STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245213	A. Building B. Wing	05/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ebenezer Ridges Geriatric Care Center	13820 Community Drive Burnsville, MN 55337

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44649 Based on interview and record review the facility failed to promote dignity and respect to 1 of 4 (R1) residents reviewed. R1 was not properly dressed when leaving her room for therapy services. R1 did not have an incontinent brief on and upon standing urinated on herself, her wheelchair, and the floor in the presence of other residents and staff. Findings include: R1's admission Minimum Data Set (MDS) dated [DATE] indicated R1 had a Brief Inventory of Mental status (BIMs) score of 15 indicating R1 was cognitively intact. R1 required maximum assistance with toileting hygiene, showering and dressing. She required moderate assistance with rolling in bed, positioning from sitting to lying and she was dependent from sitting to standing with transfers. R1 was dependent in her manual wheelchair. R1 was frequently incontinent of urine and bowel. R1's pertinent diagnoses were cirrhosis of the liver, acute respirator failure with hypoxia, portal hypertension (increased pressure in the venous system), morbid obesity and type 2 diabetes mellitus with neuropathy (nerve damage from diabetes). R1's care plan dated 5/4/24 indicated R1 required the assistance of one staff member to dress and undress. R1 had actual impairment to her skin bilaterally on her buttocks. The intervention was to wear no incontinent brief while in bed and be gentle with peri-cares. The care plan did not indicate what R1 was to wear for incontinence protection when she was out of bed. In addition, the care plan did not indicate to use towels for incontinence concerns while R1 was in bed. Upon interview on 5/13/24 at 9:46 a.m. occupation therapy assistant (OTA)-A stated she would go to R1's room to get her out of bed for therapy. R1 would be dressed in a hospital gown per her choice. She stated when staff would stand her up towels that were placed between R1's legs would fall to the floor. She stated that the therapy staff did not put a brief on her stating that the responsibility of the nursing staff. OTA-A did recall an incident in therapy where her and another therapy staff member were assisting R1 to stand and upon standing R1 became incontinent of urine on herself, her wheelchair, and the floor in the therapy room. R1 was immediately sat down in her chair, as a fall prevention, then was wheeled back to her room. OTA-A left R1 in her room and notified the nursing staff to assist her to be cleaned up. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Upon interview on 5/13/24 at 11:41 R1 stated she was usually taken to therapy without anything covering her peri-area. She stated she was o.k. with wearing a hospital gown if staff dressed her in two gowns, one to cover the front and one to cover the back of her body. She stated one day in therapy the staff assisted her to stand by the parallel bars and upon impact her bladder released, and she urinated on herself, her wheelchair, and the floor. She stated she was sat down in the urine saturated chair and taken back to her room for clean-up. She stated she humiliated as other residents witnessed the event and staff as well. In addition, R1 stated some staff would place towels between her legs since she urinated so much in bed requiring frequent bed changes. Upon interview on 5/13/24 at 11:50 a.m. R1's family member (FM)-A stated he visited R1 almost daily and was present the day she was incontinent of urine with no urinary protection in therapy. He stated he stayed with R1 all afternoon as R1 could not stop crying because she was so humiliated. Upon interview on 5/13/24 at 12:17 p.m. registered nurse (RN)-A unit manager stated she was not aware of an incident where R1 became incontinent in therapy. She stated the therapy staff proceeded correctly after the incontinence episode by bringing R1 back to her room for nursing staff to clean her up. RN-A stated therapy staff can and should be dressing and making sure the residents leave their room in appropriate attire. She stated if they are uncertain of how to dress a person than they should ask the nursing staff. Upon interview on 5/13/24 at 12:29 p.m. RN-B stated she had worked with R1 and stated she was unaware that staff were placing towels between her legs and unaware or R1 was going to therapy without an incontinent brief on. She stated the facility uses blue pads that wick away moisture from incontinent patients to assist in avoiding bed changes. RN-B was unaware of the incontinence incident therapy, stating therapy