DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 14, 2020

Administrator
Grand Avenue Rest Home
3956 Grand Avenue S0uth
Minneapolis, MN 55409

RE: CCN: 24E150
Survey Start Date: February 27, 2020

Dear Administrator:

On July 14, 2020 the Minnesota Department(s) of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of June 22, 2020. Per the CMS Memo QSO-20-20-All, enforcement remedies were suspended from March 23, 2020 to May 31, 2020 and will be evaluated at a later date.

The CMS Region V Office may notify you of their determination regarding any remedies.

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

Electronically delivered
May 27, 2020

Administrator
Grand Avenue Rest Home
3956 Grand Avenue S0uth
Minneapolis, MN 55409

SUBJECT: SURVEY RESULTS
CCN: 24E150
Cycle Start Date: February 27, 2020

Dear Administrator:

SUSPENSION OF SURVEY AND ENFORCEMENT ACTIVITIES
The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with Memorandum QSO-20-20-All, CMS is suspending certain Federal and State Survey Agency surveys, and delaying revisit surveys, for all certified provider and supplier types.

During this time, CMS is prioritizing and conducting only the following surveys: focused infection control surveys, investigations of complaints and facility-reported incidents that are triaged at the Immediate Jeopardy (IJ) level, and revisit surveys for unremoved IJ level deficiencies. With the exception of unremoved IJs, CMS will also be exercising enforcement discretion during the suspension period. For additional information on the prioritization of survey activities please visit https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0.

SURVEY RESULTS
On May 11, 2020, the Minnesota Department of Health completed a COVID-19 Focused Survey at Grand Avenue Rest Home to determine if your facility was in compliance with Federal requirements related to implementing proper infection prevention and control practices to prevent the development and transmission of COVID-19. The survey revealed that your facility was not in substantial compliance. The findings from this survey are documented on the electronically delivered CMS 2567.

PLAN OF CORRECTION
You must submit an acceptable electronic plan of correction (ePOC) for the enclosed deficiencies that were cited during the May 11, 2020 survey. Grand Avenue Rest Home may choose to delay submission of an ePOC until after the survey and enforcement suspensions have been lifted. The provider will have ten days from the date the suspensions are lifted to submit an ePOC. An acceptable ePOC will

serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. Please note that if an onsite revisit is required, the revisit will be delayed until after survey and enforcement suspensions are lifted. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- How the facility will identify other residents having the potential to be affected by the same deficient practice;
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur;
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur; and
- The date that each deficiency will be corrected.

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Sarah Grebenc, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: sarah.grebenc@state.mn.us
Fax: (651) 215-9697

INFORMAL DISPUTE RESOLUTION

You have one opportunity to dispute the deficiencies cited on the May 11, 2020 survey through Informal Dispute Resolution (IDR) in accordance with 42 CFR § 488.331. To receive an IDR, send (1) your written request, (2) the specific deficiencies being disputed, (3) an explanation of why you are disputing those deficiencies, and (4) supporting documentation by fax or email to:

Sarah Grebenc, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: sarah.grebenc@state.mn.us
Fax: (651) 215-9697

An IDR may not be used to challenge any aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

An IDR, including any face-to-face meetings, constitutes an informal administrative process that in no way is to be construed as a formal evidentiary hearing. If you wish to be accompanied by counsel for your IDR, then you must indicate that in your written request for informal dispute resolution.

Grand Avenue Rest Home may choose to delay a request for an IDR until after the survey and enforcement suspensions have been lifted. The provider will have ten days from the date the suspensions are lifted to submit a request for an IDR in accordance with the instructions above.

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES

The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at https://qioprogram.org/. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at https://qioprogram.org/locate-your-qio.

Sincerely,

Douglas S Larson

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E150	A. BUILDING ______ B. WING ______	05/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND AVENUE REST HOME	**3956 GRAND AVENUE S0UTH MINNEAPOLIS, MN 55409**

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F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control survey was conducted from 5/11/20 until 5/13/20, at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was determined NOT to be in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, a revisit of your facility will be conducted to validate substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		5/13/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/13/2020

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 880	Continued From page 1 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation,	F 880		

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F 880	Continued From page 2 depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow Centers for Medicare & Medicaid Services (CMS) guidance QSO-20-14-NH for actively screening staff in accordance with Centers for Disease Control (CDC) guidelines for COVID-19. In addition, the facility failed to ensure proper infection control practices by not utilizing the temperature threshold recommended by the CDC for screening, failure to wear eye protection when providing direct care to residents, and failure to adhere to CDC and Occupational Safety and	F 880	We believe we have had no cases of Covid because of common sense. Staff was wearing masks for source control weeks before the mandate and were screening and then blocking non-critical visitors weeks before the mandate. These were common sense measures to keep our residents safe. The facility has corrected the screening process. The nurse on duty screens anyone entering by asking the screening	

