

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER <b>245631</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED <b>04/01/2020</b>
NAME OF PROVIDER OF SUPPLIER <b>MN VETERANS HOME - LUVERNE</b>		STREET ADDRESS, CITY, STATE, ZIP <b>1300 NORTH KNISS, PO BOX 539 LUVERNE, MN 56156</b>	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0880  <b>Level of harm</b> - Minimal harm or potential for actual harm  <b>Residents Affected</b> - Many	<p><b>Provide and implement an infection prevention and control program.</b></p> <p>Based on observation, interview, and document review, the facility failed to cancel communal dining and scheduled group activities, implement active screening of staff upon entry to the facility and source control masks, and daily ongoing surveillance of all infectious processes in accordance with Centers for Disease Control (CDC) and Centers for Medicare and Medicaid Services (CMS) guidelines for COVID-19. Findings include: COMMUNAL DINING AND ACTIVITIES Interview on 3/30/20 at 11:10 a.m., with the life enrichment coordinator (LEC) identified communal resident activities continued to be offered but had been limited to 10 residents or less. Dining had been changed to keep residents in the unit they reside with meals continued to be served communally in each dining room located down Green hallway, main dining room, and special care unit. Each table has anywhere from 2 to 4 residents. Observation on 3/30/20 at 11:30 a.m., in the dining room of the Green hall identified residents were seated together for the noon meal. Tables were less than 6 feet apart and there were 3 to 4 residents seated at each table. Observation on 3/20/19 at 11:45 a.m., identified residents in the Red hall were congregating at the nurse station to wait for meal service to begin. Residents sat in close proximity, some shoulder to shoulder, in the entrance of the dining room near the nurses desk. Interview on 3/30/20 at 11:45 a.m., with TMA-A identified residents continued communal dining on the halls they resided. Residents were placed near the nurses station to wait for their meal and get their medication. Observation on 3/30/20 at 11:55 a.m., of special unit dining room identified 2 to 4 residents sitting at a table. Interview and document review on 3/30/20 at 12:20 p.m., infectious control (IC) identified residents continued to have communal dining and group activities and were not canceled as it was felt to have a potential negative effect of and depression and potential increased behaviors. Group sizes were decreased to a limit of 10 residents at each activity and social distancing was to be practiced. She was aware staff would push residents in wheelchairs into groups by the nursing station for medication pass while remaining ambulatory residents would wait in the same line for medication and agreed that failed to follow guidelines for appropriate COVID-19 related precautions. Interview on 3/30/20 at 12:52 p.m., with director of nursing (DON) identified staff were to keep residents as far apart as possible and avoid placing residents next to each other within 6 feet. DON identified canceling communal dining had been discussed but was not implemented as management felt it would be a burden for the resident's during this difficult time. The DON agreed staff the facility had not followed CMS guidelines to cancel all communal dining and group activities. There was the potential for an asymptomatic (no signs or symptoms) resident to spread the highly contagious infectious disease COVID-19 when dining activities were not canceled. Interview on 3/30/20 at 1:00 p.m., with activities director (AD) identified activities do not have a policy in place to stop all group activity and continued those activities. She had limited them to 10 or less residents. Interview on 3/30/20 at 1:05 p.m., with dietary manager (DM) identified dining room seating was the DM's responsibility. The DON had planned to space resident's further apart or even stagger meals but had not implemented any changes. The DM was unaware of CMS guidance to cancel communal dining. Review of the 3/20/20, COVID-19</p> <p>Precautions Update email identified Red and Green halls and Special Care Unit residents were to dine at separate meal times in their own hall. Communal social hour was canceled in the main dining area. Activities staff were to reduce group sizes and conduct activities separately on each wing. Staff screening was to be moved to the employee entrance. SCREENING Observation on 3/30/20 at 10:30 a.m., of nurse aid (NA)-C identified she left the facility out of the Green Hall door exit and entered her car to leave for lunch break. Interview and observation on 3/30/20 at 11:04 a.m., with NA-A identified staff were to enter and exit the facility through the employee door located in the basement (lower level). Residents continued to have group activities. Residents come out to the dining room for communal meals with 2 to 3 residents seated at each table. Interview on 3/30/20 at 11:10 a.m., with the life enrichment coordinator (LEC) identified staff had been directed to use the Employee Entrance door downstairs to enter and exit facility. Each worker before starting their shift are to enter the building and proceed to either the Red or Green hall nurses station for screening before starting their shift. No staff were actively screened occurred at the entrance prior to walking into the