STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245595	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2025
NAME OF PROVIDER OR SUPPLIER: Good Samaritan Society - Westbrook		STREET ADDRESS, CITY, STATE, ZIP CODE: 149 First Street, Box 218 Westbrook, MN 56183	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 34083 Based on observation, interview and document review the facility failed to have a current, ongoing, system of surveillance to identify potential outbreaks of infectious disease, ensure transmission based precautions were implemented timely, perform root cause analysis to identify patterns of illness in staff or residents, report an outbreak of Norovirus (highly contagious gastrointestinal (GI) virus that causes inflammation of the stomach and intestines), prohibit staff from returning to work until 72 hours from resolution of gastrointestinal symptoms occurred. and ensure 1 of 1 whirlpool tub was appropriately disinfected between resident use according to the manufacturer's directions. This had the potential to affect all 29 residents. Findings include: SURVEILLANCE/ POTENTIAL NOROVIRUS OUTBREAK Review of the September 2024 Monthly Infection Control Report identified 14 antibiotic orders utilized with 231 days of therapy. No staff/family/visitor documentation of illness was provided/identified in the document. Nine residents (R3, R5, R11, R17, R19, R24, R31, R182 and R183) were identified as having received antibiotics. 1 resident (R17) was identified as started on Paxlovid (antiviral medication used to treat COVID-19 symptoms). There was no documentation on the surveillance of a positive COVID diagnosis, date of initiation of S/S, transmission-based precautions (TBP) implemented, with start and stop dates, nor investigation into potential contacts or source of infection. Review of the October 2024, Monthly Infection Control Report identified 10 antibiotic orders utilized with 100 days of therapy. The report identified a COVID outbreak in the facility with 14 residents identified as COVID positive from September were carried over (R5, R9, R10, R14, R17, R22, R23, R24, R31, R133, R134, R185, R186 and R189). One resident (R31) was identified as having COVID and was also receiving an oral antibiotic without documented rational to support treatment for a bacterial infection. One resident was identified to be positive for Norovirus (R11) on 10/14/24, and 5 other residents (R1, R8, R17, R18, and R19) were listed as having GI symptoms on 10/21/24 through 10/26/24. Three residents, R2, R8, and R11, had documented urinary tract infections (UTI). The employee/children/family/visitor log for October 2024 identified 10 staff and/or their family members: 1) Nurse aide (NA)-C tested positive for COVID with onset of symptoms beginning 10/4/24 and returned to work when a negative COVID test was obtained on 10/9/24. (continued on next page)

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.

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

Interview and document review on 1/8/24 at 2:10 p.m., with the infection preventionist (IP) identified 1 resident (R11), began having gastrointestinal (GI) symptoms of vomiting and diarrhea on 10/10/24 which continued resulting in her being transferred to the Emergency Department (ED) on 10/14/24 where she was diagnosed with Norovirus and was hospitalized . Beginning on 10/11/24, the October Infection Summary identified staff members and residents who reported ill with symptoms of vomiting and diarrhea. The facility also experienced an outbreak of COVID which documented as beginning 9/21/24 and extending through October 2024 with 13 residents (R5, R9, R10, R14, R17, R22, R23, R24, R31, R 133, R 185, R 186, and R 189), who were identified as positive for COVID during that time. The IP logged the illness for R11 which was diagnoses as Norovirus but had not done further investigation to identify potential contacts or the potential source of the infection. She had not identified the possible correlation of R11 being diagnoses with Norovirus, and staff members and residents becoming ill with the same type of gastrointestinal (GI) symptoms. The IP identified that due to multiple residents being COVID positive residents were isolated in their rooms, and the facility was not having group activities or dining. Review of the logs for the 2-week period following 10/14/24 Norovirus diagnosis did not identify any additional residents or staff with symptoms of nausea, vomiting or diarrhea. The IP acknowledged there was no surveillance for December 2024. The IP reported she collected infection control data and prepared a summary report at the end of each month that was presented at the QAPI meetings. The IP received both electronic (if the documentation was completed correctly), and verbal notifications from the nursing staff when a resident had an infection, and/or there was a positive culture and sensitively result and/or when they were started on an antibiotic. The IP stated she had been on vacation and had not completed the December tracing information at the time of survey and agreed she had not performed daily, cumulative infection control surveillance. There was no mention of any staff member covering the IP duties while she was away from the facility.

