STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245400	A. BUILDING _____ B. WING _____	04/21/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WABASSO REHABILITATION & HEALTHCARE CENTER	660 MAPLE STREET WABASSO, MN 56293

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 screen staff in accordance with Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control (CDC) guidelines for COVID-19. Additionally, the facility failed to have up-to-date infection control surveillance with ongoing analysis to ensure patterns and trends of all potential infections, including [MEDICAL CONDITION] infections were promptly identified and acted upon. This had the potential to effect all 79 residents. Findings include: Observation on 4/20/20 at 8:30 a.m., identified the designated entrance to the facility for staff was through the back employee door. A sign on the door directed people entering the facility to ring the bell and wait for staff. A table was in the entry way. Face masks, a thermometer, disinfecting wipes, and clipboards with a temperature log and symptom screen logs was on the table. Interview on 4/20/20 at 9:45 a.m., with occupational therapist (OT)-D identified she screened herself when she entered the facility. OT-A would take her own temperature and documented her own results on the COVID-10 screening logs. No facilty staff would be present to actively screen OT-A. Interview on 4/20/20 at 9:50 a.m., with nurses aid (NA)-A identified she completed her own health screening and took her own temperature when she came to work. The facility had no staff present at the entrance to actively screen staff. NA-A identified it was her responsibility to notify the nurse at the desk and wait for further guidance if she had an elevated temperature or other symptoms. Interview on 4/20/20 at 10:00 a.m., with maintenance director (M) -A identified no staff were present at the designated staff entrance to observe staff for signs of COVID-19. She measured her own temperature and documented her answers to the questions on the form at the entrance. Interview on 4/20/20 at 11:15 a.m., with director of nursing (DON) identified staff completed their own screening which included taking and measured their own temperatures. The entrance was not monitored by a staff member to actively screen staff entering the facilty for COVID-19 symptoms. No staff were trained to actively screen for COVID-19. Interview on 4/20/20 at 1:44 a.m., with the administrator (A)-A identified today was her first day of hire. Upon entrance, she now was met by a staff member. She was asked to complete the risk assessment tool. Staff had not actively taken her temperature. A informed the staff that she would not sign the questionnaire as she had not been appropriately screened. A instructed the staff member her temperature needed to be taken by that staff. Her expectation was staff should be actively screened at the point of entry. Going forward, she would ensure staff would be trained in completing the active screening process. Review of the 4/16/20, COVID-19 Facility Guidelines identified all staff must be screened prior to each shift. If a tested temperature is higher than 99.0 degrees F (Fahrenheit), access MUST be restricted. All staff were required to be screened prior to each shift. Temperatures were to be logged on a staff temperature log. Anyone with a temperature above 99.0 degrees F, should be turned away. There was no mention employees are to be actively screened by a trained person prior to each shift. Review of the facility's undated COVID-19 Employee/Visitor Log, documented employee and visitor temperatures, presence of loss of taste or smell, and if they were sent home. Review of the undated Risk Assessment Tool, also to be used in addition to the Employee/Visitor Log identified risk factors included: 1) Persons presenting with fever and symptoms of cough and/or shortness of breath. 2) Persons presenting with acute respiratory symptoms of unknown cause. 3) Persons who traveled to a restricted country within the past 14 days. 4) Persons who had close contact with a person who traveled to a restricted country in the last 14 days. 5) Persons who had been in close contact with a person who had a confirmed case of COVID-19. 6) Persons having two or more risk factors required further investigation and evaluation. The COVID-19 Employee/Visitor Log and Risk Factor Tool documentation for all staff identified the following discrepancies: (1) The 4/14/20, COVID-19 Employee Visitor Log identified NA-B had a temperature of 99.7 degrees Fahrenheit (F). NA-B's Risk Assessment Tool was not included in the 4/14/20, Risk Assessment Tool documention and it was unknown if she was prevented from working, or what steps the facility took to ensure ill staff were not permitted to enter the facility. 2) NA-C's 4/13/20, 4/15/20, and 4/18/20, and 4/19/20, Risk Assessment Tools identified NA-C presented with acute respiratory symptoms with no known cause prior to working those days. The Employee/Visitor Logs identified NA-C was only afebrile, and had no loss of taste or smell and was not sent home. There was no mention staff had reviewed all the information to determine NA-C should not have worked when presenting with potential COVID symptoms. 