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F 880	Continued From page 3 Health Administration (OSHA) guidelines for mask utilization. This had the potential to affect all 19 residents who resided in the facility. Findings include: During an interview on 5/11/20, at 9:30 a.m. licensed practical nurse (LPN)-A stated a nurse screens employees and visitors upon arrival to the facility. Screening consisted of an active process of checking an individual's temperature and asking Covid-19 screening questions. However, nurses were permitted to check their own temperature and document their own screening questions resulting in a passive screening process. Furthermore, LPN-A stated an employees' temperature was required to be under 100.4 degrees Fahrenheit (F) in order to work. During an interview on 5/11/20, at 9:30 a.m. office manager (OM)-A stated they had not implemented eye protection for employees, stating "these ladies haven't been outside in seven weeks." OM-A indicated she was not aware of the CDC recommendation for eye protection. In addition, OM-A reported residents are screened for Covid-19 symptoms twice a day and the temperature threshold was 100.4 degrees F, above the CDC recommendation of 100.0 degrees F. During an observation and interview on 5/11/20, at 9:30 a.m. the office manager, nurse, activities personnel, cook and housekeeper were observed wearing N95 masks which, according to the CDC, are intended for use when providing care for patients with suspected or known Covid-19. OM-A stated there were no suspected or known Covid-19 residents in the facility, but "cloth masks	F 880	questions and taking the temperature and recording that. The incoming person then initials the questions and the nurse validates that the temperature is 100.0 F or below (was 100.4 F). The nurse then initials the screening. Our policy was correct, but our screening document did have the wrong temperature. We corrected that 5/12/20. Staff was trained in the change. Screening is monitored by the Director of Nursing, who is also the Infection Preventionist. Because we did adequate emergency preparedness planning, we had a supply of N95 masks. It is a fact that those prevent transmission better than a paper or cloth mask. We exclusively wore N95 masks, so there was no need for a policy to choose which mask to use. Since that time, we have downgraded to surgical masks which are less effective at the direction of MDH. We have updated the policy for which mask is appropriate for normal use and when caring for a suspected or covid-positive resident. We have changed the storage policy of N95 masks to paper bags if storage is needed. We were not aware of the new guidance on wearing eye protection during patient care at the time of this survey. The guidance from the CDC is dated 5/18/2020, which is after the date of this survey. Our previous policy reflected spill or splatter hazards. We have adjusted the policy to include all patient care and close resident contact. Staff has been wearing eye protection since	

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F 880	Continued From page 4 aren't effective enough" so staff were given N95 masks. OM-A verified that OSHA-required medical clearance had not been completed nor was the required fit testing done prior to issuing N95 masks to employees, nor was there a plan in place to do so. OM-A's mask, which was originally white in color appeared dirty and grayish in color. OM-A was observed touching it frequently as she spoke and indicated she was unaware to avoid touching the outside of the mask, and if touched, to wash hands. During an interview on 5/11/20, at 10:10 a.m. the N95 mask of activities employee (AE)-A was observed to have a colored drawing on the outside center of it. (AE)-A stated she did the drawing on her mask and was not aware this may have reduced the integrity of the mask. During an interview and observation on 5/11/20, at 10:20 a.m. LPN-A stated staff reused their N95 mask for seven shifts and stored them in Ziploc bags between shifts. Masks in Ziploc bags were observed pinned to a bulletin board in the front office rather than in a breathable container such as a paper bag. LPN-A stated she was unaware masks should be stored in a breathable container. During an interview and observation on 5/11/20, at 10:30 a.m. housekeeper (H)-A's N95 mask, originally white in color, was now grayish in color. H-A was observed pinching the mask to adjust it as she spoke, to the point where there was a gray fuzzy protrusion on the center of the mask. (H)-A stated she was not aware that she should not touch the outside of her mask and was unaware the mask should be changed if soiled. In addition, one of the two straps on the N95 mask was not	F 880	5/13/2020. Eye protection may be safety glasses with side protection, goggles, or face shields. Face shields are required when caring for a suspected or covid positive resident. All staff is trained in the proper use of PPE. The proper use of PPE is monitored and enforced by the Director of Nursing, who is also the Infection Preventionist.	

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F 880	Continued From page 5	F 880		

secured to her head but rather under her chin. When pointed out, (H)-A stated the mask felt too confining with both straps secured.

