STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245476	A. BUILDING _____ B. WING _____	09/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOOD SAMARITAN SOCIETY - PINE RIVER	518 JEFFERSON AVENUE, PO BOX 29 PINE RIVER, MN 56474

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	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to implement recommended COVID-19 infection control procedures related to the use of gowns when in direct contact for 1 of 2 residents (R1) who was put on transmission based precautions due to exhibiting potential symptoms of COVID-19. This deficient practice had the potential to affect all 24 residents who resided in the facility and staff. Findings include: R1's Face Sheet printed 9/9/20, indicated R1's [DIAGNOSES REDACTED]. R1's care plan dated 8/19/20, indicated R1 required extensive assistance to complete activity of daily living tasks (ADLs). The care plan lacked indication R1 was on transmission based precautions related to COVID-19 symptoms. On 9/5/20, at 9:49 p.m. progress notes indicated R1 had symptoms of a dry cough. R1 placed on isolation for COVID-19 symptoms, and clinical monitoring was started. On 9/9/20 at 11:00 a.m. a personal protective equipment (PPE) cart was observed in the hallway next to R1's room. A droplet precautions sign on was on the top of the PPE cart, however, R1's door lacked any precaution signage. At 11:41 a.m. registered nurse (RN)-A was observed in the hallway, outside of R1's door, donning an isolation gown, in preparation of entering R1's room. RN-A stated R1 was on precautions because of symptoms of cough and upper respiratory infection. -At 12:40 p.m. nursing assistant (NA)-A was observed to enter R1's room to answer the call light. NA-A entered R1's room without donning an isolation gown. NA-A was in R1's room for one minute, then exited R1's room and walked across the hall to obtain a Hoyer (mechanical) lift. NA-A was overheard to request assistance from licensed practical nurse (LPN)-A. NA-A entered R1's room with the Hoyer lift. NA-A did not don a gown. LPN-A approached the PPE cart outside of R1's room, sanitized her hands with alcohol based hand rub (ABHR), donned an isolation gown, and entered R1's room. -At 12:46 LPN-A was observed to be in R1's doorway, doffing and disposing of her isolation gown and gloves in the garbage container in R1's room. LPN-A exited the room. NA-A exited R1's room directly behind LPN-A, however, was observed not to have an isolation gown on. Upon exiting R1's room, NA-A immediately entered the resident room next door to respond to a call light. -At 12:48 p.m. LPN-A stated she was aware R1 was on isolation precautions because of the sign on top of the PPE cart next to R1's room. LPN-A stated she was aware NA-A had not donned an isolation gown to enter R1's room, and verified NA-A should have been wearing an isolation gown because of cares they had just provided to R1. -At 12:55 p.m. NA-A was interviewed and stated she had used the Hoyer lift to assist R1 into her bed, and provided her with a bed pan with LPN-A's assistance. LPN-A stated R1 was currently on the bedpan, and they left the Hoyer lift in the room, so they could remove her off of the bedpan when she was done. NA-A stated she was aware R1 was on transmission based precautions, and she should have been wearing an isolation gown to provide care to R1, but had been in a hurry and had forgotten. NA-A stated she had made a mistake. On 9/9/20 at 4:30 p.m. in a joint interview, both the administrator and the director of nursing (DON) stated they would expect an isolation gown to be worn for direct patient care in the isolation rooms. The DON stated if assisting with direct cares, an isolation gown should be worn. The facility's policy Infection Prevention: Emerging Threats-Acute Respiratory Syndromes Coronavirus (COVID)-19 Enterprise dated 8/14/20, directed staff to isolate residents with suspected or positive COVID-19 to their room and post a droplet precaution sign on their door. The policy directed staff to limit only essential personnel to enter the room, wearing appropriate PPE. The policy indicated appropriate PPE to include gloves, gowns, eye protection and mask.

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