STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245475	A. BUILDING _____ B. WING _____	04/07/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PARKVIEW HOME	102 COUNTY STATE AID HIGHWAY 9 BELVIEW, MN 56214

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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E 0024 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Establish policies and procedures for volunteers.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and policy review, the facility failed to ensure their emergency preparedness (EP) policies and procedures addressed emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an COVID-19 outbreak. Findings include: Interview and document review on 4/6/20 at 10:30 a.m., with the director of nursing (DON) identified no strategies were in place to address staffing for an emergency or COVID-19 outbreak in review of the EP plan. The DON agreed that was a necessary part of the EP program. During interview on 4/6/20 at 10:55 a.m., the administrator identified the facility did not have a policy for emergency staffing in the event of a COVID-19 outbreak or any other type of emergency. Review of the 3/13/20, Emergency Preparedness Plan identified provisions for COVID-19 from [MEDICATION NAME] Care Hospice and Parkview Home's COVID-19 screening form, but failed to have procedures including emergency staffing strategies.
F 0880 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**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 appropriately implement isolation and transmission-based precautions for 1 of 1 resident (R1) with signs and symptoms of COVID-19. This resulted in an immediate jeopardy (IJ) situation for 17 of 17 other residents (R2, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R14, R15, R16, R17, R18, and R19) in the facility that were exposed to R1 who had symptoms of COVID-19 and participated in a group activity and communal dining while having symptoms. The IJ began on 4/4/20, when it was identified the facility failed to immediately implement Centers for Disease Control (CDC) and Centers for Medicare and Medicaid Services (CMS) guidelines for isolation and use of transmission based precautions, for 1 of 1 (R1) resident who had signs and symptoms of COVID-19. The facility's administrator and director of nursing (DON) were notified of the IJ on 4/6/20 at 5:45 p.m. The immediacy was removed on 4/7/20 at 12:55 p.m. but non-compliance remained at the lower scope and severity of F, widespread, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Additionally, the facility also failed to actively screen employees at the point of entry to minimize potential exposure, failed to conduct active infection control surveillance since December 2019, and failed to have an infection control preventionist (ICP) qualified by education, training, experience, or certification since February 2020. Findings include: During observation on 4/6/20 at 9:37 a.m., two residents were observed to be seated across from each other at a table in the dining room eating their breakfast meals independently. During observation on 4/6/20 at 9:39 a.m., activity aide (ACT)-A entered the building through the employee designated entrance. Upon entry, ACT-A rummaged through a box of cloth masks and choose a mask, filled out a form on clip board next to time clock, and entered the resident living quarters at 9:47 a.m., walking directly to the activity office. ACT-A was not actively screened for symptoms, or temperature, upon entrance to the facility. During observation and interview on 4/6/20 at 10:00 a.m., ACT-A stated upon arrival to work she was to find a nurse to have her temperature checked. ACT-A verified she had arrived at 9:47 a.m., and had been to the activity office and the dining room to the area with the computer. ACT-A identified she just had found the nurse to have her temperature checked. ACT-A had her temperature checked by registered nurse (RN)-A in the activity office and her temperature was deemed within normal limits at 98.1 degrees Fahrenheit (F). During observation on 4/6/20 at 12:05 p.m., 16 of 18 residents were seated in the dining room. There were two residents sitting approximately three feet apart at each square table with the exception of 1 resident who sat alone at a table. During an observation and interview on 4/6/20 at 1:32 p.m., the dietary manager (DM) was observed to walk the full length of the hallway stopping at end of hall and looked into the nurse's office. The DM then walked down another hallway to her office. The DM identified she had just arrived at work and was attempting to locate the nurse on duty. The DM walked back to the end of the hallway in the nurse's office to get her temperature taken. When interviewed on 4/6/20 at 8:45 a.m., housekeeping staff (H)-A identified staff did not have to have their temperature checked upon entry when they arrived for work. H-A said when staff entered the building, they would write on paper if they had any signs or symptoms of respiratory concerns. There was no active testing performed by a staff member for those