DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 28, 2020

Administrator
Renvilla Health Center
205 Southeast Elm Avenue
Renville, MN 56284

RE: CCN: 245554
Survey Start Date: May 14, 2020

Dear Administrator:

On June 19, 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 19, 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,

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

Electronically delivered
May 29, 2020

Administrator
Renvilla Health Center
205 Southeast Elm Avenue
Renville, MN 56284

SUBJECT: SURVEY RESULTS
CCN: 245554
Cycle Start Date: May 14, 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 14, 2020, the Minnesota Department of Health completed a COVID-19 Focused Survey at Renvilla Health Center 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 14, 2020 survey. Renvilla Health Center 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 14, 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.

Renvilla Health Center 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

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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
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245554	A. BUILDING _____ B. WING _____	05/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENVILLA HEALTH CENTER	205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284

(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 5/14/20, at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.475. The facility was IN full compliance.	E 000		
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control survey was conducted 5/14/20, 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 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	F 880		6/19/20

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

Electronically Signed | 06/05/2020

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 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 (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	F 880		

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F 880	Continued From page 2 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 put on personal protective equipment (PPE) for resident (R1) on isolation prior to entering the room, ensure residents who were readmitted were isolated on precautions for 10 days (R2) following a negative COVID test or 14 days (R3) without testing, and appropriately screen residents for signs and symptoms in accordance with Centers for Disease Control (CDC) and Centers for Medicare and Medicaid Services (CMS) guidelines for COVID-19. This had the potential to affect all 46 residents in the facilty. Findings include: PPE AND ISOLATION R1's face sheet identified he was admitted to the facility on 4/1/2020, with a diagnosis of clostridium difficile (c-diff) (highly infection bacteria found in stool).	F 880	1) Upon further assessment related to R1 it was determined that Contact Precautions were no longer needed and were discontinued on 5/15/20. R2 was placed on Isolation Precautions with full PPE on 5/14/20 due to readmission on 5/12/20. R3 did not require Isolation Precautions as it was past the 14 days since readmission. The resident screening log was reviewed and information added about screening for signs and symptoms of COVID-19 including shortness of breath, cough, fever, sore throat, new body aches, chills, headache, new loss of taste or smell, nausea, vomiting, and diarrhea. 2) All residents who are on Contact Precautions have the potential to be affected. All residents who are readmitted after an overnight stay have the potential to be affected. All residents are screened	

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F 880	Continued From page 3 R1's care plan identified a risk for bowel incontinence related to impaired mobility, cognition, loose stools, and diagnoses of c-diff upon admission. R1's care plan interventions included use of incontinent products, monitoring bowel movement consistency, offer assistance to toilet, and provide medications for treatment for c-diff as ordered. The care plan further instructed staff to monitor labs and vital signs as ordered and report any abnormal's to medical doctor (MD), and provide supportive care as needed. The careplan failed to address R1's need for contact isolation precautions for c-diff. R1's bowel summary for the past two weeks identified documentation of loose stools for R1 on 4/17/20, 4/22/20 through 4/25/20, 4/28/20, 5/7/20, and again on 5/10/20. Observation on 5/14/20 at 8:37 a.m., of R1 room identified he had an isolation cart outside of his room containing PPE with written instructions visible on top of the cart identifying R1's contact precautions. The sign indicated all staff must clean their hands before entering the room, put on gloves and a gown, clean their hands when leaving the room, and remove and discard gloves/gown. Interview on 5/14/20, at 10:08 a.m. with housekeeper (HK)-A stated she did not need full PPE when entering R1's room for cleaning. HK-A stated housekeepers were required to use gloves, mask, and eye protection and did not need to use a gown. Interview on 5/14/2020, at 10:12 a.m. with environmental service manager (EM)-A identified	F 880	for signs and symptoms and have the potential to be affected. 3) All staff will be educated on the proper use of PPE when a resident is on Contact Precautions. All staff will be educated on the Isolation Precautions that will be required if a resident is readmitted after being out of facility overnight. All staff will be educated on the screening process with all residents including Vital Signs and monitoring for signs and symptoms of COVID-19. 4) Audits on proper PPE use will be completed weekly x4 weeks then monthly x3months. Audits on resident screening will be completed weekly x4 weeks then monthly x 3 months. Audit results will be reviewed at QAPI meetings for further recommendation 5) DON or designee will be responsible	

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F 880	Continued From page 4	F 880		

housekeeping staff should be utilizing full PPE when entering R1's room for cleaning, and would expect staff to follow the identified contact precautions and put on the PPE when in R1's room.

Interview on 5/14/20 at 11:48 a.m., with RN-A identified R1 had been on contact transmission based precautions for C-Diff.

Observation and interview on 5/14/20 at 12:00 p.m., with activity aide (AA)-A while entering R1's room identified she only had on a face mask and eye protection to deliver the noon meal. AA-A set the meal tray down on the bedside table and exited the room. AA-A stated she was not required to put on all the PPE to deliver a meal to R1's room, even though it was clearly identified on the signage prior to entering R1's room.

Interview on 5/14/20 at 8:38 a.m., with registered nurse (RN)-A identified R1 was the only resident on isolation precautions. RN-A indicated R2 was was recently hospitalized but was not on precautions, because she had tested negative for COVID-19 while in the hospital and therefore, had not needed to be isolated upon their return.

Interview on 5/14/20, at 9:09 a.m. with nursing assistant (NA)-B identified there were no residents on isolation or in precautions except for R1 for C-diff. NA-B identified R3 had a stay at the hospital but was unaware of any other residents having been in the hospital.

R2's progress note on 5/11/20, identified the facility received a call from the dialysis unit updating them R2 was being evaluated in the emergency department for shortness of breath

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F 880	Continued From page 5	F 880		

and rapid respirations, and would most likely be tested for COVID-19. On 5/12/20, identified R2 had returned from the hospital following an overnight stay for shortness of breath, and was tested for COVID-19 with negative results. The progress note lacked information including implementation of quarantine isolation following R2's hospital return for 10 days following a negative test.

R3's progress note on 4/18/20, identified R3 was sent to emergency room for evaluation following a fall with pain. A follow up call from the hospital identified that R3 was admitted overnight for pain control. A progress note on 4/19/20, identified R3 had returned to the facility with no mention of placing R3 on isolation quarantine including for 14 days following R3's hospital stay having no testing performed while hospitalized.

