STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245164	A. BUILDING _____ B. WING _____	**07/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NEW BRIGHTON A VILLA CENTER	**825 FIRST AVENUE NORTHWEST NEW BRIGHTON, MN 55112**

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 0726 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure 34 out-side agency direct care staff, received appropriate orientation and information needed to provide care to meet each resident needs. This had the potential to affect all 81 residents in the facility who were cared for by the agency staff. Findings include: When interviewed on 6/30/20, at 9:53 a.m. nursing assistant (NA)-A from a staffing agency #2 indicated she reported to work at the facility on a Saturday 6/27/20, for the evening shift. The administrator was the manager on duty and did the Covid-19 screening and directed NA-A to the nursing unit. NA-A reported to the TCU (transitional care unit) and was not given a report on the residents she would be responsible for and was not instructed on the facility policies. This was NA-A's first time working in this facility. When interviewed on 7/1/20, at 1:40 p.m. NA-A verified reporting to work on 6/27/20, at 3:15 p.m. and no staff informed her of the facility policies or the current Covid-19 special issues with the residents for infection control. NA-A stated, I tried to ask about care plans and how to take care of the residents and I was told by another agency staff, 'who do you think you are, a boss or something. Just sit down and be quiet'. Furthermore, NA-A indicated she did not know where to find personal protective equipment, that all the bins seemed to be empty of supplies. The residents did not have face masks available for cares and NA-A did not know what the facility directed the staff to do for interventions with Covid-19. NA-A stated, The staff were talking down to me, I felt like they were ignoring me. They intimidated me so I was unsure of what to do and had no one to turn to for help. NA-A did not know the names of the staff or who to report concerns to at the facility. NA-A indicated there was no supervisor to go to on the evening shift and that the nurse for the TCU was an agency nurse who was very busy trying to orient a new nurse for the facility and did not have time to spend with NA-A. The facility staffing coordinator (SC)-A was interviewed on 7/1/20, at 11:00 a.m. and indicated being new as the SC since 5/12/20, and was not aware of any forms or documents to be provided to agency staff first coming to the facility to know the policies. SC stated, I have not been instructed on what to do for them reporting to the facility. The SC verified no forms or packets were required that she knew of, and there was not a policy on what to expect with the agency staff. The staffing agency #1 SC-B was called on 7/2/20, at 12:15 p.m. and staffing agency #2 SC-C was called on 7/1/20, at 1:40 p.m. The SC-B & SC-C for both agencies verified that prior to a staff person coming to the facility from the agency, it was an expectation that the agency send the license verification, criminal background check, [MEDICATION NAME] testing and symptom screening. Both staffing agencies indicated it was the responsibility of the facility to spend an hour with the new staff member going over the facility specific requirements so the agency staff would know the requirements at this facility when entering for the first time. The administrator was interviewed on 7/1/20, at 12:32 p.m. and verified being the manager on duty 6/27/20, and stated, I did not do any training of the agency staff when I worked Saturday. When interviewed on 7/1/20, at 3:40 p.m. the administrator and director of nursing (DON) verified there was a change in the DON and the SC back to May 2020. The administrator and DON verified there was not a facility policy on how or what to orient agency staff to but the facility expectation would be to meet with the new agency staff and review a packet containing facility policies. The information the agency staff should have received and signed that they received the information was titled: Code of Conduct, Compliance and Ethics Training, HIPPA (Health Insurance Portability and Accountability Act, Emergency Procedures including Fire and Evacuation, Resident Rights, Reporting requirements, Standard Precautions, Performance and Hand Hygiene skills check off. PPE Donning and Doffing. Furthermore, the administrator and DON verified the agency staff should have been given a verbal report, should have been given access to the computer, and should have been given access to the resident care cards to know how to care for the residents. When interviewed on 7/2/20, at 12:00 p.m. the DON verified there were 34 agency staff that have recently worked at the facility that did not have the training paperwork completed for orientation to the facility and they were in the process of getting all of the required information. The DON verified the facility system for training the agency staff did not occur for these 34 agency staff since May 2020 but they were working to correct the process immediately.

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.