STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245585	A. BUILDING _____ B. WING _____	08/19/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TRAVERSE CARE CENTER	**303 SEVENTH STREET SOUTH WHEATON, MN 56296**

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 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Provide and implement an infection prevention and control program.** Based on observation, interview and record review, the facility failed to assure all staff followed recommendations to prevent the spread of COVID 19 according to Centers for Disease Control and Prevention (CDC) recommendations for the use of appropriate eye protection when caring for patients 5 (R3, R5, R6, R7, R8) of 5 residents observed during a COVID-19 Focused Infection Control Survey. In addition, the facility failed to follow manufactures instructions for disinfectant use of surfaces in the facility. This deficient practice had the potential to affect all 41 residents who resided in the facility and staff and visitors. Findings include: Personal Protective Equipment: CDC Coronavirus Disease 2019 (COVID-19) Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic Infection Control Guidance, updated 7/15/20, directed to implement Universal Use of Personal Protective Equipment for Healthcare Personnel(HCP) which included HCP to adhere to standard and transmission based precautions include use of eye protection and/or N95 or equivalent or higher-level respirator based on anticipated exposures and suspected or confirmed diagnoses. Universal use of a facemask for source control is recommended for HCP. On 8/19/20, at 9:34 a.m. occupational therapist assistant (OTA)-A was observed walking down the hallway with her goggles on top of her head. OTA-A wore prescription eye glasses and a surgical mask on her face. R3 was lying on his bed in his room, and OTA-A entered R3's room with goggles still on top of her head and walked to the foot of his bed on the right side. Physical therapist (PT)-A was present in the room, and stood between the wall and R3's left side of his bed and licensed practical nurse (LPN)-A was present and stood at R3's head of bed on his right side. PT-A, OTA-A and LPN-A assisted R3 to position sideways on the bed, lowered his feet to the floor, then to a sitting position. LPN-A briefly left the room to obtain the sit to stand lift. OTA-A remained on R3's left side while he sat on the bed, with her goggles on top of her head, less than 2 feet way from R3. LPN-A returned with the lift, and OT-A stood at R3's left side, inches way from R3, while she placed the lift straps around R3 and assisted him to stand. OTA-A ran the mechanical lift, while R3 was then transferred from his bed to a high back chair in his room. With her goggles on top of her head, OTA-A proceeded to walk to R3's right side, while conversing with R3. OTA-A remained within 6 feet of R3, until 9:51 a.m. when three other staff members entered R3's room. At that time, OTA-A moved her eye goggles from the top of her head to place over her glasses. On 8/19/20, at 10:53 a.m. OTA-A indicated staff were to wear eye protection when face to face with residents. OTA-A confirmed she had not worn her eye protection goggles while assisting R3 with the transfer. OTA-A indicated she had just washed her goggles prior to entering R3's room, and had left them on top of her head. OTA-A indicated she had thought the goggles were in place, and indicated she became aware they were not in place after transferring R3. On 8/19/20, at 10:04 a.m. R5 was seated in the sitting are across from the nurses desk, and trained medication aide (TMA)-A stood next to R5, within one foot, with a mediation cup in her hand. TMA wore prescription glasses, a surgical mask on her face, and goggles on top of her head. TMA-A proceeded to administer medication to R5 and as she walked back to the medication cart behind the nurses desk, she placed her goggles over her glasses. On 8/19/20, at 12:00 p.m. TMA-A indicated facility staff were to wear a mask and goggles when working with residents. TMA-A indicated she was unsure if she had them on while she administered R5's medication and indicated she should have worn the eye protection correctly while administering medications. TMA indicated the goggles steamed up her glasses, and frequently wore them on top of her head instead of over her eyes. On 8/19/20, at 10:27 a.m. registered nurse (RN)-A stood in the hallway taking R6's temperature. RN-A wore a surgical mask, prescription eye glasses and a pair of goggles clipped to the front of her shirt, while she squatted in front of R6. RN-A proceeded to enter R7's room to take her temperature and oxygen saturation with an oximeter. RN-A continued to have her goggles clipped on the front of her shirt. At 10:38 a.m. RN-A was in the front sitting area near the dining room. RN-A was observed standing near R8, taking R8's temperature and oxygen saturation, while her goggles were remained attached to the front of her shirt. At 10:31 a.m. RN-A confirmed she had taken all of the residents' temperatures and oxygen saturations in the building that day. At 2:10 p.m. during a follow up interview, RN-A confirmed she had not worn eye protection while completing temperatures and oxygen saturation checks for the residents. RN-A indicated she was not aware she was to wear eye protection while completing these resident assessments. RN-A indicated she had been