staff should be putting an incontinence brief on a resident if they are not wearing one before taking them out of their room. Upon interview on 5/13/24 at 12:45 p.m. physical therapy assistant (PTA)-A stated RN would not wear an incontinent brief in bed and therapy would find her in bed with towels between her legs. She stated after the day R1 became incontinent during a therapy session she would make sure R1 had an incontinence brief on before taking her out of her room. Upon interview on 5/13/24 at 3:02 p.m. the director of nursing (DON) stated she was aware that R1 was to be left in bed without anything covering her peri-area for skin healing. She stated she would not expect staff to be placing towels on R1, but rather be checking and changing her wicking pad. The DON stated that therapy has been trained and should be part of morning cares including insuring residents leave their room in proper attire. A facility policy titled Dignity with a revision date of 10/21 indicated the facility promotes care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This means staff must carry out activities which assists the resident to maintain and enhance his/her self-esteem and self-worth. Assisting residents to dress in their own clothes appropriate with time of day and individual preferences.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44649 Based on interview and record review the facility failed to provide a systematic approach to assess and evaluate residents' fluid status to monitor the effectiveness of interventions for 2 of 2 residents (R1 and R3) assessed. R1 and R3 were on a daily fluid restriction, the facility was documenting the intake. The facility did not have a system in place to evaluate the total daily fluid intake to determine adequacy or if the provider required notification. Findings include: R1's nursing progress notes dated 4/24/24 - 5/7/24 did not include any documentation regarding R1's fluid restriction, except on 4/25/24 at 1:29 a.m. a note indicated drank 300 cc. R1's physician orders dated 4/25/24 indicated P1 was on a fluid restriction of 1200 milliliters (ml) per day. 500 cubic centimeters (cc) day shift, 500 cc evening shift and 200 cc night shift. R1's care plan dated 4/26/24 indicated to monitor intake and record every meal. Staff was to provide and serve diet as ordered: Heart Healthy/regular textures and regular liquid. The care plan did not indicate R1 had a fluid restriction. R1's admission Minimum Data Set (MDS) dated [DATE] indicated R1 had a Brief Inventory of Mental status (BIMs) score of 15 indicating R1 was cognitively intact. R1 required maximum assistance with toileting hygiene, showering and dressing. She required moderate assistance with rolling in bed, positioning from sitting to lying and she was dependent from sitting to standing with transfers. R1 was dependent in her manual wheelchair. R1 was frequently incontinent of urine and bowel. R1's pertinent diagnoses were cirrhosis of the liver, acute respiratory failure with hypoxia, portal hypertension (increased pressure in the venous system), morbid obesity and type 2 diabetes mellitus with neuropathy (nerve damage from diabetes). R1's Point of Care response history for the task of fluids consumed indicated: 4/24/24 240 cc at 8:03 p.m. 4/25/24 400 cc at 8:49 p.m. 4/26/24 150 cc at 10:13 a.m. and 250 cc at 2:26 p.m. 4/27/24 400 cc at 10:07 a.m. and 380 cc at 1:07 p.m. 4/28/24 400 cc at 11:31 a.m. and 370 cc at 2:44 p.m. and 360 cc at 8:31 p.m. 4/29/24 400 cc at 9:52 a.m. and 390 cc at 1:10 p.m. and 480 cc at 8:54 p.m. 4/30/24 380 cc at 10:04 a.m. 5/1/24 360 cc at 2:23 p.m. and 560 cc at 2:23 p.m. [sic] (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/2/24 360 cc at 10:01 a.m. and 240 cc at 1:53 p.m. and 200 cc at 8:55 p.m. 5/3/24 480 cc at 9:18 a.m. and 240 cc at 1:53 p.m. 5/4/24 360 cc at 10:01 a.m. and 240 cc at 1:53 p.m. and 200 cc at 8:55 p.m. 5/5/24 360 cc at 2:42 p.m. and 420 cc at 2:42 p.m. 5/6/24 240 cc at 9:21 a.m. and 220 cc at 1:42 p.m. and 240 cc at 10:37 p.m. 5/7/24 400 cc at 9:33 a.m. R1's electronic treatment record (eTAR) dated 4/25/24 - 5/7/24 indicated R1's fluid intake was: 4/25/24 200 cc on the p.m. shift and 200 cc on the night shift 4/26/24 500 cc on the a.m. shift and 500 cc on the p.m. shift and 150 on the night shift 4/27/24 500 cc on the a.m. shift and 240 cc on the p.m. shift and 150 cc on the night shift 4/28/24 240 cc on the a.m. shift and 240 cc on the p.m. shift and 200 cc on the night shift 4/29/24 280 cc on the a.m. shift and 480 cc on the p.m. shift and 200 cc on the night shift 4/30/24 400 cc on the a.m. shift and 480 cc on the p.m. shift and 120 cc on the night shift 5/1/24 500 cc on the a.m. shift and 80 