| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245553 | A. BUILDING _____ B. WING _____ | 04/03/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| PARKVIEW MANOR NURSING HOME | 308 SHERMAN AVENUE ELLSWORTH, MN 56129 |

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<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Many | **Establish policies and procedures for volunteers.**<br><br>Based on interview and policy review, the facility failed to ensure Emergency Preparedness policies and procedures addressed the use of volunteers in an emergency or other 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 on 4/1/20 at 8:30 a.m., with the interim administrator (A) identified the facilty was in the process of hiring a new adminstrator and he assumed the position about a month ago. The A stated he had not focused on staffing needs during a COVID-19 outbreak because the business office manager position was vacated a week ago, and had assumed additional responsibilities of that position. The A confirmed a COVID-19 emergency plan was implemented, but no strategies were included in the plan to address staffing needs if there was an COVID-19 outbreak at the facility. Interview on 4/1/20 at 10:30 a.m., with the dierector of nursing (DON) identified the facility discussed staffing once during a manager meeting. The DON verified no strategies were in place to address surge or staffing needs during a COVID-19 outbreak. The DON planned to contact nurse and nurse aid staffing agencies if staffing needs developed. No additional strategies were in place and no staffing agencies had been contacted to implement strategies during a COVID-19 outbreak. Review of the 3/6/20, Pandemic Influenza, Coronavirus and Other Viruses policy identified all staff were encouraged to continue filling their assigned shifts. The resident population would continue to need care provided by staff in all departments. Changes in staffing level or needs were to be determined by the administrator, DON, and the nursing home board if needed. The plan made no mention of how the facility would ensure adequate staffing and surge needs during a COVID-19 outbreak. Review of the 3/24/20, COVID-10 pandemic plan identified processes and stratigies to implement during a COVID-19 outbreak. The plan made no mention of strategies address to use of volunteers in an emergency, or other emergency staffing strategies, to address staffing needs during a COVID-19 outbreak. |
| F 0880<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Many | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and document review, the facility failed to ensure staff performed appropriate transmission based precaution (TBP) intervention, ensure active screening was performed at the point of entry, and source control masks were used by staff in accordance with Centers for Disease Control (CDC) and Centers for Medicare and Medicaid Services (CMS) guidelines for COVID-19. This had the potential to affect all 28 residents in the facility. Findings include: TRANSMISSION BASED PRECAUTIONS & SOURCE CONTROL Observation at 8:05 a.m. after entering the facility and proceeding to the conference room, identified 6 staff were observed walking in the hallway without wearing source control masks. Interview on 4/1/20 at 8:10 a.m., with the director of nursing (DON) identified there were no residents with confirmed COVID-19 at the present time, and no residents were on precautions. The facility had two entrances: the front entrance and the rear entrance. Staff entered through both entryways. The facility had not designated an entrance for staff to enter. The main parking lot was located at the front entrance. Most staff entered through the front entrance. The DON identified staff were not wearing source control masks at the present time as they had no active cases of COVID-19 in the facility. She expected staff to implement personal protective equipment (PPE) if residents developed respiratory symptoms. Interview on 4/1/20 at 8:20 a.m., with director of nursing (DON) identified resident (R1) experienced an elevated temperature, headache and body aches and was on transmission based precautions by nursing staff. Interview on 4/1/20 at 8:30 a.m., with housekeeper (H)-A identified she was unaware of any resident with potential COVID-19 symptom. Infections were to be communicated verbally at daily morning meetings, and by the nurses. Source control masks were not worn by any staff at that time. R1's 4/1/20 at 8:32 a.m., progress note identified R1 experienced a temperature of 100.8 degrees Fahrenheit (F) complaints of a headache and body aches earlier that morning and was reported to the oncoming nurse. There was no mention what tranmission based precautions (TBP) were implemented at that time. R1's current face sheet identified he had comorbidities of type 2 diabetes and kidney failure which placed him at increased risk for contraction of COVID 19. Observation and interview on 4/1/20 at 9:00 a.m., with nurse aide (NA)-A and NA-B of R1's room identified there was a chair set outside of R1's room with a box of gloves, face masks, and a bottle of hand sanitizer on it. There were no gowns on the chair. There was also no signage on R1's door or chair to inform staff what type of isolation precautions were required. NA-B was inside the room providing care to R1. NA-A proceeded to the entrance of R1's room, sanitized her hands, knocked on door and entered. NA-B could be overheard advising NA-A she needed to have put on additional personal protective equipment (PPE) before she had entered the room. NA-A then exited room. Upon exit, NA-A advised the PPE had not been there earlier this morning and had not been aware R1 was on precautions or showed symptoms of COVID-19. NA-B exited R1's room wearing her contaminated face mask and gloves without removing and performing hand hygiene as R1 was on isolation precautions. NA-B pushed a commode used by R1 across the hallway to the utilities room for disinfection and touched the door handle of the soiled utility room with her contaminated glove. Neither NA-A nor NA-B had performed appropriate PPE donning and doffing for R1 who had potential COVID symptoms and was on isolation precautions. Observation on 4/1/20 at 9:30 a.m., of the facility's PPE inventory in the supply room with the DON identified the facility had 15 boxes of 50 each disposable face masks with tie strings at the facility. There was no plan in place for source control masking for facility staff. Staff were not expected to wear masks until a resident developed symptoms of COVID-19. PPE was to be initiated when a resident was discovered only with respiratory symptoms. Staff were to initiate TBP for R1 when symptoms were identified and educate staff about the type of precautions needed. Masks were placed outside of R1's