STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TUFF MEMORIAL HOME	505 EAST 4TH STREET HILLS, MN 56138

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 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**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 ensure staff were actively screened at the point of entry, residents were screened for all symptoms, direct contact staff wore eye protection to prevent or mitigate potential transmission, and continuous ongoing infection control (IC) surveillance and analysis of that data occurred in according with Centers for Disease Control (CDC) and Centers for Medicare and Medicaid Services (CMS) guidelines for COVID-19. SCREENING Interview on 5/19/20 at 11:00 a.m., with registered nurse (RN)-A identified the facility's COVID-19 resident screening process consisted of measuring their temperatures daily. Nursing staff documented the temperatures in the electronic medical records (EMR)s. Residents were not asked any questions about presence of COVID-19 signs or symptoms. Staff visualized residents multiple times daily; staff were expected to report any symptoms of infection to the nurse. All reported signs of infection were assessed and documented in the EMR by the charge nurse. Review of the 5/1/20, through 5/19/20, Prevent COVID-19, Start of Shift Daily Employee Screening Log identified the following documentation: Employee name, date of screening, presence of symptoms, temperature, cough, sore throat, and new shortness of breath. The Log also identified whether staff were sent home. The forms included a column to identify who actively screened staff entering the building for symptoms of COVID-19. The column was left blank on 23 of x entries, and lacked evidence staff were actively screened. Interview on 5/19/20, at 1:30 p.m., with the director of nursing (DON) identified designated staff were educated on how to perform COVID screens. The person completing the screening was expected to initial each staff screened. Nursing staff checked temperatures and documented them in the electronic medical record (EMR). She confirmed staff were not expected to actively screen residents daily for respiratory status. Oxygen saturation levels were not routinely measured. A full set of vital signs were measured weekly, but no additional vital signs were monitored on a daily basis unless a resident had symptoms of illness. All facility staff were responsible to observe residents and report signs and symptoms of illness to the charge nurse for further assessment. When residents had respiratory symptoms she expected the nurse to assess the resident and document findings in the progress notes. The DON felt the facility was small enough and residents were seen by staff frequently enough to exclude daily COVID-19 respiratory observations from the resident screening process. SOURE CONTROL MASKS AND EYE PROTECTION Interview on at 5/19/20 at 8:00 a.m., with the administrator identified the facility had no active cases or residents with symptoms of COVID-19. No residents were quarantined. The facility had an adequate supply of PPE at the facility. Observations and interviews on 5/19/20, identified the following: 1) At 9:00 a.m., Activity aid (A)-A was visiting residents in their rooms in the East Hallway. She entered and exited several rooms and was not wearing eye protection. A-A stated staff were not wearing eye protection because there were no residents with COVID-19. 2) At 8:44 a.m., housekeeper (H)-A was in the West hallway cleaning resident rooms. H-A was not wearing eye protection. Staff were to wear eye protection if residents were in isolation. 3) At 9:06 a.m., NA-C was in the therapy room. R1 was in the therapy room using the Nu-Step. NA-A was not wearing eye protection. NA-A identified the facility continued to provide therapy services. Staff were not required to wear eye protection. 