who came on duty. H-A stated staff would enter through the employee door and have to find the on-duty nurse in the building to take their temperatures. During interview on 4/6/20 at 8:47 a.m., R2 stated she went to the dining room for all her meals and attended group activities regularly. During interview on 4/6/20 at 9:18 a.m., nursing assistant (NA)-A identified staff were to enter through the employee entrance, write down any respiratory symptoms they may be having, wash their hands, get a mask, then locate the nurse who was assisting residents in the facility. That nurse would check their temperature. NA-A said staff were not actively monitored at the point of entry by another staff for temperature or other signs or symptoms of potential COVID-19. During an interview on 4/6/20 at 9:51 a.m., licensed practical nurse (LPN)-A stated she checked staff temperatures as part of the staff screening when staff alerted her they were onsite. LPN-A stated she had no form or procedure to document staff temperatures, nor did she ask them critical screening questions before they entered the building. LPN-A stated if a staff member had a temperature, she would write it down as a note, but verified there was no formal process for employee symptom screening. LPN- A reiterated staff were to find the nurse after they entered the building, to check their temperature when they arrived for their shifts. She verified at times staff may have to walk around the facility to find the nurse in order to have their temperature checked, because the nurse had to be on the floor with the residents and was unable to be at the point of entry. LPN-A also stated each resident was assessed for potential COVID-19 symptoms once daily in the morning. Record review of the resident assessment forms located in each resident's room, identified assessment criteria of temperature, oxygen level, cough, sore throat, or shortness of breath. Upon review, it was verified R1 had been sent to the hospital by his physician due to symptoms of COVID-19 shortly after midnight 4/6/20. R1's 3/12/20, quarterly Minimum Data Set (MDS) assessment, identified R1 had moderately impaired cognition and required extensive assist of one staff for bed mobility, transfers, ambulation, dressing, toileting, and personal hygiene. Further, R1 required only supervision for eating and was able to feed himself. Review of R1's current Medication Administration Record [REDACTED]. Review of the resident assessment form and progress notes, identified the following: 1) 4/4/20 at 7:40 p.m. R1 had a temperature of 100.3 degrees F. R1 had also been shaky, weak, and had a headache. 2) 4/4/20 at 8:05 p.m., R1 had a temperature of 102.7 degrees F. 3) 4/4/20 at 9:00 p.m., R1 had a temperature of 103 degrees F. 4) 4/4/20 at 10:10 p.m., R1 had a temperature of 102.5 5) 4/4/20 at 11:25 p.m., R1 had a temperature of 101.7 degrees F. 6) 4/5/20 at 1:05 a.m., R1 had a temperature of 102.1 degrees F. 7) 4/5/20 at 2:15 a.m., R1 had a temperature of 101.3 degrees F. 8) 4/5/20 at 2:49 a.m., it was documented R1 had been shaky at BINGO earlier that day, had complained of a huge headache, and a cough was noted. 9) 4/5/20 at 3:40 a.m., R1 had a temperature of 100.3 degrees F. 10) 4/5/20 at 9:50 a.m., R1 had a temperature of 98.8 degrees F. 11) 4/5/20 at 8:45 p.m., R1 had a temperature of 100.4 degrees F. 12) 4/5/20 at 11:05 p.m., documentation showed R1 was heard hollering and found on the floor. R1 was not acting himself and vitals were assessed. R1 had a temperature of 101.2 degrees F, oxygen saturation (SpO2) of 85% and a blood pressure (BP) of 97/51 milligrams of mercury (mg/hg). The local emergency room (ER) was contacted. Medical doctor (MD)-B gave orders to send R1

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 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) to the ER. 13) 4/6/20 at 1:49 a.m., emergency medical services (EMS) transported R1 at 12:10 a.m to the ER for evaluation. 14) 4/6/20 at 2:31 a.m., identified a nurse from the ER called and reported R1 would be admitted with aspiration pneumonia and tested for COVID-19 as R1 met the criteria. Prior to R1's transfer, at no time when fever and symptoms began were isolation measures initiated. Review of each of the other 17 residents (R2 through R17) residing in the facility, identified comorbidities that placed the residents at increased risk for complications from COVID 19 if exposed. During interview with the DON on 4/6/20 at 10:15 a.m., the DON stated she expected any resident with COVID-19 like symptoms, such as increased temperature, to be isolated in their rooms and monitored. The DON stated if a resident had other additional symptoms, staff were to move the resident to the designated isolation wing and notify the doctor immediately. The DON stated R1 had a fever and was sent to the hospital for possible aspiration pneumonia. She stated the hospital had updated the facility they were testing for COVID-19 because R1 was symptomatic. The DON stated currently, one resident (R3) had returned from a hospital stay and was placed in isolated as a precaution for 