During an interview and observation on 5/11/20 at 10:40 a.m. the N95 mask for cook (C)-A slipped down on her face as she spoke causing her to frequently adjust and push it back up. The mask appeared gray and dirty. C-A stated staff got a new mask after seven days.

During an interview on 5/11/20, at 11:15 a.m. OM-A stated they had no policy regarding masks, including which mask to use in specific clinical circumstances, no policy addressing proper handling of masks, and no policy indicating how long a N95 mask could be reused. OM-A stated the rational to wear masks for seven days was due to having a limited supply of N95 masks; however she did not know what the supply of N95 masks were as they were at her home. The decision to wear N95 masks was for extra precaution although there were no residents who had Covid-19 or who had symptoms of Covid-19. OM-A stated she had 100 surgical masks, but were not using them.

During an exit interview via telephone on 5/13/20, at 2:35 p.m. the administrator, OM-A and director of nursing (DON) were informed their screening temperature of 100.4 degrees F utilized for residents, staff and visitors was higher than the temperature of 100.0 degrees F. recommended by the CDC. The administrator stated he knew the temperature should be 100.0 degress F and had "corrected it."

During record review the two documents listed below reflected the screening temperature for

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F 880	Continued From page 6	F 880		

residents, staff and visitors to be 100.4 degrees F.

Facility policy titled GRAND AVENUE RESIDENCE COVAD-19 [sic] OUTBREAK, dated 3/30/2020 indicated:
Policy: Even before a confirmed outbreak occurs within the facility, we will take steps to reduce exposure. If an outbreak occurs, we will mitigate widespread contamination of staff and residents and treat the infected residents to the best of our ability and that of the healthcare system.
--Screening of visitors and staff may occur. When this is implemented, use the screening tool to document.
--When at high risk or during an outbreak, we suspend visitations, activity outings and unnecessary appointments to protect residents and staff. All personnel who are not employees and need to come into the building will wear a mask. Doors are locked 24x7 and anyone wishing to enter will need to call the office for clearance. All staff will wear a mask during this time.
--Staff will wear protective equipment as needed when caring for residents who are ill and performing direct care: Gloves, masks, gowns, shields, etc.
--Take vitals and listen to lung sounds at least once per shift. Temperatures will be taken at least twice per shift. Definition of fever is single oral greater than 100.4 degrees F. It is best to look at resident baseline temp.
--When a temp reaches 101 F and if any diminishing lung sounds, call MDH for advice.

Facility document titled GRAND AVENUE RESIDENCE - EMPLOYEE COVAD-19 [sic] TRACKING TOOL, updated 04/25/2020 indicated:

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F 880	Continued From page 7 --Use one form per day starting with the 7-3 shift. All staff must check in with nursing. --Please complete each box. Fill in the time, your name and initial the other boxes as appropriate. --If you have symptoms of COVAD-19 [sic], immediately notify the Director of Nursing. There were nine columns on the tracking tool which included time, staff name and six symptom-screening questions. Last column read: Temp (F) Must be below 100.4 F.	F 880		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 880	Continued From page 1 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F 880		

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F 880	Continued From page 2 (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow Centers for Medicare & Medicaid Services (CMS) guidance QSO-20-14-NH for actively screening staff in accordance with Centers for Disease Control (CDC) guidelines for COVID-19. In addition, the facility failed to ensure proper infection control practices by not utilizing the temperature	F 880		

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threshold recommended by the CDC for screening, failure to wear eye protection when providing direct care to residents, and failure to adhere to CDC and Occupational Safety and Health Administration (OSHA) guidelines for mask utilization. This had the potential to affect all 19 residents who resided in the facility.

Findings include:

During an interview on 5/11/20, at 9:30 a.m. licensed practical nurse (LPN)-A stated a nurse screens employees and visitors upon arrival to the facility. Screening consisted of an active process of checking an individual's temperature and asking Covid-19 screening questions. However, nurses were permitted to check their own temperature and document their own screening questions resulting in a passive screening process. Furthermore, LPN-A stated an employees' temperature was required to be under 100.4 degrees Fahrenheit (F) in order to work.

During an interview on 5/11/20, at 9:30 a.m. office manager (OM)-A stated they had not implemented eye protection for employees, stating "these ladies haven't been outside in seven weeks." OM-A indicated she was not aware of the CDC recommendation for eye protection. In addition, OM-A reported residents are screened for Covid-19 symptoms twice a day and the temperature threshold was 100.4 degrees F, above the CDC recommendation of 100.0 degrees F.

