| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **245333** | A. BUILDING _____ B. WING _____ | **10/02/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **FAIRFAX COMMUNITY HOME** | **300 TENTH AVENUE SOUTHEAST FAIRFAX, MN 55332** |

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 0886<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Some | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on document review and interviews, the facility failed to test all staff for COVID-19 after an outbreak occurred, and failed to perform weekly testing for a high county positivity rate. The facility's failure resulted in an immediate jeopardy (IJ) due to the risk of transmitting the COVID-19 virus to 24 of 24 residents, all staff and any visitors to the facility. Findings include: The IJ began on 8/18/20, after it was discovered the facility failed to test all staff after a new COVID-19 outbreak case was reported, and was identified on 10/2/20. The facility administrator was notified of the immediate jeopardy at 11:55 a.m. on 10/2/20. The immediate jeopardy was removed on 10/2/20, at 3:15 p.m., but noncompliance remained at the lower scope and severity level of F, widespread with no actual harm with potential for more than minimal harm. The facility's Positive COVID-19 Case Report dated 9/18/20, included an investigation document completed by the director of nursing (DON) (unknown date) indicating a contracted service provider cared for four residents in the facility on 9/12/20. The investigation further indicated the contracted service employee was notified as testing positive for COVID-19 on 9/17/20, and notified the facility of the positive results on 9/18/20. The facility's documentation indicated they had tested twenty-four residents with the point of care [MEDICATION NAME] testing equipment, BD Veritor, for rapid detection of [DIAGNOSES REDACTED]-CoV-2 (rapid test). The documentation indicated results for one resident were identified as negative 9/16/20, and the other twenty-three residents test results were identified as negative on 9/21/20. The facility's staff testing documentation, indicated there are fifty-four staff actively working at the facility. Further, the documentation indicated COVID-19 testing of staff began with the BD Veritor on 9/19/20, and concluded on 9/29/20. The testing document indicated: ten of eleven dietary staff, four of four housekeepers, two of three activities staff, two of two office staff, one of one environmental services staff, two of two maintenance staff, and three of twenty certified nursing assistant (CNA) staff listed on the facility staff roster were not tested during outbreak testing. Review of QSO-20-38 directed: Testing Trigger - Outbreak (any new case arises in the facility); Staff - Test all staff that previously tested negative until no new cases are identified; and Residents - Test all residents that previously tested negative until no new cases are identified. Review of QSO-28-38 directed: routine testing for COVID-19 should be based on the extent of [MEDICAL CONDITION] in the community, therefore facilities should use their county positivity rate in the prior week as the trigger for staff testing frequency. The facility's county positivity rate documented 9/28/20, indicated their county had a positivity rate of 6.3%, which directed testing be completed weekly until the positivity rate remained lower than 5% for two weeks when they could reduce testing to monthly. There was no documentation that weekly testing was conducted. During an interview on 10/1/20 at 10:11 a.m., the DON stated the facility has been doing the rapid testing because they currently do not have a laboratory contract for the facility. The DON stated a contract was in process, but the response has been slow. The DON stated the facility does not have enough staff to conduct the testing so they had reached out to a contracted laboratory to assign staff to perform testing as required for residents and staff. During an interview on 10/1/20 at 10:27 a.m., the DON presented their facility's COVID-19 testing plan. The DON stated the facility had been performing monthly testing but now with the higher community rate that was discovered 9/28/20, the facility would be required to conduct weekly testing. During an interview on 10/2/20 at 9:00 a.m., the DON stated, There isn't enough time to do the testing due to numerous staff on medical leave. Resident care comes first and there is only so much time to complete those cares. No one else in the facility has been trained on the rapid test and the workload prevents other staff from conducting the testing. The DON added, Not all staff were tested because there was only enough time to test staff that have direct interaction with residents. During an interview on 10/2/20 at 12:00 p.m., the facility's administrator stated, The DON is trying to do the best she can but with multiple staff out on medical leave, there just wasn't enough time to do the testing. The immediate jeopardy that began on 9/18/20, was removed on 10/2/20, when the facility was able to verify they'd contracted with a laboratory to process COVID-19 test swabs for the facility. The facility was able to verify their ability to obtain testing swabs and made plans to test all residents and staff by 10/6/20. The facility will follow QSO 20-38 for subsequent testing schedule. The facility is continuing to finalize their contract with an outside laboratory to provide onsite testing services. |

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.