4) At 9:45 a.m., without wearing eye protection, NA-C ambulated an unidentified resident in the East hallway. NA-C stood shoulder-width apart from the resident and had her hand underneath her gait belt. 5) At 9:16 a.m., NA-D, was in the East hallway and was not wearing eye protection. NA-D identified she provided direct care to residents and wore a cloth masks during her shift. NAs were required to wear either cloth or surgical masks. Staff put on masks before entering the facility. Clean cloth masks and surgical masks were located in a bin at the designated entrance. Staff replaced both cloth and surgical masks each shift. Used cloth masks put into a container at the end of each shift in a bin at the designated entrance for laundry to wash. NA-D identified she took her mask home, and washed it daily. If symptoms of COVID-19 were in the facility, all staff were to wear surgical masks. Review of the 4/15/20, untitled document summarizing the facility COVID-19 guidelines identified laundry was responsible to launder masks and replace paper bags weekly unless they were visibly soiled. Interview on 5/19/20 at 10:32 a.m., with the director of nursing (DON) identified she received the facility received the CMS Quality Safety and Overssight (QSO) memos. She checked the CDC guidance for updates in COVID-19 practices. The facility had ordered eye protection and had an adequate supply onsite. Staff were not provided eye protection because no residents had COVID-19 symptoms and there were no active cases of COVID-19 in the facility. Eye protection would be implemented when symptoms or a confirmed COVID-19 case occurred in the facility. The DON agreed CDC guidance outlined direct care staff were to wear eye protection at all times with the use of a face mask. SURVEILLANCE Review of the January 2020, Infection Control Log identified the following infections: (1) On 1/4/20, R2 had signs of shortness of breath, low oxygen saturation, and a cough. R1 was diagnosed with [REDACTED]. R2's symptoms resolved on 1/20/20. (2) On 1/24/20, R3 had symptoms of cough, fatigue, and congestion. R3 was diagnosed with [REDACTED]. R3's symptoms resolved on 1/29/20. Review of the January 2020, infection map identified R2 and R3 resided on the West wing. R2's room was across the hallway in close proximity to R3's room. R4, R5, and R6 resided on the West wing. Review of the January 2020, Infection Report identified R2 developed shortness of breath, had diminished bilateral lower lobe lung sounds, and a cough. R2's condition had not improved. On 1/7/20, she was diagnosed with [REDACTED]. R2's URI was resolved on 1/20/20. R3 was diagnosed with [REDACTED]. His symptoms resolved on 1/29/20. The report made no mention R2 and R3's rooms were in the same wing. The report lacked analysis and made no mention of corrective actions taken and preventative measures implemented to prevent transmission between residents in the West wing. Review of the 2/1/20, Infection Summary document identified in January 2020, there were two residents diagnosed with [REDACTED]. The summary identified no corrective actions were taken, no preventative measures were taken to prevent infection transmission. Review of the February 2020, Infection Control Log identified the following: (1) On 2/2/20, R4 developed symptoms of cough and was diagnosed with [REDACTED]. Four residents (R5, R6, R7, and R8) had [MEDICAL CONDITION] in the West wing. (2) On 2/6/20, R5 was diagnosed with [REDACTED]. R5's infection resolved on 2/16/20. (3) On 2/11/20, R6 was diagnosed with [REDACTED]. R5's infection resolved on 2/29/20. (4) R7 was diagnosed with [REDACTED]. Review of the February 2020, infection control map identified R4 resided in the West wing. R4's room was in the middle of the wing on the left side three rooms away from R3. R5, R6, and R7 also resided in the West wing. Review of the February 2020, Infection Control Report identified on 2/3/20, R4 developed a production cough with yellow sputum. R4 was transported to the emergency department (ED) and was diagnosed with [REDACTED]. On 2/12/20, R4's antibiotics were completed. R4's lung sounds were clear and her oxygen saturation was 94 percent (%) on room air. R4 had an occasional productive cough and yellow-tinged phlegm. R4's pneumonia was resolved. The report lacked analysis of the infection prevalence in the West wing and made no mention of possible sources of transmission. Review of the 3/1/20, Infection Summary document identified in February 2020, on the West wing, one resident had pneumonia, three residents had [MEDICAL CONDITION]. One resident's [MEDICAL CONDITION] was unresolved form the previous month. The report identified no corrective actions were needed and no preventative measures were taken, but lacked rationale for not implementing corrective actions or preventative measures.