14 days to ensure they had no signs or symptoms of COVID-19. The DON identified the facility did not have any tracking or trending for infections after December 2019. The DON identified she had not completed any tracking or trending since taking over the ICP role. The DON identified she did not have time to complete surveillance. Review of the facility's infection control surveillance tracking and trending from 2019, identified resident infections treated with antibiotics were tracked and trended throughout the year of 2019 with nothing documented after December of 2019. Of the documentation previously performed, it was identified the facility had not tracked or surveilled [MEDICAL CONDITION] activity. ACT-A stated during interview on 4/6/20 at 11:40 a.m., the infection control training received included emails, some fact sheets, and review of a communication book for information. She stated that was how the facility kept staff up to date on information. Laundry assistant (L)-B stated during interview on 4/6/20 at 12:30 p.m., staff were to complete a screening form at the time clock when they arrive, she stated they were to answer the questions and sign the form. L-B said checking temperatures could be done at home, or at the nurse's station. L-B also stated there had been no formal COVID-19 training, but the facility had sent staff emails to tell them about the screening and mask use. During interview on 4/6/20 at 12:32 p.m., NA-A identified all residents went to the dining room for meals except one resident (R3) who was on isolation. When interviewed on 4/6/20 at 1:00 p.m., the infection control nurse at the local hospital confirmed R1 had a COVID-19 test collected early that morning. The infection control nurse stated she did not expect the test results to be back until late 4/7/20. In addition, she stated R1 had an x-ray that indicated potential aspiration pneumonia and R1 was started on an antibiotic. However, he was tested in the hospital for COVID-19 and placed on isolation there while awaiting the results as the symptoms were similar for both illnesses. R4 was interviewed on 4/6/20 at 1:17 p.m., and stated residents played BINGO in the big room with other residents. R4 stated group activities had continued to occur. During interview on 4/6/20 at 1:55 p.m., RN-A identified R3 was the only resident they had isolated at the facility as R3 had recently returned to the facility after a hospital stay. RN-A verified having been aware R1 had a fever on Saturday 4/4/20, but stated she was advised the hospital indicated his symptoms may be related to aspiration of food or fluids into his lungs. RN-A stated no aspiration was witnessed, but could possibly have happened when R1 had evening snack. RN-A verified although R1 had a fever and cough on 4/4/20, he had not been isolated to his room or placed under transmission-based precautions (TBP) because there was no sore throat. RN-A stated R1 had been set farther away from the others for the evening meal, but had still eaten in the dining room. RN-A said the DON had instructed staff to put some precautions in place so they'd put his table in the dining room farther away from the other residents, but R1 had still been allowed to attend group activities. RN-A stated R1 had been sent to the hospital ER around midnight on 4/6/20, and the ER had notified them they were testing him for COVID-19 because he had a cough and fever. RN-A stated R1 had also complained of a headache, which was not identified as a symptom on the facility's list of potential signs of COVID-19. ACT-A stated during interview on 4/6/20 at 2:46 p.m., she had been notified by ACT-B a group activity of BINGO had been held on Saturday who worked 4/4/20. ACT-A said R1, R4, R5, R6, and R7 had attended the activity which had been held in the dining room. Review of emails and communication to all staff related to COVID-19 identified on: 1) 3/13/20, the facility was restricting all visitors per direction of the Minnesota Department of Health and CDC to prevent the spread of COVID-19 in the facility. Included was information about the screening process for visitors. The DON was beginning work on several policies for staff to follow. The note further informed staff of the difficulty obtaining some infection control supplies. 2) 3/25/20, all staff members were to be screened for a fever (100 degrees or above). Staff were instructed to try to take their temperature at home before they left for work. Screening included questions of dry cough with new onset or change, new shortness of breath, sore throat, travel to another country in the past 14 days, or exposure to another person with known or suspected COVID-19 with direction to staff of how to proceed if symptomatic. Staff were to notify their supervisor and/or DON immediately if they had any of the identified symptoms and they could not be at work. There were further instructions that staff were to follow if becoming symptomatic while at work. Staff were to don a face mask immediately, remove themselves from their work area, report to their supervisor and leave for home to isolate. Following isolation at home staff were to communicate with their supervisor and the DON for further screening guidance and instructions. The staff were directed to communicate with DON to report a summary of individuals, equipment and locations they have been in contact with , both at work and at home. and lastly they were to contact their physician immediately and follow their recommendations for their next steps. There was an attached form for the staff to document their answers which indicated in all capital letters: SEE THE CHARGE NURSE AFTER SIGNING TO HAVE YOUR TEMPERATURE CHECKED. 