building. An observation on 3/20/20 at 11:15 a.m., trained medication aid (TMA)-A entered through the Red-Wing's north entrance close to the staff parking lot. This entrance was not a designated entrance during COVID-19 infection prevention practices. Interview and observation on 3/30/20 at 11:20 a.m., with licensed practical nurse (LPN)-A identified staff were screened prior to the beginning of each work shift by entering the facility and reporting to the nurse's station at the hall they are scheduled to work on (Red or Green). Interview on 3/30/20 at 11:25 a.m., with housekeeper (H)-A identified all the facility doors were locked from the outside to prevent persons from entering the building. Staff were able to enter all doors using their name badges but were to enter through the basement or main entrance and report to their assigned nurse station to be screened. If a nurse was not available on their assigned hall, staff could go to the other hall to be screened. Interview on 3/30/20 at 11:35 p.m., with NA-B identified staff have been directed to enter and exit facility from employee entrance and report to a nurse's station for screening. There was a table at the employee entrance for staff to take their own temperature prior to coming into the facility to be actively screened at nursing station. Interview on 3/30/20 at 11:45 a.m., with TMA-A identified staff were to enter the building through the basement entrance. Staff were screened for signs and symptoms of COVID-19 once inside the facility at the nurse station in their assigned hall at the beginning of their shift. During breaks and other times during the shift, staff were permitted to exit the building through the other doors during the shift because they were close to the parking lot. Interview on 3/30/20 at 12:52 p.m., with director of nursing (DON) identified staff were to enter and exit through the employee entrance and were not to use any other entrance. If staff left the facility for their break, it was her expectation they would reenter the building at the employee entrance. The DON agreed the above observation of staff using alternate doors other than the employee entrance was a concern. Interview on 3/30/20 at 2:15 p.m., with NA-C identified staff have been directed to enter and exit facility at employee entrance. NA-C had used the Green hall exit door to leave for lunch and return as she was running late. Observation and interview on 3/30/20 at 2:23 p.m., identified registered nurse (RN)-C entered the facility at the beginning of the shift through the Red hall entrance, walked through the wing to the nurse station, and took her own temperature. RN-C confirmed she entered through the Red hall door at the beginning of the shift. She verified resident rooms were located near that entrance. Staff used their name badges to unlock the doors to enter the building and were permitted to use the Red hall entrance to enter the building. Further interview on 3/30/20 at 2:45 p.m., with RN-B, the infection prevention nurse (RN-B), identified 2 entrances to the facility were utilized. The main entrance and the basement employee entrance. The main entrance had COVID-19 screening area where staff were to be screened prior to entering the building by administration staff. The employee entrance connected to the upper level by an elevator and a stairway. Both opened in the Red wing corridor. If staff used that door, they would have to walk past resident rooms in the Red hall to reach that nurses station. If they were to work in the Green hall, they would continue on across the common area to reach that nurses</p>		

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  <b>Level of harm - Minimal harm or potential for actual harm</b>  <b>Residents Affected - Many</b>	<p>(continued... from page 1)</p> <p>station. RN-B was unaware staff were required to be actively screened at the point of entry to the facility. All staff recorded their own respiratory symptom screening located on a roster in each hall. If a staff member was found to have a temperature, staff would be sent to the Green hall of the facility for additional screening. No oversight or monitoring was in place to ensure staff were actively screened at the point of entry. The nurses at each station were responsible to report to management any staff found to have a temperature greater than 100.0 degrees Fahrenheit (F) or respiratory symptoms of infection. No audits were completed to ensure staff were appropriately screened upon entrance or denied entry if those symptoms were present. The facility does not record temperature when staff were screened. It only included staff names, the date, and an X but no other information was documented. Review of the 3/30/20, Staff Accountability Roster identified staff documented an X in a box labeled COVID Temp. Please X DO NOT record temp. There was no indication on the form if an X indicated staff had or had not had a temperature over the recommended CDC guideline. The roster also included staff names and the times they entered and exited the building. Review of the 3/26/20, Screening Guide by Nurse/Clinical Staff policy identified all staff were to be stopped at the entrance of the building. 1) Staff or visitors were to be asked respiratory symptom questions and perform active screening for possible exposure to COVID-19. 2) Staff and visitors were required to supply the information. If refused, they were not permitted to enter the facility. 