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING _____ B. WING _____	**05/19/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TUFF MEMORIAL HOME	**505 EAST 4TH STREET HILLS, MN 56138**

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 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 1) Review of the March 2020, Infection Control Log identified on 3/4/20, R8 developed chills and a cough. R8 was diagnosed with [REDACTED]. Review of the March 2020 facility infection map identified R8 resided in the West wing. Review of the March 2020, Infection Control Report identified R8 had a cough on 3/2/20. R8's symptoms included a low-grade temperature, chills, and yellow sputum. R8 had a chest x-ray and was diagnosed with [REDACTED]. R8's infection resolved on 3/10/20. Review of the 4/1/20, Infection Summary identified in March 2020, one staff had pneumonia on the West wing. No corrective actions were taken and no preventative measures were needed. The summary lacked rationale to support Interview on 5/19/20, at 10:32 a.m., with the DON identified she was responsible to oversee the infection prevention program. The IP nurse resigned in October/November of last year, and a new IP started training in March 2020. She was currently on maternity leave, and planned to complete training and assume IP responsibilities when she returns in June. The charge nurses maintained a line list at the nurse station to document symptoms of infections in the facility. The DON reviewed the line list three times per week and reviewed the data on a monthly basis. When R2 was diagnosed with [REDACTED]. She also had fluid overload, which likely caused her symptoms. Staff had to assist her with cares while she was ill. TBPs were not initiated. It was not determined whether or not the other respiratory infections were related to R2's RSV diagnoses. No investigation, audits or additional reviews of the infections were completed to identify potential transmission of respiratory illness or [MEDICAL CONDITION] between residents. The DON used guidance from the medical director, the CDC, CMS, QSO memos, and guidance from Leading Age and Pathway Health to ensure they used the most current COVID-19 infection prevention practices. Eye protection was not required until COVID-19 symptoms were present, or a confirmed case of COVID-19 occurred. Interview on 5/19/20 at 2:44 p.m. with the administrator identified the DON was designated as the IP until the position was filled. The nurse hired for the IP position went on maternity leave and planned to return in June 2020. He agreed the IP program was to be continuous and ongoing. Infections were to be monitored for potential outbreaks and the data analyzed to identify potential sources of infections. He expected preventative measures to be implemented when infections required additional TBPs be put in place to prevent infection transmission. The facility used the a flow chart for implementation of PPE for staff. Eye protection was recommended by the facility only when COVID-19 was present in the facility. The facility had eye protection available, but staff were not required to wear them. A copy of the document used for implementing PPE was requested, but not provided. Review of the undated Infection Control Program policy identified it was designed to help prevent the development and transmission of disease and infection. The infection preventionist was to investigate symptoms suggesting an infectious outbreak to determine the nature and magnitude of an outbreak. The infection preventionist was to identify ill persons to identify recent human and environmental contacts. The IP facilitated infection management pans, maintained rooms to isolate residents as needed who have [MEDICAL CONDITION] respiratory infections, and other infectious diseases, and ensured rooms used for TBPs for residents contained hand hygiene supplies. The program was to include surveillance including process and outcome surveillance, monitoring, and data analysis. Review of the undated Infection Control Surveillance policy identified the essential elements of a surveillance system included (1) standardized definitions and listings of symptoms of infections; (2) use of surveillance tools such as surveys and data collection templates, walking rounds throughout the healthcare facilty; (3) Identification of resident populations at risk for infection; (4) Identification of the process or outcomes selected for surveillance; (5) statistically analysis of data to uncover an outbreak; and (5) feedback of results to the primary caregivers ensure continual assessment of residents' physical conditions for signs of infection. The surveillance process included oversight of infection prevention practices in the facility to ensure compliance of IP practices, and outcome surveillance to identify and report all evidence of infection. The IP was to review resident data including resident status, diagnoses, lab results. The resident data was to be analyzed to determine origin of infection to determine whether additional precautions and preventative measures were needed and minimize the potential for infection transmission. The IP was expected to compare current and past infection control surveillance to detect any unusual or unexpected outcomes. The infection control data summaries supported the rational for infection control measures that enhance its practices to prevent future infections. Data was to be compared by type and location to previous reports to identify effective practices and change ineffective ones.