STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING _____ B. WING _____	04/28/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GIL-MOR MANOR	96 THIRD STREET EAST MORGAN, MN 56266

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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to actively screening staff prior to entry and appropriately remove personal protective equipment (PPE) prior to exiting 1 of 1 resident (R1) room in accordance with Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control (CDC) guidelines for COVID-19. This had the potential to effect all 28 residents. Findings include: SCREENING Observation and interview on 4/28/20 at 8:40 a.m., with social services designee (SSD)-A and registered nurse (RN)-B identified SSD-A arrived for her shift that day. SSD-A entered through the first door wearing a source mask and proceeded to take her own temperature and complete her own risk assessment tool screening. SSD-A walked into the facility to her office and dropped her personal items off. SSD-A proceeded through a sittiing area and the dining room to the nurse's station. SSD-A handed her self-completed risk assessment to RN-B who reviewed her answers and placed the completed tool in a folder. RN-B would review the risk assessment tool for staff who brought it to the nurses' station to ensure nothing was concerning and no further screening was required. SSD-A and RN-B identify that was the facility's usual practice. No staff were actively screened at the point of entry. Review of the undated Risk Assessment tool identified staff were to answer all questions: 1) What is your temperature? 2) Have you had a temperature 100 degrees Farenhight (F) or greater in last 24 hours. 3) Do you have a new cough? 4) Do you have new shortness of breath (SOB) and or chest tightness? 5) Do you have new respiratory symptoms that are not related to a previous diagnoses? 6) Have you had close contact with a person with suspected or confirmed COVID-19 within the last 14 days? 7) Have you visited an area with high incidence of COVID-19 within the last 14 days? 8) Have you traveled to a CDC restricted country within the last 14 days? 9) Have you had close contact with a person who has traveled to a CDC restricted country in the last 14 days? If you reply YES to any of the above risk factors or your temperature is greater than 99 degrees F, use the radio to be further assessed by staff prior to entry. Please turn into nurses station for evaluation when completed. Observation on 4/28/20 at 9:19 a.m., of the administrator-(A) identified after entering, The A completed her own risk assessment form, took her temperature, and walked through a sitting area by the entry on her way to her office to drop off her personal items. A proceeded through the sitting area and dining room to the nurse's station. The A handed RN-C her self-screening form. RN-C then placed those results into a folder. The A was not actively screened at the point of entry. Observation on 4/28/20 at 9:35 a.m., of the North exit door identified signage was posted designating the entrance for contracted physical therapy (PT) and occupational therapy (OT) staff. A small platform stand was placed directly inside of the doorway. A thermometer, ear probes, pen, blank Risk Assessment tools, and two completed Risk Assessment tools sat on the platform. Of the two completed risk assessments, neither had been signed off by a witness. Interview on 4/28/20 at 9:41 a.m., with housekeeping staff (H)-A identified staff were to come into the facility wearing a source control mask. Once inside, staff were to take their own temperature, and fill out the COVID risk assessment tool questionnaire. They would then bring the tool to the nurse's station for the nurse on duty to review. If staff had a temperature above 99.5 or said yes to any of the questions, they were not to enter the facility. Staff were to use the walkie-talkie to call the nurse to the entrance for physical assessment of symptoms and or further examination of any questions answered yes. Review of the Resident Symptom Screeing for COVID-19 identified the forms had prefilled resident room and name, followed by slots to record tempurature, oxygen level, and the presence or absence of cough, SOB, sore throat, diarrhea and included a spot to ensure staff reminded residents to perform hand hygiene.The forms had been filled out twice per day for 4/21/20, 4/22/20, 4/23/20, 4/24/20 and 4/25/20 by activies staff. Those forms were not filled out in the same manner each time.Some staff placed check marks each of the boxes, some staff wrote ok at the top and drew a line down the page, connecting each resident. It was unclear if check marks identified the presence or absence of symptoms or what signs and symptoms would be abnormal and cause to immediately inform the nurse. Of those screenings, on: 1) 4/21/20, 4/22/20, and the 4/24/20 screenings were not signed off by the nurse until 4/27/20. 