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 _____	10/14/2020

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 -** Immediate jeopardy **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 follow Centers for Disease Control (CDC) and Centers for Medicare and Medicaid Services (CMS) guidelines to prevent or minimize the transmission of COVID-19 which resulted in an ongoing facility outbreak when 13 of 40 residents (R3, R5, R6, R8, R10, R11, R12, R14, R15, R16, R21, R22, and R23), tested positive for COVID-19. The facility's failures resulted in an immediate jeopardy (IJ) situation for all 40 residents. The IJ began on 9/23/20, 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 when residents first identified with symptoms of COVID-19. The IJ was removed on 10/12/20 at 5:05 p.m., but non-compliance remained at the lower scope and severity of F, widespread, with no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: SURVEILLANCE Review of the facility's Infection Control (IC) Program Log identified it was organized by month. Each month contained an Infection Control Log, Infection Surveillance Data Collection Form, a Facility Map, and an Infection Summary. The Infection Log columns were labeled Name, Onset Date, Signs and Symptoms, Cultured Organism, Not Cultured, Antibiotic Ordered, Corrective Action, Date Resolved, and Exhibited By. The Surveillance Data Collection Form consisted of individual resident infection information with infection criteria definitions, and antibiotic treatment information to track antibiotic effectiveness. The facility map marked where infections were located in the facility. The Infection Summary contained a table of rows and columns to record the types and numbers of infections present in the facility for a month, and included a review of the previous month's infections. The summary also included staff infection surveillance, any trend analysis, applicable corrective actions taken and additional comments. The August 2020, IC log made no mention of any symptoms of COVID-19 present in the facility, and the September 2020, IC made no mention of any symptoms of COVID-19 present in the facility until the first positive test was recorded on 9/30/20. At that time, the log only identified residents who tested positive for COVID-19. The October 2020, IC log identified residents who tested positive for COVID-19 on 10/1/20, 10/4/20, 10/5/20, 10/7/20, and 10/8/20. The IC log made no mention of symptomatic residents who had tested negative. Review of the resident electronic medical records (EMR)s identified the following: R5's nurses' notes identified R5 had experienced loose incontinent stools between 9/9/20 and 9/10/20. On 9/21/20 and 9/28/20, R5 had increased anxiety and shortness of breath. On 9/30/20, R5 tested positive for COVID. The notes made no mention as to whether R5 was placed on transmission based precautions at the time these symptoms, consistent with COVID-19, began. R12's nurse notes identified R12 had intermittent symptoms of nausea, vomiting, headache, sore throat, and weakness, and lethargy beginning 8/19/20 through 10/7/20. On 10/7/20, R12 tested positive for COVID. The notes made no mention R12 was placed on transmission based precautions at the onset of symptoms to prevent potential spread of COVID. R3's nurses' notes identified R3 experienced intermittent loose stools between 8/19 and 9/4/20. On 9/5/20, R3 experienced shortness of breath while ambulating. On 9/30/20, R3 tested positive for COVID. R3's nurses' notes made no mention as to whether R3 was placed on transmission based precautions when R3 exhibited these symptoms consistent with COVID. R6's bowel records identified R6 experienced loose stools between 9/12 and 9/20/20. R6's nurses' notes indicated R6 tested positive for COVID on 10/5/20. The notes made no mention whether R6 was placed on transmission based precautions when the diarrhea, a potential symptom of COVID, developed. R21's nurses' notes identified between 9/23 and 9/26/20, R21 had loose stools. On 10/4/20, the notes indicated R21 had a mucus like discharge when using the toilet. R21 was tested for COVID on 10/6/20 with negative results. There was no mention R21 was placed on transmission based precautions at the onset of diarrhea for potential COVID-19. R10's bowel records identified between 9/26 and 10/6/20, R10 experienced intermittent loose stools. Between 9/30 and 10/5/20, R10's nurses' notes indicated R10 exhibited a dry, hacking cough, and increased confusion. On 9/30/20, R10 returned from a clinic visit and requested to be tested for COVID. R10 initially tested negative for COVID at that time, however, on 10/5/20, R10 tested positive for COVID. The notes made no mention R10 was placed on transmission based precautions at the onset of these symptoms consistent with COVID. R11's bowel record identified between 9/26 and 10/7/20, R11 experienced loose stools. On 9/30/20, R11's nurse notes identified R11 refused COVID testing. On 10/4 and 10/5/20, R11 complained of nausea. The notes made no mention R11 was placed on transmission based precautions at the onset of symptoms to prevent potential spread of COVID. R8's nurses' notes identified on 9/30/20, R8 had a dry hacking cough. On 10/1/20, R8 continued with a dry, non-productive cough, and felt run-down and staff were to continue to monitor. On 10/2/20, R8 felt like he was going to throw