Interview on 5/14/20 at 12:43 p.m., with the infection preventionist (IP) identified not everyone needed PPE for R1, and indicated when R1 was admitted with C-diff contact precautions. IP identified that PPE was required for the staff providing direct care per the facility policy. IP further identified that the policy indicated PPE was for contact or potential contact with C-diff so staff must wear the PPE during those times, and because R1 had not had not had loose stools recently other staff would not have to be using PPE at this time. IP identified R1 was diagnosed with C-diff since December and had an increased risk for recurring C-diff infection. IP identified residents readmitted from the hospital were to be placed on quarantine for fourteen days, and verified the facility had not implemented precautions with the use of full PPE for residents who were new admissions or hospital returns

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F 880	Continued From page 6	F 880		

unless they were symptomatic. IP indicated she had been unaware of any requirement for precautions while quarantined. During a subsequent interview at 1:55 p.m. IP agreed that there could be potential for confusion for staff if the facility did not follow the direction on their contact precaution instruction form.

Interview on 5/14/20 at 2:46 p.m., with the director of nursing (DON) identified the contact precautions sign indicated all staff needed to put on PPE before entering the room and remove PPE before exiting. DON verified not all staff were utilizing PPE when in R1's room. Hospital returns required a fourteen day quarantine to their room, but did not require implementation of full PPE use during quarantine. The DON agreed facility IC policies and procedures were to follow CDC guidance.

Review of the 4/2/20, St. Francis Health Services of Morris COVID-19 Segregation and Isolation Measures policy identified isolation as used for a resident with potential or contagious illness or disease restricted to their immediate living area. Precautions and isolation measures were to be used for residents requiring isolation restrictions requirements with potential exposure. Staff should use the recommended PPE for COVID-19 during isolation in a non-segregated areas like their room. Residents with no known symptoms upon admission and or no COVID-19 testing completed would be placed in isolation for fourteen days. There was no mention in the policy residents who were readmitted with a negative test would need further isolation for 14 days. Those who had no test would require 14 days per CDC guidance.

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F 880	Continued From page 7 Review of the 9/11/17, St. Francis Health Services of Morris C-Diff policy, identified it directed staff to implement contact precautions for residents with suspected or known infections of C-Diff as it could be transmitted by indirect contact with the environment or direct contact with the resident. All staff should wear PPE for residents with C-Diff, and during all interactions in which they may come into contact with body fluids or potentially contaminated items within the room. Review of the 9/13/17, St. Francis Health Services of Morris Environmental Cleaning and Disinfection Program policy identified enhanced disinfection and cleaning was required when residents had communicable infectious diseases including Clostridium Difficile. Residents with communicable diseases or infection required the use of transmission-based and isolation precautions per Minnesota Department of Health (MDH) and CDC guidelines, and directed staff to use proper PPE when cleaning a room. RESIDENT SCREENING Review of the Resident Screening log dated 5/14/20, identified staff were to document the residents vital signs (VS) twice daily, and instructed staff to report any temperatures over 100.0 degrees Ferenheiht (F) or a pulse oximeter reading less than 90 percent (%) to the charge nurse immediately. The log lacked documentation of staff actively screening residents for all COVID-19 symptoms. Interview on 5/14/20 at 8:38 a.m., with registered nurse (RN)-A identified NA's were responsible for monitoring the resident VS taken every day shift, and a partial set of vital signs (temperatures and	F 880		

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F 880	Continued From page 8	F 880		

respirations) in the evening. RN-A stated the charge nurse reviewed the resident screening logs to ensure they were complete, and within normal parameters. RN-A indicated active COVID-19 symptom screening was not performed for residents unless they were quarantined.

On 5/14/2020, at 9:12 a.m. RN-B stated NAs obtained and recorder resident vital signs on a log twice daily, and would reported any signs of infection to the charge nurse. RN-B identified the charge nurse reviewed the vital signs and signed the log when completed. RN-B indicated nursing staff was not expected to actively screen residents for symptoms of COVID-19 unless a nursing assistants had reported signs of illness. RN-B agreed, if staff were not instructed to screen for all symptoms and only temperature and oxygen levels, they could likely miss key elements of infection.

Interview on 5/14/20 at 12:43 p.m., with the infection preventionist (IP) identified resident symptom screening for COVID-19 was done by the charge nurse only when symptoms were reported. The IP stated NA's were trained to monitor vital signs, and observe/report signs and symptoms of COVID-19 to the charge nurse to assess the residnet and take additional actions if needed. The IP was unaware if all staff knew all signs and symptoms of COVID-19 to ensure those were identified at the time of their procuring VS data.

On 5/14/2020, at 2:46 p.m. the DON stated nursing staff had not actively screened residents for symptoms of COVID-19 because they were continually observed by staff throughout the day.

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F 880	Continued From page 9 The DON stated all staff were instructed to report any signs of illness to the charge nurse, IP, or DON immediately. The DON identified NA's measured and documented residnet vital signs twice daily, and were instructed to report any temperature greater than 100 degrees F, oxygen saturation below 90 %, or any signs of infection to the charge nurse immediately. There was no procedure on what signs and symptoms to report readily available to staff, or documentation of those signs and symptoms to ensure they were being monitored. Review of the 5/8/20, Coronavirus Prevention, Screening, and Identification policy identified the purpose of the policy was to provide guidance for care center staff to prevent, screen, and identify potential COVID-19. COVID-19 symptoms appear 2-14 days after exposure and symptoms included cough, shortness of breath (SOB), difficulty breathing, fever, chills, muscle pain, sore throat, and new loss of taste or smell. The policy directed the facility to provide active screening of residents and staff including monitoring vital signs and respiratory symptoms ongoing.	F 880		

Progress Notes By Resident By Staff Member

For Date Range: 5/15/2020 To 5/15/2020

Resident Name	Staff Name	Medical Record #	Unit & Room
Juel, John N	Okins, Natasha	1305	Veteran's Drive 211 - S

05/15/2020 08:57

Progress Notes electronically signed by Okins, Natasha, RN, Registered Nurse-- **Quick Notes**

Comments: General Quick Comments = resident admitted to facility with diagnosis of C-diff, precautions put in place at this time. bowel movements monitored each shift. last liquid stool was on 4/20/2020. had had soft formed stools since than. remains at this time on Vancomyocin every other day with last dose of medication due on 4/26/20. no other symtpoms of C-diff noted. denies pain or discomort. intake at meals improving with noted weight gain. precautions lifted due to no further evidence of disease at this time. staff will continue to document all bowel movements and medication will be administered per orders..