2) 4/26/20, no resident screening occurred and there was no mention licensed nursing staff ensured screeing occured that day. If any of the symptoms were present, licensed nursing staff were to be made aware immediately. The nurse would then evaluate if symptoms were explainable or suspicious for COVID. If symptoms were suspicious staff were to isolate the resident to their room, close the door, wear a mask, and call administration immediately for further instructions. Interview and docuement review on 4/28/20 at 10:00 a.m,, with RN-B identified resident screenings were completed by activities staff using the Screening for COVID-19 log and return to the nurse. Nurseing staff were to review and sign off to review each resident screening was completed. Nursing staff were to complete the resident screening if the activities staff had not. RN-B confirmed nursing had not always evaluated the forms that same day. On 4/26/20, resident screening had not been completed. RN-B was unaware who was to oversee the completion of the forms by activities or nursing staff. Interview on 4/28/20 at 10:00 a.m., with activities aide (AA)-B identified nursing staff had instructed her how to take resident temperature and oxygen saturations. Activities staff were to complete the resident assessments by taking the temperature and oxygen saturations and asking the residents the questions of cough, shortness of breath, sore throat, or diarrhea. She was to remind them to wash their hands and document on the Resident Symptom Screening for COVID-19 form and give to the nurse when completed. AA-B was to notify the nurse of any temp higher than 99.0 degrees F or oxygen saturations lower than 90%. Activities staff do not work every other sunday and failed to complete the screening on 4/26/20. There was no mention how the activities aide, although trained to take temperatures and oxygen levels, was able to assess residents for other potential signs and symptoms of COVID with no health background in assessment. Interview on 4/28/20 at 12:38 p.m., with AA-A identified activites staff were to complete the resident screenings. She had been trained how to take temperature and oxygen saturations at another facility. She completed the Resident Symptom Screening for COVID-19 form by taking the residnets temperature, oxygen saturations and asked the questions on the form. After completion of the form it was given to the licensed nurses. There was no mention how the activities aide, although trained to take temperatures and oxygen levels, was able to assess residents for other potential signs and symptoms of COVID with no health background in assessment. Interview on 4/28/20 at 1:28 p.m., with the DON identified she was unaware of what training had been provided to the activities staff regarding completion of the resident screening and was unaware of those staff holding any healthcare assessment background. The DON indicated activities staff knew how to take a resident's temperature or oxygen level and give the daily screening sheet to the nurses when completed. The DON was unaware there was no resident screening completed on 4/26/20 nor the 4/21/20, 4/22/20 and 4/24/20 screenings were not reviewed by a nurse until 4/27/20. Her expectation was resident screenings were to be completed by nursing staff if activities staff were unavailable to complete the screening. Nursing staff should have reviewed the screenings in a timely manner. She was unaware of a policy regarding the screening of the residents. Interview on 4/28/20 with RN-B infection preventionist identified she had trained the activities staff how to take a temperature and check oxygen saturations. This included waht temperatures and oxygen levels to report to the nurse. what symptoms to ask the residnets and remind the resident to perform hand hygiene. Licensed nurses were to review the forms right away and make sure the information was accurate and further assess if indicated. Nursing staff were to complete the resident screenings