3) If staff had a temperature over 100.0 degrees Fahrenheit (F), or answered Yes to any questions, A second-level screening was to be conducted. 4) The second level screening included the type and longevity of symptoms or if symptoms were of new onset, if staff had been on a cruise, in a level -3 COVID affected region in the past 14 days or in contact with a person who tested positive for COVID-19 in the past 14 days. 5) If staff or visitors answered 'Yes to any second-level questions, a third-level screen was to be completed. 6) Information identified during screening a document was to be kept on file at the facility. Review of the 3/26/20, Changes to Staff Covid-19 Screenings email identified a nurse was required to screen all staff who reporting to work. Staff were assigned to the Red and Green wings. Housekeeping, nurses, and homemakers were to report to the wing they were assigned to work. Dietary and laundry staff were to report to the Red wing for screening. Maintenance was to report to the Green wing for screening. All office staff who sign in at the front entrance were to report to the business office for screening by an RN. A nurse on duty was to ask questions and take staff temperatures. All staff were responsible to sign the accountability forms as proof screening occurred. There was no mention why the facility stopped active screening upon entrance to the facility as directed in the Screening Guide above. A 3/27/20, Changes to Staff COVID-19 Screenings email identified nurses were assigned to the main entrance starting at 7:15 a.m., Monday through Friday, to screen staff who entered through the main entrance. Staff entering the building before 7:15 a.m. were to go to the Red or Green hall nurses station to be screened. Each staff was responsible to sign the Accountability Rosters to identify they had been screened. Non-nursing staff were to sign the Accountability Rosters located in their departments. There was no mention how the facility would ensure oversight of the screenings to prevent potential symptomatic staff from entering the building. SOURCE CONTROL Interview on 3/30/20 at 10:45 a.m., with the administrator during the entrance conference, identified the facility had no suspected or confirmed cases of COVID-19. He received the Center for Medicare and Medicaid (CMS)'s Quality, Safety, and Oversight (QSO) memos related to COVID-19 guidelines. The facility had not initiated source control mask use in the facility as even though there was an ample supply of disposable personal protection equipment (PPE) masks. He was waiting for their new supply of cloth masks to be laundered prior to providing staff any source control masks. Observation on 3/30/20 at 10:45 a.m., in the Red hall identified several staff were providing care to residents. No masks were worn for source control by staff. Interview on 3/30/20 at 11:25 a.m., with housekeeper (H)-A identified staff were not required to wear masks. Interview on 3/30/20 at 11:45 a.m., with TMA-A identified staff were not required to wear masks for source control. There was no policy related to source control measure provided by the facility for the prevention of COVID-19. INFECTION SURVEILLANCE Interview on 3/30/20 at 3:20 p.m., with RN-B identified residents and staff who had potential signs or symptoms of COVID-19 were communicated to her by staff emails or verbal communication. Currently, no staff had presented with COVID-19 symptoms. Surveillance was completed by RN-B by checking with each nurse station several times daily, reviewing emails, and resident records. Although RN-B gathered information daily, it was not entered into the facility's spreadsheet to analyze patterns or trends in real time. Current data in the spreadsheet had ended February 2020. RN-B had yet to enter any data for March 2020. Her usual process was to enter data at the end of each month. The facility had no process on real-time tracking and trending or analysis of data. Review of the March 2020, Infection Monitoring Surveillance Record had no data entered into the spreadsheet. Interview on 3/30/20 at 3:30 p.m., with the administrator identified staff were to enter and exit the facility through the main entrance and basement entrance of the facility. No other doors were to be entered by staff or visitors. Staff were to follow guidance provided by the MN Veterans Affairs, Centers for Disease Control (CDC), and CMS for guidance of infection practices for COVID-19. Review of the 3/10/20, Infection Prevention and Control Program policy identified the facility was to comply with regulatory requirements by following the recommendations of the professional infection control organizations, maintaining its infection control policies and procedures, and by providing ongoing staff education. The infection preventionist (RN-B) was responsible to direct day-to-day infection control activities and complete surveillance data collection, evaluation, tracking, reporting, auditing, and coordination. The surveillance program was to include assessing the population and facility risk, selecting outcome measures, collection, analysis, and reporting data as required to analyze trends and changes in infection rates in a timely manner. Outbreak prevention and management identified RN-B was to maintain an active line list and surveillance to readily identify outbreaks as they occurred.</p>		