05/15/2020 15:57

Progress Notes electronically signed by Okins, Natasha, RN, Registered Nurse-- **Quick Notes**

Comments: General Quick Comments = PHYSICIAN COMMUNICATION: We have been flushing his catether TID per order each shift. has been flushing without difficulty and has been having adequate output each shift. He is sleeping now on the overnight shift and does not want to be disturbed. May we have orders to change cath flushed to BID please?.

Comment added by author on 05/18/2020 08:06 :
recieved orders to change catheter flushing to BID

05/15/2020 16:21

Progress Notes electronically signed by Okins, Natasha, RN, Registered Nurse-- **Quick Notes**

Comments: General Quick Comments = ATX Stewardship: Currently recieving Vanco every other day with end date of 5/26/2020 for medication for enterocolitis and diagnosis of C-diff. No adverse response to use of medications. has remained afebrile. Will continue with POC...

Progress Notes by Resident

For Date Range: 5/14/2020 To 5/14/2020

Resident Name	Medical Record #	Unit & Room
Romero, Juana L	1079	

05/14/2020 03:52

Progress Notes electronically signed by Curry, Kim, RN, Registered Nurse-- **Quick Notes**

Comments: General Quick Comments = Date:05/14/2020 Time: 3:51:14 SBAR identifier:JR5644404 This is a Watch and Wait possible Infection Pertinent patient info: MRN: 1079 Nurse Entering Information:Kim Curry RN Signs and Symptoms: SPO2 91% RA Precautions being taken: Standard Precautions Addtional Precautions: Covid 19 monitoring continues for resident who was seen in Rice ER, Willmar for shortness of breath and low SPO2. Tested negative for covid again, continuing to monitor. No changes and is asymptomatic at this time. Vitals BP: 140/53 HR 85 Resp. rate 12 Temp 98.5.

05/14/2020 05:17

Progress Notes electronically signed by Curry, Kim, RN, Registered Nurse-- **Pain Control**

Comments: General Pain Comments = per resident statement pain was relieved so she could relax..

05/14/2020 09:51

Progress Notes electronically signed by Okins, Natasha, RN, Registered Nurse-- **End Stage Renal Disease**

History:
History of Dialysis: While a Resident, Within Last 14 Days,While a Resident, Prior to Last 14 Days,Resident has diabetes mellitus,Resident has renal insufficiency,Resident has chronic renal failure,Resident has hypertension.

Observation: No bladder distension palpable,Respiration is even and unlabored.

Dialysis:
Hemodialysis: Lab dry weights and report obtained from dialysis center weekly,Resident has dialysis3 times weekly,Dialysis is received offsite,External shunt free from redness, swelling and pain,A-V fistula adequate blood flow, bruit auscultated,A-V fistula adequate blood flow, pulse and thrill palpated,Resident compliant with renal diet.

05/14/2020 22:07

Progress Notes electronically signed by Schularick, Gloria, RN, Registered Nurse-- **Quick Notes**

Comments: General Quick Comments = Date:05/14/2020 Time: 22:06:52 SBAR identifier:JR5644404 This is a Watch and Wait possible Infection Pertinent patient info: MRN: 1079 Nurse Entering Information:Gloria Schularick RN Signs and Symptoms: No signs/symptoms of infection Precautions being taken: Standard Precautions Addtional Precautions: COVID 19 precautions Vitals BP: 143/69 HR 60 Resp. rate 20 Temp 98.9.

Comment added by Hanson, Shannon, RN, Registered Nurse on 06/15/2020 13:26 :
Res was in the ER overnight from 5/11 to 5/12/20 for observation and returned to our facility. On 5/14 res was placed on Contact Precautions due her overnight visit. Communication on Contact Precautions was completed with staff and gowns were made available outside res' room door. Staff are already wearing eye protection, surgical mask, and gloves.

05/14/2020 22:09

Progress Notes electronically signed by Schularick, Gloria, RN, Registered Nurse-- **End Stage Renal Disease**

History: Resident began dialysis over 3 years ago.
History of Dialysis: While a Resident, Prior to Last 14 Days,Resident has chronic renal failure,Resident has hypertension.

Observation: No bladder distension palpable,Resident's weight is stable,Respiration is even and unlabored.

Dialysis:
Hemodialysis: Resident has dialysis 3 times weekly,Dialysis is received offsite,A-V fistula adequate blood flow, pulse and thrill palpated,Resident compliant with renal diet.

Renal Disease Interventions: Transportation arranged to dialysis,Skin care provided,Administered antihypertensive as per PA, NP or MD's orders.

Comments: General Renal Disease Comments = Resident has no signs or symptoms of infection.

Current Care Plan by Category for Leroy J Folkerts

new admit 6/5/20

Medical Recored #: 1307 Unit & Room #: Mission Street 412 - S

Category Infections		
Problem	Goal	Approach
Start Date: 06/05/20 [Hanson, Shannon] At risk for signs and symptoms of COVID-19 due to new admission.	Start Date: 06/05/20 [Hanson, Shannon] Res will have no s/s of infection. Goal Date: 09/30/20	Start Date: 06/05/20 [Hanson, Shannon] Contact Precautions initiated upon admission Disciplines: Nursing Start Date: 06/05/20 [Hanson, Shannon] MD will be updated with any s/s of infection Disciplines: Nursing Start Date: 06/05/20 [Hanson, Shannon] Res will be monitored for s/s of COVID-19 and Vitals completed BID Disciplines: Nursing

Current Care Plan by Category for Michael C Abrahamson

Medical Recored #: 1306 Unit & Room #: Centennial Circle 601 - P

Category Infections		
Problem	Goal	Approach
Start Date: 06/03/20 [Hanson, Shannon] At risk for signs and symptoms of COVID-19 due to recent hospital stay and his admission from hospital.	Start Date: 06/03/20 [Hanson, Shannon] Res will have no s/s of infection. Goal Date: 09/30/20	Start Date: 06/03/20 [Hanson, Shannon] Contact Precautions initiated upon admission Disciplines: Nursing Start Date: 06/03/20 [Hanson, Shannon] MD will be updated with any s/s of infection Disciplines: Nursing Start Date: 06/03/20 [Hanson, Shannon] Res will be monitored for s/s of COVID-19 and Vital signs BID. Disciplines: Nursing