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 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 1) in the abcense of activities staff. Interview on 4/28/20 at 3:06 p.m., with the administrator identified she was unaware that no screening was completed on 4/26/20 or that the 4/21/20, 4/22/20 and 4/24/20 screenings were not reviewed by a nurse until 4/27/20. Her expectation was that it would be completed by nursing staff if activities staff were unavailable to complete the screening and licensed nurses would review the screenings in a timely manner. Review of 4/9/20, About Coronavirus 2019 Update memo identified all staff were to monitor and be aware of COVID-19 symptoms. Those symptoms were fever, cough, SOB, muscle aches, headaches, sore throat, diarrhea and loss of taste or smell. All staff were to monitor and be aware of COVID-19 symptoms. Those symptoms were fever, cough, SOB, muscle aches, headaches, sore throat, diarrhea and loss of taste or smell. If staff had any of those symptoms, they were to notify the charge nurse or administrator immediately. A licensed nurse was to evaluate those symptoms. There was no indication those symptoms were updated on the above Risk Assessment Tool to potentially restrict staff and visitors who had those symptoms in accordance with CDC guidelines or have a licensed nurse evaluate for active screening as mentioned above. Review of 4/20/20, Therapy Changes Policy and Procedure During COVID-19 identified PT and OT were to be actively screened by nursing staff prior to entrance to the facility. There was no mention how that process was to be audited for compliance. PPE Observation and interview on 4/28/20 at 10:00 a.m., of R1's room with PT-B identified PT-B had provided therapy to R1. R1 was on isolation precautions. Directly outside the room were bins for contaminated linen and trash. Without removing her PPE, (PT)-B exited R1's room wearing face mask, face shield, gown and gloves and the electronic stimulation machine (ESM). PT-B identified she had disinfected the ESM prior to removing it from the room. R1 was placed on quarantine status due to recent admission on 4/21/20. PPE was to be removed outside the room in the hallway and contaminated PPE placed in either the waste paper basket or bin marked gowns. PT-A would enter the facility to begin her shift through the North door. PT-A performed her own self-assessment and laid the paper on the desk at that entrance. No facility staff actively screened PT-A. R1's 4/27/20, admission Minimum Data Set (MDS) identified R1 was admitted to the facility on [DATE] after a hospital stay. R1 was placed on a 14 day isolation for potential exposure to COVID-19 in the hospital. R1 had no signs or symptoms of COVID-19 at that time. Interview on 4/28/20 at 11:15 a.m., with registered nurse (RN)-B identified staff were to don PPE before entering R1's room and doff PPE outside of R1's doorway. A waste paper basket and a bin marked soiled gowns set right outside of R1's doorway in the hallway. RN-B identified she was responsible for training staff. She used CDC guidelines to train staff. RN-B was unaware CDC guidelines required PPE to be removed inside of the resident's room prior to exit. RN-B agreed removing PPE outside of an isolation room was not within CDC guidance. Interview on 4/28/20 at 11:30 a.m., with nurse aide (NA)-A identified all facility staff entered through the front door. All other doors were to be locked from the outside. R1's room was located close to the North door. PT and OT entered the facility through the North entrance located close to R1's room. PT and OT are the only persons allowed to enter through a separate door as R1 was quarantined in that area of the facility. Interview on 4/28/20 at 1:27 p.m., with director of nursing (DON) identified designated entrance for OT and PT was the North entrance. OT and PT were instructed to take their own temperatures and complete a Risk Assessment form. The DON agreed PT and OT were not actively screened prior to entering the building. All staff were expected to self-assess signs and symptoms of COVID-19. If staff answered yes to any questions on the Risk Assessment Tool, they were to call the nurse via walkie-talkie to actively assess them at that time. The DON agreed self-assessment was not active screening. Interview on 4/28/20 at 3:06 p.m., with the A identified her expectation was when therapy arrived at the facility they were to be screened prior to entrance by facility staff. PT and OT were to notify staff to screen them upon arrival. She was unaware PPE was removed inappropriately outside of R1's room. The A explained R1 was in a secluded hallway, therefore, removing PPE in the hallway was not of concern. The A was unaware active screening for all staff or visitors was required by CDC and CMS to occur prior to entrance to the facility. Review of undated, How to Safely Remove PPE equipment identified all PPE was to be removed prior to exiting the patient room. Review of 4/9/20, About Coronavirus 2019 Update memo Staff were to take time to familiarize themselves with proper donning and doffing of PPE. That was noted to be a critical aspect of infection control and prevention. There was no mention in the update staff were to receive hands on training to ensure they donned or doffed PPE appropriately, or had followed CDC guidance with placement of waste receptacles for PPE and linen to be inside the patient room.