3) 3/31/20, included directions for self-screening when staff arrived to work for respiratory symptoms. Staff were to find the charge nurse to have their temperature checked and leaving their cloth mask at end of shift to be washed at the facility. 4) 3/31/20, staff were informed if they did choose to travel out of the area, upon return, they would not be able to work for the CDC recommended 14 days of self-quarantine. The 14 days of quarantine would be unpaid but staff could use there personal time off during their self-quarantine time. 5) Undated, COVID-19 Precautions Update identified beginning 4/1/20, a cloth mask must be used by all staff and therapists the entire time in the facility and would be available by the time clock. There would be a hamper for staff to place their mask in when they leave at end of shift. The facility would launder the cloth masks. The Minnesota Department of Health had approved the use of homemade masks when disposable masks were not available for use. There was no mention cloth masks were to be used as source control only and not during the care for a resident who was symptomatic or diagnosed with [REDACTED]. When interviewed on 4/6/20 at 3:00 p.m., the DON stated she had been aware of the CMS Quality/Safety & Oversite Group (QSO) 20-14 revised memo providing guidance to long term care facilities to cancel communal dining and all group activities. The DON verified this had not been implemented as it was difficult to do and felt canceling dining and group activities would have had a negative impact on the resident's psychological well-being. The DON stated R1 was currently in the hospital with suspected aspiration pneumonia and was being tested for COVID-19. The DON said she had directed staff to isolate R1 and implement TBP after he developed a fever. The DON acknowledged she had not ensured that had occurred, so was unaware R1 had not had TBP or isolation had not been initiated. The DON stated she was unaware R1 had continued to participate with communal dining, or engaged in group activities potentially exposing others. The DON verified she'd directed staff to check their own temperatures prior to coming to work as the facility did not have a supply of probe covers for the facility thermometer. The DON stated she had assumed the IC duties of the former infection control preventionist (ICP), when the ICP left employment in February 2020. The DON agreed no IC surveillance had occurred since December 2019. Further the DON verified neither she nor the administrator had created policies and procedures related to COVID-19 verifying there had been no formal education provided to staff other than emails and paper communication as identified. The medical director (MD)-B was interviewed on 4/7/20 at 10:00 a.m MD-B stated he was R1's primary care physician. MD-B was made aware of R1's symptoms late in the evening of 4/5/20. MD-B advised staff to send R1 to the ER for evaluation. MD-B agreed R1 had signs and symptoms of COVID-19 but was not aware R1 had exhibited symptoms beginning 4/4/20. MD-B was aware of the communal dining and group activities restrictions placed by CMS. MD-B identified the facility had not asked for assistance with their process to prevent potential exposure to COVID-19 in the facility. MD-B was unaware no surveillance had occurred since 2019. MD-B stated the last Quality Assurance Performance Improvement (QAPI) meeting had been conducted in January 2020. Review of the Parkview Home Infection Control Surveillance and Data Collection Policy dated 10/16/19, indicated all residents of Parkview Home were to be continuously monitored for infections. Notifications to physician, and responsible party would be made for any identified infection or change of condition. Staff were to document all collected data. A monthly infection control log for residents and staff was to be maintained and reported at the quarterly QAPI meeting. The IJ that began on 4/6/20, was removed on 4/7/20, when it could be verified the facility had re-assessed all residents for potential COVID-19 signs and symptoms, had developed and implemented staff education on newly formed policies and

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) procedures using CDC and CMS guidelines: for screening, monitoring, assessment, prevention, and reporting for potential COVID-19. In addition it was verified the facility had implemented immediate cancellation of communal dining and group activities and had initiated active infection control surveillance.