-19 meetings were held three times a week, but did not include all departments. The IP identified the dietary manager and activity manager did not attend. She identified each department manager is responsible for providing training to staff in their department. The IP identified there was no training packet available for COVID-19 which included signs and symptoms, or detailed the screening process for employees. She received updated information weekly from listening to the long term care (LTC) calls every Wednesday. Interview on 5/7/20 at 12:49 p.m., with medical director (MD)-A identified staff should be actively screened upon entry to facility. He agreed someone who had symptoms would be identified through an active screening process. MD-A felt the facility may have struggled to implement active screening due to staffing issues and work schedules he was aware of. MD-A agreed facility management needed to have oversight of all COVID-19 activities to ensure each staff was trained appropriately and followed policies and procedures. Interview on 5/7/20 at 2:00 p.m., with director of environmental services (ES) identified that in the past there had been an educator in charge of staff training but those duties had been delegated to the department managers. He identified it would be beneficial to have an education coordinator that could work with the infection control preventionist at this time to improve the training and implementation of protocols. He identified currently his training had mostly been provided by the ambulance service, of which he was a member. He identified that the training material he provided to staff in his department came from the Department of Health (MDH) or Centers for Disease Control and Prevention (CDC). He ensured staff in the environmental service department signed and dated updates after they were reviewed. Review of the 3/16/20, all staff memo identified staff were to report to the DON prior to the start of their shift to review the process for COVID-19 screening. The memo included four screening questions and how to measure a temperature. An electronically created staff list with nursing department names and dates of training completion was included. Review of the nursing department list identified NA-A was not included in the list to verify she received training. No additional documents were provided to identify all staff were trained to screen for the additional COVID-19 symptoms identified by the CDC, and to report them to the IP or DON if symptoms were present. Review of the 4/20/20,(NAME)Healthcare Services Coronavirus (COVID-19) policy identified the goal was to reduce transmission, protect healthcare personnel, decrease mortality and preserve the functions of healthcare. The policy identified staff were to self-monitor by taking their temperature every shift and document it. Staff were to notify their supervisor of the development of symptoms including fever and/or respiratory symptoms. The policy made no mention of the parameters and made no mention of what the respiratory symptoms were. Additionally, the policy did not include additional symptoms identified by the CDC. Copies of communication emails from management to staff had been requested but not provided. |