Review of the infection control logs for residents from September 2024 through November 2024, (December had not been completed), failed to document the resolution of the identified infection following the use of antibiotic treatment, nor was there investigation documented as to potential contacts, or sources of the infection. The employee logs of illness September 2024 through November 2024 (December not available), failed to investigate the potential illness and ensure the employees remained off duty for 48-72 hours following the resolution of signs and symptoms.

WHIRLPOOL

Observation on 1/8/25 at 9:16 a.m. with nursing assistant (NA)-B as she performed cleaning and disinfection of the Air Spa Advantage Bathing System. NA-B followed the manufacture's posted instructions for cleaning the tub, chair and cushions and rinsing surfaces, however, she failed to ensure the interior surfaces of the tub and chair remained wet for 10 minutes per the manufacturer's instructions.

Interview on 1/8/25 at 10:00 a.m. with NA-B reported she had read the posted direction for cleaning and disinfecting the tub and noted the direction for the surface to remain wet for 10 minutes with the disinfectant but was not aware of how she could do that. She had not been trained to ensure surfaces remained wet with disinfectant and stated that was the way everyone did it.

Interview on 1/8/25 at 1:25 p.m. with the medical director identified his expectation for infection control documentation to be complete and investigation into potential root cause, and or contact with other persons to be documented following an outbreak or infectious virus. He reported he would need to investigate the Infection Control process further as the medical director.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 1/9/25 at 9:43 a.m., with the director of nursing (DON), reported she was not aware of any potential correlation between the resident diagnosed with Norovirus, and other residents and staff beginning to report similar symptoms. Her expectation was for the IP to report any potential contagious conditions to be investigated, interventions implemented, surveillance implemented with appropriate documentation by the IP. The DON was interviewed related to the jetted tub and confirmed her expectation for the jetted tub to be disinfected according to the manufacture's direction listed in the manual and the posted direction on the surface of the tub. She was unaware staff were not following the direction of ensuring a wet contact time of 10 minutes in order to appropriately disinfect the whirlpool tub time and would need to provide re-education to staff to correct the issue. Interview on 1/9/25 at 9:50 a.m., with the administrator reported she was not aware of the tub not being disinfected correctly and expected staff to follow the instructions as listed in the manual. She was also unaware of a possible correlation between other staff and resident illness and the resident that had been diagnosed with Norovirus. The IP had been on vacation and failed to identify anyone designated to cover infection control surveillance. The administrator would expect potential outbreaks to be reported to the State Agency. Review of the 12/2/24, policy Definitions of Infection-For Surveillance Purposes only identified the presence of new GI symptoms in a single resident could prompt increased surveillance for any additional residents with symptoms that could indicate additional cases or outbreak. If an outbreak was suspected stool specimens were to be collected and sent to the lab to determine the presence of Norovirus or other contagions. Norovirus Gastroenteritis-if laboratory confirmation is not available, an outbreak (two or more cases in a nursing home) due to Norovirus infection can be assumed present if: 1) vomiting in more than half of residents, 2.) incubation period of 24-48 hours. 3) duration of illness 12-60 hours. 3) No bacterial pathogen in a stool culture. There was no indication how the facility determined its qualifiers for potential outbreak based of standards of practice or quality. Review of the 12/2/24, Infection Prevention and Control Program Policy identified the program was to work to prevent, identify, investigate, and report in the attempt to control infections and communicable diseases for residents, staff, and visitors in a facility. The program was to follow the nationally accepted standards, and guidelines for infection control. The program was to include an acceptable system to monitor and document infection control and prevention. The program was to be reviewed annually by the IP or designee, to ensure compliance. The IP utilizes surveillance date to identify outcomes, trends and patterns with results communicated to the QAPI committee.