room and were to be worn. Gowns were not implemented for use with R1. Staff were not instructed to don gowns when in R1's room. Gowns had been depleted from an outbreak of influenza at the beginning of March 2020 and she was unable to restock the facility supply. There were 2 boxes labeled Isolation. The boxes contained numerous cloth gowns and several pairs of goggles. The DON was unaware of the cloth gowns in those boxes. She identified she had not performed a complete inventory of supplies. In the absence of disposable gowns, the DON identified staff could use the cloth gowns for PPE until disposable gowns had arrived. The DON agreed there was an ample supply of masks with appropriate re-use as source control masks. During observation and interview on 4/1/20 at 9:40 a.m., of R1's doorway and room with housekeeper (H)-A identified she would be notified of anyone requiring TBP by her supervisor. R1's room had no waste basket inside door of room for staff to discard PPE before exiting the room. There were no disinfecting wipes located in or near R1's room for staff to disinfect multiple-resident use equipment. Equipment would have to be brought across the hall into the soiled utility room for disinfection. Further interview on 4/1/20, at 10:30 a.m., with the DON identified she was responsible for the facility's infection control program (ICP). Staff were instructed not to wear masks until there was an active case of COVID-19 in the facility. The DON stated she reached out to area clinics and hospitals for recommendations on when to initiate source control masks. She had also worked with the regional Emergency Preparedness representative on implementation of COVID-19 practices. The DON was aware of CDC and CMS guidance for healthcare workers to wear source control masks. The administrator received the memos would routinely update managers and staff of changes to COVID-19 infection control practices. Interview on 4/1/20 at 10:45 a.m., with the administrator |

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<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Many | (continued... from page 1)<br>identified he received the QSO memos, the facility had not implemented use of source control masks. The facility's plan was to conserve the existing ample supply of masks to use until a resident had symptoms of COVID-19, or an active case occurred in the facility. PPE was currently on backorder. He had just received additional masks from the southwest coalition last evening. Later interview on 4/1/20 at 11:40 a.m., with NA-B identified R1 had no designated commode. NA-B would remove the soiled commode, return to the soiled utility, disinfect it and place the commode in the common storage area. NA-B was aware of the TBP placed on R1. Interview on 4/1/20 at 11:40 a.m., with DON identified her expectation was staff were to place signage on the door of a resident in isolation to inform and instruct staff of what type of isolation precaution was needed and what types of PPE were required. All equipment unable to be designated for the isolation resident was to be disinfected before it left that resident's room. The DON had not performed any training recently with regard to isolation precautions and correct PE usage. The DON identified there were no written policies in place for masks to be used for source control. Interview on 4/1/20 at 12:50 p.m., with NA-C identified she had not received training on donning and doffing PPE recently amid the COVID pandemic.<br><br>SCREENING Observation on 4/1/20 at 8:00 a.m., identified the entrance to the facility had signs posted visitors were to refrain from entering to prevent COVID-19 exposure to residents. Interview on 4/1/20 at 8:30 a.m., with housekeeper (H)-A identified staff were to enter through the front entrance and report to the nurses station to be screened for fever, cough, and shortness of breath prior to clocking into work before every shift. If the nurse was not at the desk, staff would search the facility for her to screen them prior to the start of their shift. Observation on 4/1/20 at 8:30 a.m., identified a sign was posted at the staff time clock in the north wing near the rear entrance of the facility instructing staff to check in at the nurses' station for COVID-19 screening before beginning their shift. Interview on 4/1/20 at 8:37 a.m., with trained medication aid (TMA)-A identified when staff entered through the back facility door and identified she had trouble finding nurses to screen her after she had arrived to work. Interview on 4/1/20, at 10:30 a.m., with the DON identified was aware of CDC and CMS guidance requiring healthcare facilities to actively screen visitors and staff prior to entrance to the facility. Review of the 3/6/20, Pandemic Influenza, Coronavirus and other viruses, identified the facility would attempt to minimize the spread of any serious [MEDICAL CONDITION] illness among its residents and staff. Residents were to be isolated the first sign of respiratory illness, including cough, lethargy, or muscle aches. Staff were to be encouraged to wear gowns, masks and gloves for all patient interactions. A tight fitting facial mask should be worn at minimum for respiratory protection. In the event of a pandemic or other viruses, the facility was to follow protocols for isolation measures, disinfection measures for environmental surfaces and monitoring for outbreak. Review of the October 2018, Isolation - Categories of Transmission-Based Precautions, identified TBP were additional measures that protected staff and residents from becoming infected and determined by the pathogen. The CDC maintained a list of diseases, modes of transportation and recommended precautions. When a resident was placed on TBP, notification was to be placed on the room entrance door and the front of the resident's medical record so staff was aware of the need and type of precaution. When TBP were in effect, non-critical resident care items were to be dedicated to a single resident. If re-used for another resident, the item was to be disinfected according to current guidelines before use on another resident. A resident on droplet precautions identified staff were to wear masks when entering the room. Gloves, gowns, and goggles were to be worn if a risk of spraying secretions. Review of the 3/6/20, Influenza, Coronavirus, and Other Viruses Protocol, identified when a resident within the facility exhibited symptoms of coronavirus or other like illness, affected residents were to be isolated to their rooms when symptoms were noted. Masks and gowns were to be available for staff to wear when caring for residents. Coronavirus symptoms listed were fever cough and shortness of breath. There was no mention the list of symptoms had been updated to align with current symptoms identified by the CDC. |