STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245259	A. BUILDING _____ B. WING _____	04/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LUTHER HAVEN	1109 EAST HIGHWAY 7 MONTEVIDEO, MN 56265

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 -** Some	**Provide and implement an infection prevention and control program.** Based on observation, interview, and document review, the facility failed to ensure employees were actively screened prior to entering the facility and cancel communal dining and group activites in accordance with the centers for Disease Control (CDC) and Centers for Medicare and Medicaid Services (CMS) guidelines for COVID-19. This had the potential to effect at least 13 of 79 residents who ate meals in the dining room. Findings include: Observation on 4/9/20 at 8:15 a.m., of the main entrance staff and contracted therapy employees entered through designated entrance which lead into an enclosed entryway separating front door from resident living. Signage indicated facility restrictions and the need for all staff and visitors to stop for active screening. Staff were to proceed to the nursing station to be screened. Interview on 4/9/20 at 8:25 a.m., with the director of nursing (DON) and administrator identified the facility continued to have communal dining. They were aware of the Center For Medicare & Medicaid Services (CMS) QSO-20-14-NH guidance canceling communal dining and all group activities but at this time had not chosen to implement the measures as the facility was attempting to socially distance residents inside the dining room. Observation on 4/9/20 at 8:45 a.m., in the dining room identified 2 residents eating breakfast independently with no assistance from staff. Interviews on 4/9/20, identified at: (1) 8:58 a.m., trained medication aid (TMA)-A identified staff enter facility through the front door and were screened at the nurses station. The residents continued to eat meals in the dining room for meals with meal times staggered, although staff were trying to socially distance residents once inside the dining room. Residents were to be 6 feet apart and have only resident per table. The resident's who required feeding stay in their rooms and staff go into the room to assist with feeding those residents. Residents did not wear source control masks when out of their rooms. (2) 9:08 a.m., with nurses aide (NA)-A identified staff enter the facility at the front door and proceed to the nurses station to be screened. Once there, staff receive a mask to wear for the day for source control. (3) 9:15 a.m., with laundry aide (LA)-A identified staff enter through the main entrance of the facility and were screened at the nurses station prior to beginning their shift. Observation on 4/9/20 at 9:30 a.m., in the East dining room identified 3 residents who were seated at each table were eating breakfast independently. No residents wore source control masks when entering or exiting the dining room. Interview on 4/9/20 at 9:40 a.m., with NA-B identified residents were directed to sit one at a table to dine. Staff would enter the facilty for their shift through the front door, screened at the nurse station, and provided a face mask. Interview on 4/9/20 at 10:26 a.m., with registered nurse (RN)-A identified staff and contracted therapy staff are allowed to enter the facility through the main entrance and be screened at the front nurses station located on facility floor. The interdisciplinary team (IDT) had discussed whether to continue communal dining because residents had been feeling loss of socialization. The IDT determined the facility should allow communal dining for residents who ate independently, and provide social distancing once inside the dining room. RN-A remarked the facility determined the residents were feeling a loss from social isolation. Communal dining was thought to help them to cope. RN-A agreed of those residents eating in the dining room, were self-ambulating into the dining room or were assisted by staff. There was no way to ensure they were not in close contact with one another during that time. Observation on 4/9/20 at 11:05 a.m., identified the East dining room had 8 residents seated at individual tables for the meal. Staff continued to assist additional residents through the hall in close contact to the dining room. None of the residents were wearing face masks while in public areas coming to the dining room and were within close proximity (less than 3 feet). 1 unidentified resident seated in the dining room sneezed and was not assisted to perform hand hygiene. Interview and document review 4/9/20 at 12:00 p.m., with the DON expected staff were to enter the facility through the main front entrance and be screened at the nurse station. The DON agreed, staff had to pass through the resident area to the nurses station. When the weather turned colder, the facility allowed screening process inside and at nursing station. Communal dining and church activities had not been canceled. The facility was trying to socially distance residents. The DON agreed the facility had not followed CMS guidance in canceling communal dining, group activities, or active screening at the point of entry. Interview on 4/10/20 at 2:13 p.m., with the facility Chaplin (FC)-C identified she had provided 1:1 spiritual care in resident rooms and provided Palm Sunday and Wednesday services in the dining room where residents had been located during meal time. Review of the 3/15/20, Suspected (or confirmed) Coronavirus (Covid-19) Outbreak Policy failed to mention staff were to be screened prior to entering the facility for their shift. The facility would continue communal dining but alter seating arrangements of residents to attempt social distancing. Group activities were to be canceled with the exception residents would be allowed to be out in a common area if they were 6 feet apart. There was no mention of source control for residents who were out of their rooms.

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