instructed today to wear eye protection when in direct contact with the residents, such as taking their vital signs. On 8/19/20, at 1:06 p.m. director of nursing (DON) confirmed staff were to wear face masks and eye goggles when in direct contact with residents. DON indicated direct contact with residents was any direct cares with residents, which included assisting residents with transfers, medication administration and taking vital signs. DON indicated she had been doing weekly audits and observed staff not wearing eye protection also during those audits. DON indicated she provided reminders to staff, with training at the time when she observed them not wearing them. Environmental Cleaning: On 8/19/20, at 11:08 a.m. housekeeper (HK)-A indicated she performed daily cleaning of resident rooms and common areas. HK-A indicated she used a disinfectant which she allowed to remain on the surface for a minute or two then would wipe it off. HK-A indicated when she disinfected the hand rails in the hallways, she would spray it all down, then return to wipe it off after a minute or two. HK-A stated she used Hillyard 19 product for disinfecting and reviewed manufactures instructions on the label of Hillyard 19 bottle at that time. She confirmed the Hillyard 19 instructions for disinfecting instructed users to allow the product to remain wet for 10 minutes. On 8/19/20, at 11:24 p.m. head housekeeper (HHK)-A indicated Hillyard 19 was used for disinfecting for COVID-19 in the facility. She reviewed the instructions for use for Hillyard 19 and confirmed the instructions directed to leave the product wet on the surface for 10 minutes. She indicated there were 3 different products in the facility to chose from, Hillyard 19, Clorox Fusion and Vindicator 6. HHK-A indicated both she and HK-A usual practice was to leave the Hillyard 19 product on surfaces for 2-3 minutes. HHK-A indicated the facility also used Vindicator 6 and Clorox fusion, and stated she thought the time for the Vindicator 6 was the same as the Hillyard product and the Clorox product she left on surfaces for 5-7 minutes. On 8/19/20, at 12:07 p.m. environmental service director (ESD)-A confirmed the facility used Hillyard 19 as a disinfectant for COVID in the building. ESD-A indicated she could not remember the kill time for Hillyard 19, but thought it was 10 minutes. She stated the facility also utilized Vindicator 6 and Clorox Fusion, and confirmed she expected the housekeeping staff to know the appropriate kill times for the products they used. ESD-A indicated if the products were not left on the correct time, they would not work the way they were supposed to. After review of the manufacture's instructions, ESD-A indicated she would expect Hillyard 19 products would be left on surfaces for 10 minutes. She indicated she had educated housekeeping on the use of the various products used for disinfection on multiple occasions in the past. On 8/19/20 at 12:20 p.m. during a phone interview, Hillyard's representative (HR)-A confirmed Vindicator 6 had a kill time of 10 minutes, and they should let it sit for 10 minutes to let it kill, then can wipe off any additional moisture. HR-A also confirmed Hillyard 19 product was also to be left on the surfaces for 10 minutes. HR-A indicated he would expect both these products would be kept on the surfaces wet for 10 minutes. DON provided a copy of the Health Dimensions Group 2020 COVID 19 PPE Use Guide, dated 2020, which she indicated the facility used as a guide for PPE use in the facility, and the guide listed goggles were required for direct patient care. The facility COVID-19 Preparedness Plan, dated 6/24/20, identified regular practices of cleaning

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	(continued... from page 1) and disinfecting have been implemented, including a schedule of two times a week for routine cleaning and disinfecting of work surfaces, equipment, and areas in the work environment including, but not limited to, restrooms, break rooms, and meeting rooms. Frequent cleaning and disinfecting is being conducted of high-touch areas including, but not limited to, workstations, countertops, handrails, light switches and door handles. The facility provided the document CDC Cleaning And Disinfecting Your Facility memo dated 4/1/20, instructed to disinfect to follow the instructions on the label to ensure safe and effective use of the product. The CDC memo further identified many products recommend keeping surface wet for a period of time (see product label). The facility provided product label from the bottle of Hillyard Non Acid Restroom/Disinfectant Cleaner 19 Arsenal 1 disinfectant instructions instructed user to wet all surfaces thoroughly then allow to remain wet for 10 minutes, then remove excess liquid. The facility provided product label from the bottle on Hillyard Vindicator + 6 Arsenal 1 disinfectant instructions instructed user to wet all surfaces thoroughly then allow to remain wet for 10 minutes, then remove excess liquid. MDH Contingency Standards Of Care For COVID-19 Personal Protective Equipment For Congregate Care Settings, updated 6/15/20, identified congregate care settings included long-term care, assisted living, hospice, home care, and other non-acute care facilities. The standards included the recommendation for HCP with face-to-face contact with COVID negative residents to include surgical mask, eye protection and hand hygiene.