cc on the p.m. shift and 120 on the night shift 5/2/24 500 cc on the a.m. shift and 80 cc on the p.m. shift and 120 cc on the night shift 5/3/24 240 cc on the a.m. shift and 110 cc on the p.m. shift and 200 cc on the night shift 5/4/24 500 cc on the a.m. shift and 200 cc on the p.m. shift and 200 cc on the night shift 5/5/24 480 cc on the a.m. shift and 400 cc the p.m. shift and 200 on the night shift 5/6/24 480 cc on the a.m. shift and 400 cc on the p.m. shift and 100 cc on the night shift R1's Hospital emergency department (ED) note dated 5/7/24 at 11:11 a.m. indicated R1's chief complaint was abdominal pain. R1 had a history of pleural effusion (build-up of fluid between the lungs), and liver cirrhosis with ascites (fluid build-up in the abdomen) who presented to the ED for abdominal pain and bloating. On 5/7/24 at 12:00 p.m. R1 was diagnosed with severe sepsis (a life-threatening infection). R1's other admission to the hospital diagnoses were portal vein thrombosis, acute urinary tract infection, liver cirrhosis and pleural effusion. Clinically significant risk factors were hyperkalemia (high potassium in the blood), hypercalcemia (high calcium in the blood), hypoalbuminemia (a condition when the body doesn't produce enough albumin protein that's responsible for keeping fluid in your blood vessels). (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Upon interview on 5/13/24 at 11:46 a.m. R1 stated she was still in the hospital stating she had been admitted with portal vein hypertension, a urinary tract infection and a bunch of my labs were off. R1 stated she did not understand how the facility was managing her fluid restrictions. She stated no one talked to her about it, other than one unidentified nursing assistant (NA) told her that the fluids on her meals were planned out. R3's eTAR dated 4/14/24 - 5/13/24 indicated R3 had an order for a 1200 cc fluid restriction. The nursing staff did not documentation how much fluid R3 consumed during the shift. The nursing staff only checked the boxes indicating the fluid restriction was administered. R3's nursing progress notes reviewed from 4/4/24 - 5/13/24 did not have any documentation of a fluid restriction or intake measures. R3's care plan dated 4/8/24 indicated R3 was at risk for nutritional altercation related to dialysis. R3 had a renal-dialysis diet. Staff was to monitor food and fluid intake at meals and monitor for signs of dehydration. R3's care plan did not indicate any fluid restrictions. R3's Point of Care Response History for the tasks of fluid consumed dated 4/14/24 - 5/13/24 indicated: 4/14/24 480 cc at 10:11 a.m. and 480 cc at 1:59 p.m. and 550 cc at 10:19 p.m. 4/15/24 R3 not available in the a.m. and 200 cc at 1:04 p.m. 4/16/24 300 cc at 9:38 a.m. and 300 cc at 1:10 p.m. 4/17/24 R3 not available in the a.m. and 500 cc at 10:28 p.m. 4/18/24 360 cc at 11:00 a.m. and 360 cc at 2:12 p.m. and 300 cc at 10:13 p.m. 4/17/24 R3 not available in the a.m. and 500 cc at 10:28 p.m. 4/18/24 360 cc at 11:00 a.m. and 360 cc at 2:12 p.m. and 300 cc at 10:13 p.m. 4/19/24 R3 not available in the a.m. and 120 cc at 2:24 p.m. 4/20/24 480 cc at 11:04 a.m. and 240 cc at 2:21 p.m. and 120 cc at 7:08 p.m. 4/21/24 480 cc at 9:14 a.m. and 480 cc at 2:24 p.m. and 120 cc at 7:18 p.m. 4/22/24 R3 not available in the a.m. and 300 cc at 12:53 p.m. and 120 cc at 7:08 p.m. 4/23/24 300 cc at 9:17 a.m. and 300 cc at 1:03 p.m. and 120 cc at 7:39 p.m. 4/24/24 R3 not available in the a.m. and 200 cc at 1:18 p.m. and 500 cc at 10:05 p.m. 4/25/24 380 cc at 10:07 a.m. and 280 cc at 1:48 p.m. and 120 cc at 7:09 p.m. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/26/24 R3 not available in the a.m. and 360 cc at 1:55 p.m. and 120 cc at 7:26 p.m. 4/27/24 240 cc at 1:17 p.m. and 180 cc at 1:18 p.m. and 120 cc at 6:32 p.m. 4/28/24 300 cc at 9:11 a.m. and 300 cc at 2:10 p.m. and 500 cc at 10:57 p.m. 4/29/24 R3 not available in the a.m. and 240 cc at 2:05 p.m. 4/30/24 300 cc at 9:10 a.m. and 300 cc at 2:10 p.m. and 550 cc at 10:57 p.m. 5/1/24 R3 not available in the a.m. and 300 cc at 2:22 p.m. and 120 cc at 6:46 p.m. 5/2/24 R3 not available in the a.m. and 240 cc at 1:12 p.m. and 120 at 8:02 p.m. 5/3/24 R3 not available in the a.m. and 250 cc at 2:11 p.m. 5/4/24 480 cc at 11:21 p.m. and 240 cc at 2:13 p.m. and 120 cc at 7:17 p.m. 5/5/24 390 cc at 9:08 a.m. and 400 cc at 2:14 p.m. 5/6/25 R3 not available in the a.m. and 300 cc at 1:07 p.m. 5/7/24 300 cc at 9:04 a.m. and 300 cc at 1:32 p.m. and 120 cc at 8:09 p.m. 5/8/24 R3 not available in the a.m. and 300 cc at 2:23 p.m. and 500 cc at 6:00 p.m. 5/9/24 360 cc at 10:48 a.m. and 200 cc at 2:01 p.m. and 120 cc at 7:46 p.m. 5/10/24 R3 not available in the a.m. and 120 cc at 7:11 