

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER <b>245372</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED <b>04/27/2020</b>
NAME OF PROVIDER OF SUPPLIER <b>ST LUKES LUTHERAN CARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP <b>1219 SOUTH RAMSEY BLUE EARTH, MN 56013</b>	
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  <b>Level of harm - Minimal harm or potential for actual harm</b>  <b>Residents Affected - Some</b>	<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 implement a comprehensive infection control program to include the Centers for Medicaid and Medicare Services (CMS) COVID-19 recommendations to discontinue communal dining and/or maintain appropriate social distancing for 20 of 21 residents (R1, R2, R3, R4, R5, R6, R7, R8, R10, R11, R12, R13, R14, R15, R16, R17, R18, R19, R20, R21) observed in the Moonlight memory care unit during the lunch meal. This had the capacity to effect all 21 residents residing on the unit. Findings include: On 4/27/20, at 10:40 a.m. activities and nursing staff were observed gathering residents into the dining areas on the Moonlight memory care unit. Staff were assisting with placing residents together at tables (2-3 residents per table), in each dining area located on opposite sides of the kitchenette. The residents were approximately 3-4 feet from each other at each table. When interviewed at that time, the activity director (AD) confirmed all residents ate their meals in one of the 2 dining rooms with no more than 10 residents on each side. AD further confirmed many of the residents required assistance with eating. On 4/27/20, at 11:13 a.m. the food cart arrived for the lunch meal on the Moonlight memory care unit. Nine residents were observed seated together at tables in the dining room to the right of the kitchenette. R10 and R14 were seated together at a table and were able to eat independently after set-up. R7 and R11 were seated together at a table and received assistance from nursing assistant (NA)-A and activity assistant (AA)-A. R2, R12, and R17 were seated together at a table with the beautician providing assistance to R12 and R17, and AD providing assistance to R2. R1 and R21 were seated together at a table and ate independently after set-up. The residents seated together were not socially distanced at 6 feet or more. Two residents, R6 and R15, were observed seated on either side of the counter on the left side of the kitchenette. The residents were approximately 2-3 feet from each other. Nine residents were also observed seated together at tables in the dining room to the left of the kitchenette. R18 and R20 were seated together at a table and able to eat independently after set-up. R4 and R16 were seated at a table together and received assistance from NA-B. R3 and R19 were seated together at a table and received assistance by registered nurse (RN)-A and licensed practical nurse (LPN)-A. R5, R8, and R13 were seated together at a larger round table and received assistance from NA-C and AA-B. The residents seated together were not socially distanced at 6 feet or more. When interviewed on 4/27/20, at 12:09 p.m. LPN-A confirmed the current seating arrangement in the Moonlight dining areas had been implemented since the COVID-19 pandemic. LPN-A stated staff were directed that as long as they do some distancing and have no more than 10 residents on each side, that would be an acceptable arrangement. LPN-A confirmed the residents were not seated 6 feet apart or more at the tables. LPN-A further stated not having enough staff to provide assistance to all the residents who needed help and socially distance at the same time.</p> <p>During interview on 4/27/20, at 12:15 p.m. the director of nursing (DON) indicated dining and social distancing was challenging in the Moonlight wing. The DON indicated they had made dining tables available on both sides of the kitchenette and were doing the best we can. The DON confirmed all 21 residents residing on the unit are served the noon and evening meals together in the dining area. The DON verified residents should be kept as far apart as possible and staff should avoid placing residents next to each other within six feet. The DON agreed residents could be distanced more with a limited number of residents per table. A facility policy dated 3/14/20, included guidance to cancel communal dining. The policy directed: 1. Provide in-room meals service for those that are assessed to be capable of feeding themselves without supervision or assistance. 2. Identify high-risk choking residents and those at-risk for aspiration who may cough, creating droplets. Meals for these residents should ideally be provided in their rooms; or the residents should remain at least six feet or more from others if in a common area for meals, and with as few other resident in the common area as feasible during their mealtime. Staff should take appropriate precautions with eye protection and gowns given the risk for these residents to cough while eating. 3. If residents need to be brought to the common area for dining, do this in intervals to maintain social distancing. a. Attempt to separate tables as far apart as possible; at least six feet if practicable. b. Increase the number of meal services or offer meals in shifts to allow fewer residents in common areas at one time. c. Ideally, have residents sit at tables by themselves to ensure that social distancing between residents can be maintained, or depending on table and room size. d. If necessary, arrange for meal sitting with only two residents per table, focusing on maintaining existing social relationships and/or pairing roommates and others that associate with each other outside of mealtimes. 4. Residents who need assistance with feeding should be spaced apart as much as possible, ideally six feet or more or no more than one person per table (assuming a standard four person table). Staff members who are providing assistance for more than one resident simultaneously must perform hand hygiene with at least hand sanitizer each time when switching assistance between residents.</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.