PPE COMPLIANCE AUDIT TOOL

Patient Care Unit/Dept.: _____ **Month/Year:** June, 2020

Initials of Monitor: ICFRD

Healthcare Worker (HCW) Type:

1: Registered Nurse
2: LPN
3: CNA
4: Activity Staff
5: Dietary Staff
6: Housekeeping
7: Laundry
8: Other

KEY
HW: Hand Wash
HR: Alcohol Hand Rub
Y: Yes
N: No

Date	Shift	HCW Type	Proper PPE BEFORE Entering room				Correct DONNING/DOFFING of PPE			
		(See Key)	HW/HR	Yes PPE	No PPE	Education Needed	Yes	No	Education Needed	HW/HR
6-4-20	Day	3	✓	✓			✓			✓
6-4-20	Day	3	✓	✓			✓			✓
6-4-20	Eve	1	✓	✓			✓			✓
6-4-20	Eve	3	✓	✓			✓			✓
6-8-20	Day	3	✓	✓			✓			✓
6-8-20	Day	2	✓	✓			✓			✓
6-8-20	Day	3	✓		✓	YES			✓	✓
6-9-20	Nig	3	✓	✓			✓			✓
6-9-20	Nig	3	✓	✓			✓			✓
6-10-20	1948 Eve	3	✓	✓			✓			
Totals										

KA

Hand Hygiene Monitoring Tool Instructions

The purpose of this hand hygiene audit tool is to determine health care worker (HCW) compliance with hand hygiene practice. Hand hygiene refers to cleaning your hands by using an alcohol-based hand rub or by washing hands with soap (antimicrobial or plain) and water.

The observer/auditor records the occasions they observe where a staff member should have carried out hand hygiene, called "opportunities." Examples of hand hygiene opportunities include:

- Before touching a patient
- Before performing a clean or invasive procedure
- After handling body fluids
- After touching the patient, environment, or objects involved in the patient's care
- After removing gloves
- Before touching or handling patient's food

A total of ten observations should be performed each month. Submit completed monitoring forms to the Infection Control Designee on or by the 5th of each month.

1. Write the name of the individual performing the audit on the form, record the month and year, and write your initials on the line indicated
2. Refer to the key on the tool for health care worker type and other abbreviations used on the monitoring form
3. For each opportunity, the observer records the following:
    - **Date:** include month, day, and year
    - **Health Care Worker (HCW) Type:** use the number that corresponds with the title of the person you are observing
    - **Hand Hygiene BEFORE touching the patient:**
        - If a HCW cleans her/his hands with an alcohol hand rub *before* touching a patient, place an **X** in the box labeled **Yes HR**
        - If a HCW washes her/his hands with soap and water *before* touching a patient, place an **X** in the box labeled **Yes HW**
        - If a HCW did not clean their hands *before* touching the patient, place an **X** in the box labeled **No**
        - If a HCW enters a patient's room, but does not touch the patient, then hand hygiene was not necessary, so put an **X** in the box labeled **N/A**
    - **Hand Hygiene AFTER touching the patient, environment, or other objects:**
        - If a HCW cleans her/his hands *after* touching the patient, environmental surfaces, or other objects in the room, put an **X** in the appropriate box (**Yes HR** or **Yes HW**)
        - If a HCW did not clean their hands *after* touching the patient, environmental surfaces, or other objects in the room, put an **X** in the box labeled **No**
        - If a HCW enters the patient's room, but does not touch anything, mark the box **N/A**

On Monday May 18th, 2020 the DON met with staff and discussed the MDS Infection Control Survey that took place at our facility on May 14th. The areas of concern were discussed and it was reviewed what we will be doing differently at this time due to the concerns. The areas of concerns discussed included the following:

-Consistent use of PPE with contact precautions
-PPE use upon admit or readmit from hospital setting
-documentation of monitoring for s/s of Co-Vid-19 for all residents.

The immediate plan of correction was also reviewed that included if any resident was on Contact Precautions, all staff all departments would wear full PPE, including gown.
Any residents who is out of the building overnight and returns will be placed on Contact Precautions.
Resident screening log was updated to include signs and symptoms of COVID-19.

Shannon Hanson, RN DON

Renville Health Services
Attendance Sign-In Sheet

Name of Training:

Topics: Huddle, CoVid-19 Updates

Presenter/s:

First Name	Last Name	Signature
Dalton	Nichole	nichole Walton
Raske	Mary	Mary Raske
Vanesa	Escarcno	
Tatyana	EVA	
Brown	Tanya	Tanya Brown
Luna	Lizeth	Lizeth Luna RN
Gaulke	Tashia	RN
Wohnoutka	McKayla	
Ramirez	Leticia	CNA
Rhonda	Marcus	
Debbie	Thiele	
Rob	Feldman	
Leslie	Gonzalez	
Natasha	Okine	
Natasha	Segelstrom	
Gloria	Schularick	
Kayla	Fitzner	
Gloria	Schularick	
Robin	Feldman	
JOE	SCHWARTZ	
Sean	Dworshak	Sean Dworshak
Vanesa	Escarcno	
Dawn	Pike	
Cynthia	Tungubiardes	
Debbie	Thiele	
Christine	Toupal	
McKayla	Wohnoutka	
Ramirez	Leticia	CNA
Rachel	Somers	
Marcus	Rhonda	
Luna	Crisay	
Walton	Nichole	nichole Walton
Dikken	Jane	
Brown	Tanya	

Renville Health Services
Attendance Sign-In Sheet

Name of Training:

Topics: COVID-19 Updates

Presenter/s: Leadership-Huddles

Last Name	First Name	Signature	Department
SCHUMACHER	JOE	Joe Schumacher	NASO.
STIMPER	Richard	Richard Stimper	N RSG
Prechel	Somer	Somer Prechel	CNA
Dworshak	Sean	Sean Dworshak	Dietary
morales	vanessa	vanessamorales	nrsg.
Ramirez	Leticia	Leticia R	CNA
Raske	Mary	Mary Raske	CNA
Wohnoutka	Mckayla	Mckayla Wohnoutka	CNA
Gulke	Tashia		Nsg.
OKINS	Tasha	Tasha Okins	NSg
Beckendorf	Jessica	Jessica Beckendorf	NSg
Young	LaChundra	LaChundra Young	CNA
Dikken	Jane	Jane Dikken	Admissions
Terwilliger	Cindy L	Cindy Terwilliger	CNA
FELDMAN	Robin		Hskp/Laund
Gonzalez	Eren	Eren Gonzalez	Nursing
OKINS	Natasha	Natasha Okins	NSG
Garcia	Jenniter	Jennifer Garcia	CNA
morales	vanessa	vanessamorales	nsg.
Gulke	Natashia		NSG.
Escarcno	Vanesa	Vanesa Esc	CNA
Schulaick	Gloria	Gloria Schulaick	RN
Tatro	EVA	Eva Tatro	CNA
Pope	Lollie	Lollie Pope	CNA
Raske	Mary	Mary Raske	CNA
Dikken	Jane	Jane Dikken	Admissions
Prechel	Somer	Somer Prechel	CNA
Luna	Liza	Liza Luna	Nursing
WALTON	Nichole	Nichole Walton	HUC
Fitzner	Kayla	Kayla F	nursing
Garcia	Jennifer	Jennifer Garcia	CNA
Pope	Lollie	Lollie Pope	CNA
Wohnoutka	Mckayla	Mckayla Wohnoutka	CNA
Marcus	Rhonda	Rhonda Marcus	LPN

**Report any temperature over 100.0, a pulse oximeter under 90%, and signs/symptoms of COVID-19 to the Charge Nurse Immediately.

Monday June 22, 2020—DAY SHIFT

Resident	Temp	B/P	Pulse	Resp	Oximeter	Signs or symptoms of COVID-19? Yes/No	Initials

** COVID-19 Symptoms: SOB (new), cough, fever, sore throat, body aches (new), chills, headache, loss of taste or smell (new), nausea, vomiting, diarrhea

I have reviewed the Completed Vital Signs and asked staff if residents have signs or symptoms of COVID-19:

Licensed Staff Signature:_____

Audits related to Resident Screening Log

Screening Log updated 5-15-20 with S/S of covid.

Screening Log reviewed; 5-15 to 5-17-20

VS and monitoring for s/s completed; yes

Charge nurse reviewed and signed log; yes

Comments: SHannon 5/18/20

Screening Log reviewed; 5/18 to 5/21/20

VS and monitoring for s/s completed; yes

Charge nurse reviewed and signed log; yes

Comments: SHannon 5/22/20

Screening Log reviewed; 5/22 to 5/25/20

VS and monitoring for s/s completed; yes

Charge nurse reviewed and signed log; yes

Comments: SHannon 5/26/20

Screening Log reviewed; 5/26 to 5/31/20

VS and monitoring for s/s completed; yes

Charge nurse reviewed and signed log; yes

Comments: SHannon 6/1/20

Audits related to Resident Screening Log

Screening Log reviewed; 6/1 to 6/5/20

VS and monitoring for s/s completed; yes

Charge nurse reviewed and signed log; yes

Comments: SHannon 6/10/20

Screening Log reviewed; 6/6 to 6/9/20

VS and monitoring for s/s completed; yes

Charge nurse reviewed and signed log; yes

Comments: Res had fever on 6/8 in evening and order rec'd to do covid-19 test which was completed 6/8 SHannon 6/10/20

Screening Log reviewed; 6/10 to 6/14/20

VS and monitoring for s/s completed; yes

Charge nurse reviewed and signed log; yes

Comments: Some VS not filled on sheet but are in Optimus VS report. SHannon 6/15/20

Screening Log reviewed;

VS and monitoring for s/s completed;

Charge nurse reviewed and signed log;

Comments:

St Francis Health Services of Morris

Coronavirus Prevention, Screening, and Identification

POLICY: St. Francis Health Services (SFHS) will implement appropriate infection prevention and control policies to prevent and manage Coronavirus (COVID-19).

PURPOSE: To provide guidance for care center staff to prevent, screen, and identify potential Coronavirus (COVID-19).

PROCEDURE: Coronavirus symptoms may appear 2-14 days after exposure and can include cough, shortness of breath or difficulty breathing, fever, chills, muscle pain (new), sore throat, and new loss of taste or smell. The interim policy for suspected or confirmed Coronavirus (COVID-19) includes:

A. PREADMISSION IDENTIFICATION AND PREVENTION: Prior to admission, identify during the preadmission screening if the potential resident is exhibiting symptoms of any respiratory infection (i.e. cough, fever, shortness of breath, chills, sore throat, etc.) to determine appropriate placement within our care center (isolation or segregation). Symptom resolution would include no fever for minimally 72 hours without fever reducing medication, and at least 10 days since beginning of respiratory symptoms. If resident has been tested for COVD-19 and test is negative (2 negative tests preferred), further evaluate for symptoms should occur to determine no longer infected. At this time, we will not admit any resident with respiratory symptoms unless able to place within the segregated area.

B. NEW RESIDENTS: (or residents with recent hospitalization or travel) obtain details of:
   a. Contact with anyone with lab confirmed COVID-19 disease,
   b. Identify if resident exhibits fever and acute respiratory illness, and
   c. Identify any recent travel history from a facility with identified case, or from restricted areas of the country or other countries.
   d. If possible, care center will dedicate a unit/wing exclusively for residents coming or returning from the hospital. This could serve as a unit where they remain for 14 days with no symptoms.
   e. All new residents will be quarantined to their room and monitored for symptoms of respiratory infection (i.e. cough, fever, shortness of breath, etc.). Residents will have a full set of vital signs obtained, including O2 SATs daily along with a second assessment of respiratory symptoms including a pulse, temperature, and O2 SATs on a different shift.
      i. Dialysis patients will have their vital signs and respiratory assessment completed within one hour of leaving the care center.
   f. If the resident exhibits any symptoms of respiratory infection, the resident's Provider will be notified immediately. Droplet precautions will be initiated.
      i. Monitoring of vital signs and respiratory symptoms will be increased to <u>at least</u> twice a day for AL and every shift for skilled. MDH will be

contacted at 651-201-5414 or 1-877-676-5414.for further instructions on testing.