p.m. 5/11/24 240 cc at 12:55 p.m. and 120 cc at 12:55 p.m. and 550 cc at 10:00 p.m. 5/12/24 300 cc at 8:59 a.m. and 300 cc at 1:02 p.m. and 550 cc at 6:12 p.m. 5/13/24 R3 not available in the a.m. R3's quarterly MDS dated [DATE] indicated R3 had a BIMs score of 15 indicating she was cognitively intact. R3 required extensive assistance with bed mobility and total dependence for transferring. R3's pertinent diagnoses were Asthma, respiratory failure, end stage renal disease and congestive heart failure. R3's clinical physician order dated 4/30/24 indicated R3 had a fluid restriction of 120 ml at nighttime, 180 ml in the a.m. and p.m. and 240 ml with meals. Upon interview on 5/13/24 at 1:23 R3 stated she wasn't certain how the facility monitored her fluid intake. She stated she has never had a discussion from the nursing or dietary department. R3 was a former health care professional and stated she watches her intake on her own. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Upon interview on 5/13/24 at 1:45 p.m. LPN-A stated the nursing staff enforce fluid restriction by educating the residents and the nursing assistants. She was uncertain who is responsible for auditing the total daily intake and reporting to the provider if there are concerns. Upon interview on 5/13/24 at 1:54 p.m. RN-A the unit manager stated she was uncertain who manages the fluid restrictions. She stated, I think dietary does. Upon interview on 5/13/24 at 2:02 p.m. the assistant dietary manager stated the facility does not have a dietician currently, so the corporate dietician provides direction to the facility. She stated the Point of Care forms are where the NA's document after resident eats. The kitchen supplies fluid restriction residents with the order provided on their trays. She stated the eTAR where the nursing staff document the resident fluid intake with their medication administration. The manager was uncertain who monitored the fluid restrictions daily. Upon interview on 5/13/24 at 3:02 p.m. the director of nursing (DON) stated the dieticians are responsible for watching for an increase in fluid concerns with the residents. She stated the dialysis department watches the fluid levels for R3. The DON stated if the nursing staff were to notice any symptoms of a fluid concerns for a resident, they would report the concern to the dietician and/or the provider. The DON was unable to provide daily fluid totals for R1 or R3. Upon interview on 5/13/24 at 3:46 p.m. the corporate registered dietician (RD)-A stated she was new to her role and was not completely familiar with the process of fluid restriction. She stated she is aware the kitchen follows the restriction orders when placing beverages on the meal trays. She was not certain who was to be watching fluid restrictions at the end of the day. She stated she looks closely at the resident assessment and completes her own assessment quarterly for the MDS. The RD attempted to run a report on the Point Click Care (the facilities software system) to find daily intake totals and stated, I can't find this, it would be helpful, this is a concern. A facility policy titled Intake and Output Monitoring revision date of 12/13 indicated. -Enter Resident name and/or identification on the daily intake and output record. -Measure and record all liquids ingested. -Estimate and record ice and foods that becomes liquid at room temperature (i.e., ice cream, Jello). -Instruct Resident to urinate in bedpan, urinal, or collection graduate in toilet. -Measure urine and record amount on individual record. -If any bleeding, emesis, diarrhea, or drainage occurs, measure and record as output. -When enteral nutritional therapy, or intravenous fluid is administered record amount on individual record. -The intake and output are to be totaled and recorded in medical record every shift. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Intake and output are totaled every twenty-four hours. -The total I & O is placed in the Resident's medical record. -The nurse is responsible to evaluate the total I & O per shift. If the intake and output is not adequate, notify the MD/NP. -Take action per physician orders. -Licensed nurses will evaluate the resident's I & O on a 24-hour bases and weekly basis to determine adequacy.