up. On 10/8/20, R8 tested positive for COVID related to having symptoms of weakness, diarrhea at request of family. The notes made no mention R8 was placed on transmission based precautions at the onset of his symptoms. R14's nurse notes identified on 9/30/20 at 8:30 a.m., R14 had a non-productive cough, hoarseness, and loss of taste during the night shift. On 9/30/20 at 3:50 p.m., R14 tested positive for COVID. The notes made no mention R14 was immediately placed on transmission based precautions when symptoms were identified. R15's nurses' notes identified between 10/2 and 10/5/20, R15 had symptoms of not feeling well, weakness, shakiness, orange-colored loose stools, nausea and yellow-colored vomit. On 10/5/20, R15 tested positive for COVID. The notes made no mention R15 was placed on transmission based precautions at the onset of symptoms consistent with COVID. R16's nurses' notes identified between 10/3 and 10/7/20, R6 was not feeling the best, had a hoarse voice, cough, chest pain, body aches, bloody stools and increased irritability. R16 was tested for COVID on 10/3/20. R6's test was negative. R6 continued to have COVID-like symptoms and was retested for COVID on 10/5/20, and 10/7/20, R16 requested to be tested for COVID again and was negative both times. On 10/7/20, R16 was transported to the emergency department (ED) for increased behaviors. R16 was tested for COVID in the ER, and was positive. The notes made no mention R16 was placed on transmission based precautions at the onset of her symptoms. R22's bowel record identified between 9/2 and 9/28/20, R22 had frequent loose stools. On 9/30/20, R22 tested positive for COVID. The notes made no mention R22 was placed on transmission based precautions at the onset of symptoms consistent with COVID. R23's nurses' notes identified on 9/30/20 at 8:21 a.m., R23 had symptoms of dry cough, wheezing, runny, stuffy nose, and chest tightness. That same day, R23 tested positive for COVID. The notes made no mention R23 was placed on transmission based precautions when R23's symptoms were identified. Interview with registered nurse (RN)-A identified she assumed the role of infection preventionist (IP) in September 2020. She assisted the director of nursing (DON) with the infection data. The DON was responsible for the IC program. Interview on 9/12/20 at 2:12 p.m., with RN-B identified the DON was out of the facility due to having COVID. The administrator, RN-A, and herself assumed responsibility for maintaining the IC program while the DON was out. The infection surveillance process included to have charge nurses enter the data on the IC Log at the nurses' desk when infection symptoms occurred. Only infections treated with antibiotics were included on the log. Other types of infections and symptoms of potential infection were documented in the nurse notes. RN-B was unsure how infections not treated with antibiotics were tracked in the facility. Charge nurses documented COVID symptoms in nursing progress notes and the Respiratory Infection Screener in the EMRs. The screener generated a score. Staff could view the screens in the assessment tab to identify if COVID symptoms were present. Upon review of the Respiratory Infection Screener with RN-B, RN-B agreed,

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 -** Many	(continued... from page 1) the screener did not include the additional known symptom of diarrhea. Review of the IC Log The log with RN-B identified symptoms of COVID, and other infections were not included on the log. She agreed the log should include any symptoms of infection to be able to identify potential symptoms of infections to identify potential outbreaks. The first positive case of COVID occurred on 9/30/20. R3 had new onset diarrhea prior to testing positive for Covid, and was not placed on droplet precautions. Communal dining and group activities were discontinued. Residents were encouraged to remain in their rooms. Droplet precautions were not implemented on any residents with COVID symptoms prior to 9/30/20. TBS were implemented when residents were identified as COVID positive, not at the onset of resident symptoms. Interview on 9/12/20 at 11:00 a.m., with the administrator identified the DON was responsible for the IC program. He was not trained in IC, but expected the DON to maintain the IC program and ensure all symptoms and actual infections were tracked and actions taken immediately upon identifying potential outbreaks to prevent infection transmission. Interview on 10/12/20 at 3:21 p.m., with the medical director identified many residents had pre-existing conditions with symptoms similar to COVID. Any new respiratory symptoms, changes in respiratory status, bowel patterns, and general condition should have been documented and a physician contacted to help determine a potential COVID outbreak in the facility. A line list should have in place to identify any potential signs of COVID to identify patterns so TBP's could have been implemented as soon as symptoms were identified to prevent transmission of COVID. PPE Observation on 10/9/20 at 10:00 a.m., of the West and East wing PPE carts identified multiple carts were placed in the hallways. The carts containing PPE were uncovered. Folded gowns, masks, gloves, hand sanitizer and disinfecting wipes were placed on the carts. Face shields and unfolded gowns were piled on top folded gowns and supplies