C. RESIDENT CARE TO PREVENT TRANSMISSION OF COVID-19:

a. Active screening of residents and staff for fever or respiratory symptoms (fever, cough, difficulty breathing) will be ongoing.
b. Residents will be reminded to practice social distancing and perform frequent hand hygiene.
c. Residents will be requested to wear masks when leaving room and when in close contact with staff.
d. Non-essential appointments (e.g. dental and eye exams) will be postponed.
e. Activities that take the residents out into the community will be postponed, as well as external groups coming into the care center.
f. Normal communal dining will be cancelled.
g. Group activities will be cancelled. If residents are out in an area of the building, residents will be encouraged to separate from others by > six feet.
h. In lieu of resident visits, alternative means of communicating with family and/or persons who would otherwise visit will be offered, such as phone or video communication.
i. Staff will be assigned as primary contact with families for calls to keep families up to date.
j. Residents will still have the right to access the Ombudsman program. If in-person access is not available due to infection control concerns, care center staff will facilitate resident communication (by phone or other format) with the ombudsman program (or any other State or Federal entity).
k. Vital signs (BP, pulse, temperature, and O2 saturation) will be monitored once daily with a second respiratory assessment (pulse, O2 SATS, and temperature) on a different shift.
    i. Dialysis patients will have their vital signs and respiratory assessment completed within one hour of leaving the care center.
l. If the resident exhibits any symptoms of respiratory infection, the residents Provider will be notified immediately. Droplet precautions will be initiated.
    i. Monitoring of vital signs and respiratory symptoms will be increased to <u>at least</u> twice a day for AL and every shift for skilled. MDH will be contacted at 651-201-5414 or 1-877-676-5414.for further instructions on testing.
m. Any vital sign changes will be identified and further licensed nurse assessment will occur.
n. Staff entering resident rooms will be documented on *<u>Room Visit log CCP.QC.IPCP.026CV-F1</u>*.
o. Any breach of Personal Protective Equipment (PPE) will be reported immediately to the supervisor or designee and documented on the <u>Breach Log CCP.QC.IPCP.026CV-F5</u>. A breach of PPE can result in the spread of infectious pathogens. Breach of PPE can include but is not limited to:
    i. Inappropriate use of facial mask
    ii. Poor hand hygiene

iii. Improper donning/doffing PPE
iv. Not using appropriate PPE for the infectious agent
v. Tears or damage to PPE

p. Any PPE that has tears, damage or soiled should be removed and replaced with new PPE.
q. In the event of an unprotected exposure (within 48 hours) to person infected with COVID-19 the resident:
    ii. Will be quarantined to their room and monitored for symptoms of respiratory infection (i.e. cough, fever, shortness of breath, etc.) for 14 days.
    iii. Will have a full set of vital signs obtained, including O2 SATs, and respiratory assessment daily. Additional assessment of respiratory symptoms including pulse, temperature, and O2 SATs will be completed on other shifts.

D. VISITORS: The care center will restrict all visitors and non-essential health care personnel.
a. Visitors will be restricted to only 'essential' individuals who are critical to operational or care needs, such as 'end of life' care.
b. The care center will notify visitors to defer visitation until further notice (through signage on the main entrance door, calls, letters, etc.).
c. Essential visitor access to the building will be limited to one entrance.
d. Personnel will be assigned to monitor the visitor entrance and evaluate appropriateness of any visitor, utilizing a visitor screening tool.
e. Each visit will be documented on a Visitor Log.
f. Decisions about visitation during an end of life situation will be made on a case by case basis, which should include:
    i. Careful screening of the visitor (including clergy, bereavement counselors, etc.) for fever or respiratory symptoms (fever, cough, shortness of breath, or sore throat).
    ii. Those with symptoms of a respiratory infection will not be permitted to enter the care center at any time (even in end-of-life situations).
    iii. Those visitors that are permitted, will restrict their visit to the resident's room or other location designated by the facility.
    iv. They should also be reminded to frequently perform hand hygiene and use Personal Protective Equipment (PPE), such as facemasks when indicated.
g. Exceptions to restrictions:
    i. Health care workers: Other health care workers, such as hospice workers, EMS personnel, or dialysis technicians that provide care to residents will be permitted to come into the facility as long as they meet the CDC guidelines for health care workers.
    ii. Surveyors: CMS and state survey agencies are constantly evaluating their surveyors to ensure they don't pose a transmission risk when entering a facility. For example, surveyors may have been in a facility with COVID-19 cases in the previous 14 days, but because they were wearing PPE effectively per CDC guidelines, they pose a low risk to transmission in the next facility,

and must be allowed to enter. However, there are circumstances under which surveyors should still not enter, such as if they have a fever.

h. If Minnesota state implements actions that exceed CMS requirements, such as a ban on all visitation through a governor's executive order, the care center would not be out of compliance with CMS' requirements. In this case, surveyors would still enter the facility, but not cite for noncompliance with visitation requirements.

E. STAFF: Staff **who have** signs and symptoms of a respiratory infection **and** a temperature (100 degrees or higher) should not report to work.

a. Staff who test positive for COVID-19 will notify MN Department of Health and the care center and follow instructions from the care center.
    i. If asymptomatic, based on staffing needs, an HCP may be required to report to work in specific circumstances at the discretion of the administrator.
b. Staff will wear a mask and eye protection, as available, during working hours.
c. Staff will be screened at the beginning of their shift and may be restricted entry to the care center for the following:
    i. If answering yes to any respiratory screening question on the questionnaire, they will seek an evaluation by the charge nurse to determine appropriateness to work.
    ii. If recent travel with possible exposure and respiratory symptoms; staff will be evaluated by the charge nurse.
d. If signs or symptoms of a respiratory infection, such as a fever, cough, shortness of breath, or sore throat:
    i. If has a temperature (100 degrees or higher) will be asked to self-isolate at home until 72 hrs. after temperature returns to normal (without the use of fever-reducing medications).
    ii. If fever and respiratory symptoms, will be asked to self-isolate at home until 72 hrs. after temperature returns to normal and/or 10 days from when the respiratory symptoms began (without the use of fever-reducing medications).
    iii. Monitor for symptoms if have had close contact with someone confirmed or suspected (and in process of being confirmed) of having COVID-19 disease, will wear a mask while working.
    iv. May be requested to obtain a COVID-19 laboratory test.
e. Any staff that develops signs and symptoms of COVID-19 disease (fever, cough, shortness of breath or sore throat) while on-the-job, should:
    i. Immediately stop work and report to the supervisor, who will assess the staff.
    ii. If no temperature, will be asked to wear a mask for remainder of shift.
    iii. If has a temperature, will self-isolate at home until 72 hrs. after temperature returns to normal.
    iv. Inform the facility's Infection Preventionist, and include information on individuals, equipment, and locations the person came in contact with; and

v. Contact and follow the Minnesota Department of Health recommendations for next steps (e.g. testing, locations for treatment), and return to work instructions. Contact MDH @ 651-201-5414 or 1-877-676-5414.
vi. May be requested to obtain a COVID-19 laboratory test.

f. MN Department of Health may contact the care center when a positive case occurs.
   i. MN Department of Health will request a structured risk assessment to be conducted with individual staff with recommendations for health monitoring, voluntary quarantine, and social distancing, based on assessment.

