Electronically delivered
August 2, 2020

Administrator
Tuff Memorial Home
505 East 4th Street
Hills, MN 56138

RE: CCN: 245548
Cycle Start Date: May 19, 2020

Dear Administrator:

On July 28, 2020, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Electronically delivered
June 3, 2020

Administrator
Tuff Memorial Home
505 East 4th Street
Hills, MN 56138

SUBJECT: SURVEY RESULTS
CCN: 245548
Cycle Start Date: May 19, 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 19, 2020, the Minnesota Department of Health completed a COVID-19 Focused Survey at Tuff Memorial 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 19, 2020 survey. Tuff Memorial 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:

Nicole Osterloh, Unit Supervisor
Health Regulation Division
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230 Cell: 218-340-308
Fax: 507-537-7194

INFORMAL DISPUTE RESOLUTION

You have one opportunity to dispute the deficiencies cited on the May 19, 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:

Nicole Osterloh, Unit Supervisor
Health Regulation Division
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230 Cell: 218-340-308
Fax: 507-537-7194

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.

Tuff Memorial 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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A COVID-19 Focused Infection Control survey was conducted 5/18/20 through 5/19/20, at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.73(b)(6). The facility was IN full compliance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facilty acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control survey was conducted 5/18/20 through 5/19/20, at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was NOT in compliance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Upon receipt of an acceptable electronic POC, an revisit of your facility will be conducted to validate that 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) §483.80 Infection Control The facility must establish and maintain an	F 880		6/9/20

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

Electronically Signed | 06/09/2020

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 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, depending upon the infectious agent or organism involved, and	F 880		

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F 880	Continued From page 2 (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 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	F 880	Department heads will remind staff that they must have the charge nurse, Jane, or Emily do the COVID assessment before they enter past the timeclock and start their shift. Department heads will have a checklist to ensure that they have spoken and described the screening process to each of their staff. A large sign was posted on the door to remind all staff of the procedure as well. A radio is placed by the door as well for staff to radio if one of the designated temperature takers is not there, this is on the sheet as well as explained by their department head. The	

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F 880	Continued From page 3 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	F 880	staff members who did not have the designated people take their temps in the past have been spoken to and educated on the importance of having someone qualified take the temperature. Further infractions will result in discipline following our facilities policy. All residents' screenings will consist of a set of Vital Signs daily along with O2 sat. Those that are alert and able to answer questions will be asked the standard COVID questions in regards to if they are experiencing any symptoms. If the resident cannot answer questions, lung sounds will be assessed and assigned staff will be asked about new onset of cough, shortness of breath, or change in appetite. Our infection control nurse will monitor the screening daily of both residents and staff to ensure it is getting completed correctly and accurately. These results will be brought monitored through out monthly QAPI meetings. These will be monitored daily through the remainder of the Pandemic and will be decided at the QAPI team's discretion when to stop monitoring it. Eye goggles have been ordered and will be used by direct care staff once they arrive. Education will be provided in the form of on the spot training where all staff are educated and sign off on the proper procedures for utilizing eye goggles and a refresher on other PPE.	

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F 880	Continued From page 4 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.	F 880	Our infection control program will have 2 nurses work on analysis, source of transmission, corrective actions, and preventative measures until our new infection preventionist is trained (away on maternity currently). The 2 nurses will work together at designated time 3 times a week. These items will be completed or started on 6/9/2020 besides the eye protection as that will begin as soon as we have sufficient supply which is on its way from a vendor.	

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F 880	Continued From page 5 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.	F 880		

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F 880	Continued From page 6	F 880		

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 an early onset upper respiratory infection (URI). 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 an URI and cough. 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 RSV (a viral respiratory infection). R2's URI was resolved on 1/20/20. R3 was diagnosed with an URI on 1/24/20. 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

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F 880	Continued From page 7	F 880		

two residents diagnosed with URIs and one resident with cellulitis in the West wing. 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 pneumonia. R4's symptoms resolved on 2/12/20. Four residents (R5, R6, R7, and R8) had cellulitis in the West wing.
(2) On 2/6/20, R5 was diagnosed with left lower extremity cellulitis. R5's infection resolved on 2/16/20.
(3) On 2/11/20, R6 was diagnosed with left lower extremity cellulitis. R5's infection resolved on 2/29/20.
(4) R7 was diagnosed with cellulitis. The log lacked the infection date of onset and date of resolution.

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 pneumonia. R4 was treated with antibiotics. 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

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F 880	Continued From page 8	F 880		

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 cellulitis. One resident's cellulitis 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.

Review of the March 2020, Infection Control Log identified on 3/4/20, R8 developed chills and a cough. R8 was diagnosed with pneumonia. R8's symptoms resolved on 3/10/20.

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 pneumonia. R8 was treated with antibiotics. 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

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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 RSV, no additional preventative measures were taken because she rarely left her room. 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 cellulitis 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

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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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 viral 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)

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F 880	Continued From page 11 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.	F 880		