and were in direct contact with the cart contents. An unidentified nursing assistant (NA) walked from the front of the hallway to the rear of the hallway wearing a gown. The NA removed the gown, opened the fire extinguisher door, and hung the gown on the hook above the fire extinguisher at the end of the hallway, and left the area. Interview on 10/9/20 at 10:00 a.m., with trained medication aid (TMA)-A identified residents in the last five rooms of the West Hallway were COVID positive. Staff used washable gowns. There were no concerns with the facility's PPE supply. She was unsure if staff were able to wear gowns in all the rooms, or if they had to change gowns between each room. Staff were not to reuse gowns and were to place used gowns into the laundry bins located in each residents' room. They were not supposed to hang gowns to reuse on the hook inside the fire extinguisher door, nor place them on the clean PPE carts after using them. Observation on 10/9/20 at 10:40 a.m., on the East wing identified NA-B exited R35's room after providing personal care. NA-B walked down the hallway to a PPE cart in the East hallway removed her faceshield, wiped the shield with a disinfectant wipe and before it dried placed it directly on top of clean folded gowns on top of the PPE cart. Interview on 10/9/20 at 10:40 a.m., with NA-B identified there was no designated place to put face shields after being disinfected. Staff were either to disinfect the face shields or throw them away after use. Observation and interview on 10/12/20 at 4:30 p.m., in the West Hallway identified a gown lying on top of the clean PPE cart at the beginning of the hallway outside R9's room. There were both positive and negative COVID residing in the area of the West wing. NA-B was unsure who placed the gown on top of the clean PPE, and removed it an placed the gown in R9's room. NA-C identified R9 was COVID positive, so it didn't matter if the gown was in his room or not. Staff could use it later. Interview on 10/12/20 at 4:35 p.m., with the administrator identified there were no concerns of gown shortages at the present time. Staff were able to wear gowns between COVID positive rooms. Staff were not to store soiled gowns on the PPE carts or in rooms for reuse. Disposable gowns were to tossed in the trash inside resident rooms when cares were completed, and washable gowns were to be placed in the laundry bins inside resident rooms. The facility's undated Infection Prevention Surveillance policy, identified infection prevention begins with ongoing surveillance to identify infections causing or, have the potential to cause an outbreak. The facility was to monitor all residents exhibiting signs and symptoms of infection through ongoing surveillance. The facility was to have a systemic method of collecting, consolidating,and analyzing data concerning the frequency and cause of a disease or event followed by review of to identify areas to improve outcomes. The intent of surveillance was to identify clusters, changes in prevalent organisms, or increases in rates of infection in a timely manner. Environmental rounds were to be performed to ensure staff were in compliance with the infection control policies and procedures. The facility's 9/30/20, Pandemic COVID-19 Plan identified the IC nurse was responsible to create a system to monitor and internally review transmission of COVID-19 among residents and staff in the facility. Monitoring information was used to implement prevention interventions such as isolation, cohorting, and PPE. Staff were to don PPE upon entering the room of symptomatic residents. The facility's undated COVID-19 Community Testing Plan identified a negative COVID-19 test only indicated an individual had no [MEDICAL CONDITION] at the time of testing, and repeat tests could be required. Testing was to complement existing IC interventions but was not a replacement for good IC. The facility's undated Infection Control Program identified the program was designed to prevent the development and transmission of disease and infection. Staff were to investigate, control and prevent infections in the facility, determine what TBP's were to be placed at the time of infections, and maintain records of incidents and corrective actions related to infections. Staff were to handle, store, process, and transport linens to prevent the spread of infections. The facility's responsibility to manage infections included to (1) provide surveillance, investigation and monitoring to prevent the onset and spread of infection; (2) prevent and control outbreaks and cross-contamination using transmission-based precautions in addition to standard precautions; (3) develop, implement, maintain nursing home processes using data records of incidents, corrective action taken, and staff education to improve infection outcomes; and (4) demonstrate proper storage, handling, processing, and transport of linens to minimize contamination. The IJ was removed on 10/12/20 at 5:05 p.m. after observation, interview, and document review determined the facility implemented active monitoring for COVID-like symptoms, implemented TBP if necessary. The facility educated staff to identify, document, and initiate TBP's for residents at onset of symptoms of COVID-19 and notify the provider. IC surveillance was updated to include any potential new COVID-like symptoms or [MEDICAL CONDITION] activity.