F. IDENTIFY AT-RISK STAFF: Care center will keep a list of any staff **unprotected exposure** to COVID-19.
   a. The list will include all staff that interacted with the positive person from 48 hours before symptoms started. The following will occur for potential staff exposure:
      i. Complete Assessment for Health Care Workers (HCW) CCP.QC.IPCP.026-F2 Assessment for Health Care Workers Potentially Exposed to COVID-19 in Minnesota. Identify the risk level using assessment.
      ii. Contact tracing may indicate low risk when there is no direct exposure to a COVID-19 infected person.
      iii. Contact risk is identified as close contact of person(s) with COVID-19 within 48 hours.
      iv. Communicate the risk level to the staff with work-related recommendations. Using the following criteria:
         1. **No identifiable risk of exposure:** These staff should continue working and should participate in their facility's routine process for health screening.
         2. **Low-risk exposure:** These staff should continue working and should conduct twice daily self-monitoring of health, including temperature checks.
         3. **High risk exposure:** These staff should undergo voluntary quarantine and stay out of work for 14 days after the last exposure to a person with COVID-19 while not wearing all necessary PPE. These staff can be asked to return to work if they are not sick (no fever or symptoms of illness) and the facility has exhausted all other staffing options.
      v. Inform staff that MDH will contact those with medium- and high-risk exposures with recommendations to stay out of work and for health monitoring.
      vi. Collect and send MDH the names and phone numbers of staff identified to have had medium- or high-level risk. Include the name of the person (staff or resident) with confirmed COVID-19 and the facility name on the staff list.
      vii. Recommendations will be followed for staff who have had a medium- or high-risk workplace exposure to COVID-19 and staff with household or intimate contacts who have confirmed or suspected COVID-19.

b. COVID-19 EXPOSURE RECOMMENDATIONS FOR STAFF
    i. Limit interactions with the public as much as possible for 14 days after preventive measures are put into place.
    ii. Adhering to social distancing.
    iii. If limitations to social interaction are not possible, the staff should take on a non-direct patient care role, when feasible.
    iv. If it remains necessary for the staff to continue providing direct care during this 14 day period, they should:
        1. Avoid seeing high-risk patients (e.g., elderly and immunocompromised persons and those with co-morbidities).
        2. Practice diligent hand hygiene and wear a surgical face mask at all times.
        3. Monitor themselves closely for any new symptoms associated with COVID-19 (i.e., measured or subjective fever, cough, shortness of breath, chills, headache, muscle pain, sore throat, or loss of taste or smell), and measure temperature daily before going to work.
        4. Remain at home and notify their supervisor if they develop respiratory symptoms OR have a measured body temperature of ≥100.oF.
        5. If at work when fever or respiratory symptoms develop, the staff should immediately notify their supervisor and go home.
        6. Notify their supervisor of other symptoms (e.g., fever <100.oF, nausea, vomiting, diarrhea, abdominal pain, runny nose, fatigue), as medical evaluation may be recommended. Staff living with someone who has symptoms consistent with COVID-19 should separate themselves from the ill household member within the home as much as possible.

c. If an staff chooses to work during the 14-day voluntary quarantine period, they must wear a medical-grade facemask at all times when providing resident care and at all times when within six feet of any other person. **No staff may work while ill.**

G. CARE CENTER-WIDE TESTING (Point Prevalence Testing CCP.QC.IPCP.026CV-F4): If the care center becomes aware of a COVID-19 positive case among staff and/or residents care center-wide testing may be needed. The following guidelines will be followed for Point Prevalence Testing (care center-wide testing):
    a. Administrator or designee will complete the REDcap survey at https://redcap-c19.web.health.state.mn.us/redcap/ Once the survey is completed, the care center will be contacted by MN Department of Health for desired testing options.
    b. Administrator or designee will determine the involvement of who will be completing the testing. Testing may occur using care center personnel, the local healthcare system, contract or corporate resources, or State resources. This will then determine the lab used for the samples.
        i. Ensure all staff can be tested, not just those on duty at time of facility-wide testing.
        ii. Ensure all residents can be tested.

iii. Arrange for staff member(s) to assist with managing and collecting specimens from both residents and staff.
    1. Requested documentation will be completed prior to the time of testing. Including COVID-19 testing information and consent forms. CCP.QC.IPCP.026CV-F7 COVID-19 Testing Resident Consent and CCP.QC.IPCP.026CV-F8 COVID-19 Testing Staff Consent.
    2. Specimens will be collected using proper procedures with proper PPE to minimize risk of infection. Swabs may be sent prior to testing.
    3. Testing will be carried out in a manner that protects confidentiality consistent with applicable laws and regulations.
iv. Documentation will include which residents and staff were tested or were unable to be tested (Point Prevalence Testing (care center-wide testing CCP.QC.IPCS.026CV-F4).
    1. If refusal, document the reason for refusal.
v. Staff who are not able to participate in testing may be tested when returning to work.
    1. Ensure swabs and direction to send specimen is available.
vi. Depending on the chosen method of testing, laboratory test result timeframe of return may vary.
vii. The designated laboratory may send results directly to the care center or the MN Department of Health, the care center and health department will coordinate how results will be shared.

c. Staff tested will report to work if asymptomatic until test results indicate positive COVID-19.
d. If staff test positive, they will follow positive COVID-19 guidelines.
    i. If asymptomatic positive COVID-19 test, based on staffing needs, an staff may be required to report to work in specific circumstances at the discretion of the administrator.
e. Care center will maintain records of staff and residents who have positive tests. Point Prevalence Testing (care center-wide testing CCP.QC.IPCS.026CV-F4
f. MN Department of Health desires to complete care center-wide testing every 7 days, care centers will support testing guidance provided by MN Department of Health.
g. Residents, staff, and families will be notified of positive COVID-19 cases within the facility.
h. Residents who test positive for COVID-19 will be segregated to contain and manage infection (CCP.QC.IPCP.009CV Segregation and Isolation Measures).
i. If the number of staff who test positive cause staffing shortage the staffing crisis plan will be instituted.
    i. Staff who test positive for COVID-19 may be required to be out of work for 10 days.
    ii. Staffing plans for crisis staffing will be followed (*Emergency Progression Staffing Plan (CCP.QC.IPCP.026CV-F3*).
    iii. Return to work criteria will be followed (CCP.QC.IPCP.027CV Suspected or Confirmed Corona Virus).
    iv. Final Testing Checklist CCP.QC.IPCP.026CV-F6.

