STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245440	A. BUILDING _____ B. WING _____	04/07/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WHISPERING CREEK	102 EAST NORTH STREET JANESVILLE, MN 56048

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 implement a comprehensive infection control program to include the Centers for Medicare and Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) COVID-19 Long-Term Care (LTC) Facility Guidance for all LTC facility personnel to cancel congregate dining, and all group activities. In addition, the facility failed to ensure COVID-19 screening for employees and visitors was completed immediately upon entering the facility utilizing an active process. This had the potential to affect all 29 residents currently residing in the facility. Findings include: Upon arrival to the facility on [DATE], at 9:15 a.m. the main entrance door was locked. Surveyors were let into the building by an employee and escorted approximately 40 feet, past resident areas, to the nurses station for COVID-19 screening. While waiting at the nurses station to have temperature checked by a registered nurse (RN) and complete screening questions, residents were observed self-propelling in wheelchairs near the nurses station and in the adjacent hallways. In addition, upon entrance into the facility, observed many residents and some staff in the dining room watching worship service on a big screen TV. During interview on 4/7/20, at 9:30 a.m. the director of nursing (DON) stated staff do self-screening for COVID-19 symptoms when they arrive to work. DON stated staff enter through the main entrance or the basement entrance and walk to the conference room where the time clock is located; check their temperature and complete screening questions. During same interview, DON stated residents are still free to attend dining at the time of their choosing (facility has open dining hours: 7 to 9 a.m., 11 a.m. to 1 p.m. and 4 to 6 p.m.) and that meals were not routinely served in resident rooms. DON further stated they are still doing group activities ensuring residents are six feet apart. DON stated the facility was following COVID-19 guidelines from the Mayo Clinic, a three page document and a guide from Pathways. During interview on 4/7/20, at 9:45 a.m. activity aide (AA)-A stated they decreased their activity groups to 13 residents in the dining area, spaced at least six feet apart. In addition, the AA-A stated she was aware of the COVID-19 screening process for employees when arriving to work and stated she screened herself. During observation on 4/7/20, at 9:55 a.m. observed 12 residents and two staff members in the dining room watching worship service on TV. While observing, another resident walked in and sat down at a table. Each resident was at their own table; tables appeared to be at least six feet apart. During observation on 4/7/20, at 10:00 a.m. the worship service ended and staff wheeled some residents back to their rooms. Other residents walked or self-propelled their wheelchairs toward the nurses station and hallways. This resulted in congestion around the nurses station and in the hallway. As staff were returning residents to their rooms in wheelchairs, other residents were self-propelling in wheelchairs going the opposite direction; only inches apart due to the narrow width of the hallway. Staff did not ensure residents maintained a distance of six feet apart. During interview on 4/7/20, at 10:05 a.m. in a resident hallway, nursing assistant (NA)-A stated most residents are taken by wheelchair to the dining room for meals where there is one resident to a table. NA-A further stated group activites are the same with one resident per table in the dining room. While speaking to NA-A, a resident was observed walking in the same hallway that other residents were self-propelling in wheelchairs; not maintaining a distance of six feet. At end of interview, observed two residents sitting in wheelchairs near the nursing station watching the activity of the facility. The nurses station was at a juncture that allows visualization of the dining room and the three hallways. On 4/7/20, at 10:15 a.m. observed an employee arrive at the facility main entrance. She was let in by staff and walked approximately 50 feet through resident areas to the conference room where she punched in, checked her own temperature and wrote on the screening log. She did not put on a mask. Later learned this was the facility social worker (SW) who stated she put on a mask once she arrived to her office, located in a resident hallway. During interview on 4/7/20, at 10:30 a.m., dietary assistant (DA)-A stated residents eat in the dining room, 13 at a time; one resident to a table and six feet apart. DA-A stated she was aware of the new COVID-19 guidelines, and stated she screened herself when arriving to work. On 4/7/20, at 11:05 a.m. observed 11 residents and one staff in the dining room for lunch; each resident at a separate table, all facing the front of the room. On 4/7/20, at 11:09 a.m. observed an employee arrive to the facilty main entrance. She was let in by staff and walked unmasked to the nurses station and stood there until a nurse arrived to check her temperature. Nurse checked her temperature with a temporal thermometer and employee wrote in the screening log. During interview on 4/7/20, at 11:30 a.m. DON stated the facility continued to have residents eat in the dining room and attend group activities in the dining room, but had reduced dining and activities to only 13 residents at one time. DON indicated that having 13 residents spaced six feet apart did not qualify as communal dining or communal activities. DON verified having read the Centers for Medicare & Medicaid Services (CMS) memo regarding canceling communal dining and group activites; but stated he did not interpret the guidance as needing to stop group dining and activites all together. DON confirmed that the residents paths do cross in the hallway and that they are in close range (less than six feet apart) when coming and going from dining and activities. Furthermore, DON again confirmed that employees are self-screening for Covid-19 symptoms. Facility guide titled: Staff Educational Update Infection Control Practices COVID-19 Information and Practices, dated 3/19/20, indicated: 1. Screening process & monitoring A. Staff screening - remember we are part of the screening process. We must self screen when we come into work. Screening station at the time clock. The questions and criteria are listed on the screening form. Pathways Health Services, Inc policy titled Infection Prevention and Control Manual; Interim Policy for Suspected or Confirmed Coronavirus (COVID-19); undated, indicated: 1. Policy: It is the policy of this facility to minimize exposures to respiratory pathogens and promptly identify residents with Clinical Features and an Epidemiologic Risk for the COVID-19 and to adhere to the Federal and State/Local recommendations (to include, for example: Admissions, Visitation, Precautions: Standard, Contact, Droplet and/or Airborne Precautions, including the use of eye protection). 2. No group activities (internal or external) or communal dining will occur in the facility at this time. 3. Residents will be reminded to practice social distancing and perform frequent hand hygiene. 4. Screening Employees: a. Facility will actively verify absence of fever and respiratory symptoms when employees report to work-beginning of their shift. Three page document DON stated was from Mayo Clinic; however the document does not include the name Mayo Clinic, titled: Covid-19 Facility Exposure Management; After you have a suspected or confirmed case of Covid-19; dated 3/16/20, indicated: 1. Staff Management a. Take temp of all staff before beginning of shift. Record on temp log and absence of symptoms.

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.