During an observation and interview on 5/11/20, at 9:30 a.m. the office manager, nurse, activities

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personnel, cook and housekeeper were observed wearing N95 masks which, according to the CDC, are intended for use when providing care for patients with suspected or known Covid-19. OM-A stated there were no suspected or known Covid-19 residents in the facility, but "cloth masks aren't effective enough" so staff were given N95 masks. OM-A verified that OSHA-required medical clearance had not been completed nor was the required fit testing done prior to issuing N95 masks to employees, nor was there a plan in place to do so. OM-A's mask, which was originally white in color appeared dirty and grayish in color. OM-A was observed touching it frequently as she spoke and indicated she was unaware to avoid touching the outside of the mask, and if touched, to wash hands.

During an interview on 5/11/20, at 10:10 a.m. the N95 mask of activities employee (AE)-A was observed to have a colored drawing on the outside center of it. (AE)-A stated she did the drawing on her mask and was not aware this may have reduced the integrity of the mask.

During an interview and observation on 5/11/20, at 10:20 a.m. LPN-A stated staff reused their N95 mask for seven shifts and stored them in Ziploc bags between shifts. Masks in Ziploc bags were observed pinned to a bulletin board in the front office rather than in a breathable container such as a paper bag. LPN-A stated she was unaware masks should be stored in a breathable container.

During an interview and observation on 5/11/20, at 10:30 a.m. housekeeper (H)-A's N95 mask, originally white in color, was now grayish in color.

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F 880	Continued From page 5 H-A was observed pinching the mask to adjust it as she spoke, to the point where there was a gray fuzzy protrusion on the center of the mask. (H)-A stated she was not aware that she should not touch the outside of her mask and was unaware the mask should be changed if soiled. In addition, one of the two straps on the N95 mask was not secured to her head but rather under her chin. When pointed out, (H)-A stated the mask felt too confining with both straps secured. During an interview and observation on 5/11/20 at 10:40 a.m. the N95 mask for cook (C)-A slipped down on her face as she spoke causing her to frequently adjust and push it back up. The mask appeared gray and dirty. C-A stated staff got a new mask after seven days. During an interview on 5/11/20, at 11:15 a.m. OM-A stated they had no policy regarding masks, including which mask to use in specific clinical circumstances, no policy addressing proper handling of masks, and no policy indicating how long a N95 mask could be reused. OM-A stated the rational to wear masks for seven days was due to having a limited supply of N95 masks; however she did not know what the supply of N95 masks were as they were at her home. The decision to wear N95 masks was for extra precaution although there were no residents who had Covid-19 or who had symptoms of Covid-19. OM-A stated she had 100 surgical masks, but were not using them. During an exit interview via telephone on 5/13/20, at 2:35 p.m. the administrator, OM-A and director of nursing (DON) were informed their screening	F 880		

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F 880	Continued From page 6 temperature of 100.4 degrees F utilized for residents, staff and visitors was higher than the temperature of 100.0 degrees F. recommended by the CDC. The administrator stated he knew the temperature should be 100.0 degress F and had "corrected it." During record review the two documents listed below reflected the screening temperature for residents, staff and visitors to be 100.4 degrees F. Facility policy titled GRAND AVENUE RESIDENCE COVAD-19 [sic] OUTBREAK, dated 3/30/2020 indicated: Policy: Even before a confirmed outbreak occurs within the facility, we will take steps to reduce exposure. If an outbreak occurs, we will mitigate widespread contamination of staff and residents and treat the infected residents to the best of our ability and that of the healthcare system. --Screening of visitors and staff may occur. When this is implemented, use the screening tool to document. --When at high risk or during an outbreak, we suspend visitations, activity outings and unnecessary appointments to protect residents and staff. All personnel who are not employees and need to come into the building will wear a mask. Doors are locked 24x7 and anyone wishing to enter will need to call the office for clearance. All staff will wear a mask during this time. --Staff will wear protective equipment as needed when caring for residents who are ill and performing direct care: Gloves, masks, gowns, shields, etc. --Take vitals and listen to lung sounds at least	F 880		

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once per shift. Temperatures will be taken at least twice per shift. Definition of fever is single oral greater than 100.4 degrees F. It is best to look at resident baseline temp.
--When a temp reaches 101 F and if any diminishing lung sounds, call MDH for advice.

Facility document titled GRAND AVENUE RESIDENCE - EMPLOYEE COVAD-19 [sic] TRACKING TOOL, updated 04/25/2020 indicated:
--Use one form per day starting with the 7-3 shift. All staff must check in with nursing.
--Please complete each box. Fill in the time, your name and initial the other boxes as appropriate.
--If you have symptoms of COVAD-19 [sic], immediately notify the Director of Nursing.

There were nine columns on the tracking tool which included time, staff name and six symptom-screening questions. Last column read: Temp (F) Must be below 100.4 F.