H. VENDORS AND OTHER NON-HEALTHCARE PROVIDERS: The care center will take the following actions to prevent potential transmission from outside providers:

a. Supply vendors (e.g. food delivery, equipment and supplies, etc.) will be notified to drop off supplies at a dedicated location (e.g. loading dock), then call the care center to let them know it is there.
b. Transportation providers (e.g. when taking residents to offsite appointments) will be advised to wait outside in an appointed area for the resident.
c. Physicians and other Providers, including Hospice staff, are encouraged to use telehealth under the 1135 Waiver, to protect spreading of COVID-19. If telehealth is not available, they will be allowed entry, as long as they are screened and are following the appropriate CDC guidelines for Transmission-Based Precautions.
d. EMS personnel will be allowed entry as long as are following the appropriate Transmission –Based Precautions.

References and Resources:

Minnesota Department of Health: Patient Care Strategies for Scarce Resource Situations: https://www.health.state.mn.us/communities/ep/surge/crisis/standards.pdf

CMS: QSO-20-12-ALL, memo regarding survey activity for COVID-19 ***3/15/20***

GuidancQSO-20-12-ALLe for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in nursing homes: ***Updated 3/9/20:***
https://www.cms.gov/medicareprovider-enrollment-and certificationsurveycertificationgeninfopolicy-and/guidance-infection-control-and-prevention-coronavirus-disease-2019-covid-19-nursing-homes-revised

QSO-20-14-NH https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.html ***Updated 3/13/20***

CDC: Centers for Disease Control and Prevention. Interim Infection Prevention and Control Recommendations for Patients with Confirmed Coronavirus Disease 2019 (COVID-19) or Persons Under Investigation for COVID-19 in Healthcare Settings February 21, 2020: https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html

Centers for Disease Control and Prevention. Coronavirus Disease 2019 (COVID-19). Evaluating and Reporting Persons Under Investigation (PUI). ***Updated 3/17/20:***
https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html

Coronavirus Situation Summary: ***Updated 3/15/20***
https://www.cdc.gov/coronavirus/2019-nCoV/summary.html

https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html

https://www.cdc.gov/nonpharmaceutical-interventions/tools-resources/planning-guidance-checklists.html
https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html

QAPI Committee Agenda/Minutes

Care Center: Renville Health Services—VIA WEB-EX **Date:** 05/20/20

Committee member	*Name*	*Present*
Administrator	Casie Knoshal	X
Director of Nursing	Shannon Hanson	X
Medical Director/designee	Dr. Mark Ahlquist	--
Social Services Director/Activities Director	Deb Vizecky	X
HR Director	Natasha Segelstrom	X
Dietary	Debbi Thielen	X
Consultant Pharmacist	Rebecca McCleery	---
Infection Preventionist/ADON	Kayla Fitzner	---
Environmental	Bryce Irwin	X
Admissions Coordinator	Jane Dikken	
Housing RN	Deb Wertish	X
Housing Manager	Amy Klawitter	X
Other	Christine Toupal-NOW grant coordinator	X

Purpose of meeting: Analyze and identify opportunities for Quality Improvement
Provide oversight of Quality and Compliance performance
Identify and communicate best practices and lessons learned

Meeting Process: Agenda reviewed/Minutes approved

Old Business: Previous Action Plans

	Task(s)	Person(s) assigned	Completion Date	Follow up
Falls	Education on FSI and interventions	Nrsg		Continued training at meetings r/t RCA and appropriate Interventions. Falls committee meeting monthly

Objective	Task(s)	Person(s) assigned	Completion Date	Follow up
Quality Improvement Incentive Program (QIIP):	Weight Loss is our new QIIP and this will correlate with our PIIP grant.	QIIP Committee		Ongoing
Performance-Based Incentive Payment Program (PIPP):	New PIIP Grant…NOW (Nutrition & Optimal Weight) This grant started 1/1/19 and will incorporate our facility to look at our dining experience, food, meal service, etc.	NOW Committee		Ongoing, Kind Dining training completed by Grant Coord, Christine. Kind Dining Training is tentatively on hold d/t COVID-19

• Other		family members arranged through SS/Act. Staff. Resident and Families were all educated on the need for staff to wear face masks. **Grievance**-None **Resident Council**- Activities completed a resident satisfaction survey. The outcome of these surveys were shared with the Resident Council President and there were no noted concerns from the President. LSW has been checking in with residents individually due to not being able to hold official meetings due to COVID-19 parameters. Nothing was brought up relating to Resident Council. **Family Council**- Next meeting was to be held in April 2020. Family Council will not be held in April due to COVID-19 parameters in place. LSW is asking family members at Care Conferences and during other conversations if they have any concerns or items that they want to discuss. None as of today. Administrator Knoshal sends weekly emails updating the resident's families that have chosen to participate in this email group on the status of COVID-19 protocols within our facility.
Dining Services • 4 meal plan • Restaurant style service (Serve resident as arrives in DR) • Open breakfast • Other		• d/t COVID-19 breakfast will be served in both dining rooms, lunch and supper will be served in centennial circle • 5 residents are sitting in the dining room, these are residents with choking issues. • Extra staff on to help at noon and supper meals • Ongoing menu change • 2 weight loss triggers-1end of life, 1 working on diet texture, 1 assist at meals, supplements and snack basket in room
Culture change • Consistent assignments • Resident Centered Care • Other		Consistent Assignment continues with nursing department.

Compliance/Regulatory:

Survey Activity: • Annual Survey • OHFC • OSHA • Life Safety		**Tags/Summary of Root Cause Analysis - any Trends…** MDH Survey window is now open. IC MDH Survey here on Thursday 5/14/20. We are waiting for 2567. 3 areas of concern -Consistent use of PPE with contact precautions -PPE use upon admit or readmit from hospital setting -documentation of monitoring for s/s of Co-Vid-19 for all residents.
Mock Survey:		Completed Dec 10th thru 13th, 2019. Kim Holland, QA RN continues to follow up.
Consultant visits/reports:		Rebecca McCleery, Pharm consultant from Thrifty White Pharmacy does her monthly visits. SEE ATTACHED REPORT if quarterly QA meeting.