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44649 Based on observation, interview, and record review the facility failed to follow recommended precaution process for disinfecting medical equipment between resident use for 1 of 1 resident (R4) when observed. Licensed staff failed to disinfect the vital signs machine following the use on R4 who was on contact precautions and then used on another resident. In addition, the facility had placed R4 on incorrect isolation precautions. R4 was found to be on precautions due to suspicion of Covid requiring droplet precautions and he was on contact precautions. Findings include: Upon observation on 5/13/24 at 8:19 a.m. licensed practical nurse (LPN)-A was taking vital signs in R4's room. R4 had a cart with gowns, gloves, hand sanitizer and masks out of side of his room. The sign on the wall indicated R4 was on contact precautions that required staff to cleanse hands before entering and exiting room, don gloves and a gown when in room and discard before exiting the room. In addition, the staff were to use dedicated or disposable equipment or clean and disinfect reusable equipment before use on another person. LPN-A wheeled the vital sign machine out P4's room and placed the machine by the medication cart without sanitizing it. Upon observation and interview on 5/13/24 at 8:28 a.m. LPN-A wheeled the same vital sign machine into an unidentified resident's room and proceeded to take her vitals signs. LPN-A stated she usually wipes down the machine between each resident but was having a busy morning and realized she should have disinfected it. LPN-A was not certain why R4 was on contact precautions. She stated, I think because he is a new admit. LPN-A stated the facility constantly had Covid-19 outbreaks. Upon observation on 5/13/24 at 8:37 a.m. LPN-B used a vital sign machine on an unidentified resident room. The resident was on contact precautions. LPN-B did not sanitize the machine prior to taking the vitals signs. LPN-B placed the vital signs machine by her medication cart without disinfecting it after use. There is not an observation of LPN-B, or another staff member using the unsanitized machine on another resident. R4's nursing progress notes dated 5/10/24 - 5/13/24 did not indicate reason R4 was on contact isolation precautions. R4's care plan dated 5/13/24 indicated R4 had a localized infection that does not require precautions. R4's admission minimum data set (MDS) dated [DATE] was in progress, no isolation data identified. Upon interview on 5/13/24 at 7:52 a.m. the Administrator stated the facility is in Covid-19 outbreak and the facility had 11 cases between two units. Upon interview on 5/13/24 at 3:02 p.m. the director or nursing (DON) stated she was uncertain why R4 was on contact precautions. She stated the expectation of the staff is to disinfect equipment after use on each patient. She stated ideally equipment would be disinfected before and after each use. (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Upon interview on 5/13/24 at 3:58 p.m. the infection preventionist (IP) stated R4 admitted with suspicions of Covid-19 since he was a new admission from a hospital setting. The IP was uncertain which precautions R4 was on. She stated R4's Covid test came back on 5/13/24 as negative so he could be taken off any precautions for Covid-19, however, would be assessed for enhanced barrier precautions due to a new pacemaker and surgical wound. A facility policy titled Transmission/Isolation precautions dated 11/1/23 indicated: DROPLET: Examples; Influenza, Mumps, Respiratory Disease, COVID-19, Mpox Droplet transmission involves contact of the conjunctivae or the mucous membranes of the nose or mouth of a susceptible person with large-particle droplets (larger than 5 mm in size) containing microorganisms generated from a person who has a clinical disease or is a carrier of the disease. Droplets are generated from the source person primarily during coughing, sneezing, talking, Transmission of large-particle droplets requires close contact between source and recipient persons. Private room and when a private room are not available, cohort with patient(s) who has active infection with the same microorganism but with no other infection. Perform hand hygiene. Mask, face shield/goggles, gown and gloves required prior to entering room. Isolation gowns must be impermeable to fluids. N95 mask to be worn when providing care for COVID-19 positive or suspected COVID-19 positive residents or unvaccinated residents during COVID-19 outbreak and with Mpox positive or suspected Mpox residents. -Remove PPE before leaving the patient's room. -Perform hand hygiene. -Eye protection should only be removed and reprocessed if it becomes visibly soiled or difficult to see through. -Use disposable equipment or patient dedicated equipment to stay in patient room if possible, disinfect between patient use, follow product wet times. -Limit the movement/transport of patients from room to essential purposes only. Place a universal mask on patient if possible, during transportation. -Maintain at least 6 feet from other patients and visitors when possible.