3) NA-D's 4/17/20, COVID-19 Employee/Visitor Log identified NA-D's temperature was 99.0. NA-D had no loss of taste or smell and was not sent home. NA-D's COVID-19 Risk Assessment Tool identified NA-D had answered No to all risk factor questions. There was no documentation to support the facility had denied entry to the building in the presence of potential COVID-19 symptoms. Further interview and document review on 4/21/20 at 12:20 p.m., with the DON identified staff were screened for symptoms of COVID-19 by monitoring their own temperatures, presence of respiratory symptoms, and exposure to COVID-19 outside of the facilty. The DON expected staff to report symptoms and elevated temperatures identified during the screening process. She expected staff to self-report anytime staff suspected they had symptoms of COVID-19. Staff were to be sent home if they had two or more symptoms. The DON verified no staff had been sent home for elevated temperatures. Review of the COVID-19 Employee/Visitor Logs, the Risk Assessment Tool, and the COVID-19 Facility Guidelines with the DON identified she was aware: 1) NA-D had an elevated temperature and was not aware of any other staff with elevated temperatures. The DON had no concerns with the COVID-19 screening process. The DON identified NA-D had no additional symptoms, and the elevated temperature she felt was likely due to her pregnancy. NA-D's temperature was checked later in the shift to ensure no elevated temperature continued. The DON had no additional documentation available to verify NA-D's continued to be monitored for symptoms of COVID-19. 2) NA-B's 4/14/20, Employee/Visitor Log, Risk Assessments identified NA-B had a temperature of 99.7 F and no Risk Assessment had been completed. The DON agreed she should have been notified of the elevated temperature and a symptom screen should have been completed. The DON had no additional documentation available to identify NA-B's Risk Assessment was completed. NA-D should have been sent home due to a temperature above 99.0 F. No additional documentation was available as evidence to ensure NA-A completed a symptoms screen prior to entering the building. The DON agreed without appropriate oversight and active screening, those staff had been allowed entry into the building. There were no residents symptomatic for COVID-19 at the time of the survey. Review of the facility's infection prevention surveillance documentation identified no infection surveillance was entered after February, 2020. The facility's former infection preventionist maintained infection surveillance data at the sister facility and had no documentation kept at this facility. When the position was terminated, that data remained at the sister facility. After February, 2020, the DON was responsible to ensure ongoing surveillance of all potential infections occurred. Charge nurses completed an individual resident Infection Treatment/Tracking Form when a resident's infection was treated with antibiotics. There were no [MEDICAL CONDITION] illnesses tracked on any resident form. None of those forms were tracked in a main database for infection surveillance. The DON and the pharmacist reviewed the infection forms for bacterial illnesses and medication orders on a monthly basis to identify trends for those treated with antibiotics. The nurses were expected to report suspected infections during daily morning meetings, and contact the DON if any infections occurred when she was out of the facilty. Infection surveillance for other types of infections were discussed in daily

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

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 1) stand-up, however those infections not treated with antibiotics were not tracked or trended in any way. No process was in place to identify and monitor other types of infections in the facilty. Additionally, only infections treated with antibiotics were included in the monthly QAPI infection reports. Review of the Quality Assurance and Performance Improvement (QAPI) committee meeting minutes identified in March, 2020, the facility's infection rate was 21 percent (%). The facility's goal was to have an infection rate of 7%. Six residents had received antibiotics in January, 2020. infections included [REDACTED]. One of six residents was admitted with orders for antibiotics. The minutes made no mention of staff infections, or tracking or trending any non-bacterial infections in the facility. Interview on 4/21/20 at 12:20 p.m., with the director of nursing (DON) identified the facility's infection preventionist position vacated in February 2020. The DON assumed the position. She had not received infection prevention training, and was unable to receive education due to cancellation of education during COVID-19 restrictions. She was not involved in the hiring process, and was unsure if the facilty planned to fill the infection prevention position. Review of the undated Infection Control Guidelines did not include guidelines for surveillance of resident and staff infections in the facilty. A policy was requested for infection surveillance, however, no policy was provided.