STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245028	A. BUILDING _____ B. WING _____	06/02/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HIGHLAND CHATEAU HEALTH CARE CENTER	2319 WEST SEVENTH STREET SAINT PAUL, MN 55116

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 -** Many	**Provide and implement an infection prevention and control program.** Based on observation, interview, and document review, the facility failed to ensure hand hygiene was performed appropriately for 4 of 12 residents (R3, R4, R8 and R9), and use of personal protective equipment (PPE) for 2 of 12 residents (R15 and R23) observed for cares. The facility also failed to monitor for signs and symptoms of Covid-19 for 5 of 5 residents (R1, R2, R3, R4 and R5) reviewed for monitoring practices. The facility also failed to properly quarantine recently admitted residents in accordance with Centers for Disease Control (CDC) infection control guidelines affecting 4 of 4 residents (R2, R4, R9, R10 and R11) reviewed for new admissions. These practices had the potential to affect all 63 residents residing in the facility at the time of the survey. The facility also failed to properly disinfect lift equipment after use for 4 of 4 residents (R3, R8, R7 and R4) reviewed, which had the potential to affect 17 of 17 residents (R1, R3, R4, R5, R6, R7, R12, R13, R14, R15, R16, R17, R18, R19, R20, R21 and R22) who required the use of mechanical lifts for transfer. Findings include: Hand hygiene: When observed on 5/28/20, at 1:00 p.m. nursing assistant (NA)-C transferred R3 to bed using an EZ Stand (a mechanical lift which helps the resident stand up and transfer). NA-C then removed gloves and washed hands for 7 seconds with soap and water. When observed on 5/28/20, at 1:21 p.m. NA-C came out of a dirty utility room carrying a full trash bag, stopped at the medication cart and removed the trash bag from the cart, then went to the nurses station and removed the trash from behind the desk. NA-C then took the bags outside, returning at 1:28 p.m. NA-C then washed hands for 8 seconds. When interviewed on 5/28/20, at 1:44 p.m. NA-C stated hand sanitizer should be used or hand washing performed after all patient care. NA-C also stated that he should wash his hands for five minutes, but he does not always have the time, so sometimes hand washing was done really quick. When reminded 20 seconds of hand washing was the current recommendation, NA-C shrugged and stated that he did not have a lot of time today, so hand washing was quick, not even 20 seconds. NA-C confirmed he received recent education on hand hygiene to include hand washing. When observed on 5/28/20, at 1:06 p.m. nursing assistant NA-D went into R4's room, and stood at the bedside, with his bare left hand resting on the tray table next to the bed. The resident was in bed, having finished lunch. NA-D wore a mask and goggles. NA-D took a plate cover from the room, and brought it down the hall and into R8's room, without performing hand hygiene in between rooms. At 1:08 p.m. NA-D left R8's room carrying a meal tray from the room, and the plate cover from the previous room. NA-D placed both items on a cart in the hallway, then went directly into R9's room without performing hand hygiene. While in the room, NA-D moved the tray table closer to the resident, then left the room. NA-D did not perform hand hygiene upon leaving the room, and at 1:11 p.m. pushed the tray cart down the hallway, and onto the elevator. NA-D returned to the unit without the tray cart at 1:13 p.m. and washed his hands in the sink at the nursing station. When interviewed on 5/28/20, at 1:14 p.m. NA-D stated he did not have hand sanitizer to carry in his pocket to use when going from room to room. NA-D stated he did not usually wash his hands in the resident room, but rather preferred to come down the hall to wash his hands in the nurses station sink. NA-D clarified he would sometimes wash his hands in the resident rooms if his hands were really dirty. When interviewed on 5/28/20, at 2:53 p.m. the director of nursing (DON) stated the expectation was for staff to wash hands for 20 seconds using soap and water. At 3:00 p.m. the DON also clarified if staff went into a room and touched a resident or the environment, staff should perform hand hygiene. The undated facility policy Procedure for Handwashing, instructed staff to wash hands with soap and water for at least 10 seconds and outlined many appropriate situations including the following: before and after each resident contact and after handling any contaminated items like garbage. The Centers for Disease Control (CDC) website recommended when cleaning hands with soap and water, to rub hands together vigorously for at least 15 seconds. The CDC noted that other entities have recommended that cleaning your hands with soap and water should take around 20 seconds, and either time was acceptable. The facility provided competency Handwashing and Glove Use Observation Audit dated 3/10/20, which indicated staff should wash hands with soap and water for at least 15 seconds. Universal PPE use: When interviewed on 5/28/20, at 11:32 a.m. the DON stated all staff were wearing either cloth masks or N95 respirators. Any staff wearing N95 respirators had supplied their own. The DON also stated staff were wearing eye protection if doing patient care or if within six feet of a resident. When observed on 5/28/20, at 12:42 p.m. NA-B was wearing a face shield and a cloth mask. NA-B stated, They just gave me this face shield 10 minutes ago. I did not have one before this. NA-B also stated she had not used any eye protection when doing patient cares before 5/28/20. NA-B also stated that she did not know what to do with the face shield at the end of the day and thought someone would probably tell her. She was unaware of any cleaning/disinfection techniques for face shields. When observed on 5/28/20, at 12:52 p.m. licensed practical nurse (LPN)-A was observed coming out of a R15's room with goggles on his head and a mask under his nose. When observed on 5/28/20, at 1:06 p.m. LPN-A was observed coming out R23's room with goggles on his head and face mask under his nose. When interviewed on 5/28/20, at 1:18 p.m. LPN-A stated he would wear a gown and face shield while suctioning a resident or if a change in status was identified. LPN-A also stated eye protection had been used for a couple weeks now but these particular goggles fogged up and that was why he had them on his head. Current CDC guidance for HCP (health care providers) working in areas with minimal to no community transmission should use eye protection, a surgical mask or an N95 or higher-level respirator whenever recommended for patient care as a part of Standard or Transmission-Based Precautions. Universal use of a facemask for source control is recommended for HCP. Covid-19 monitoring: R2's temperature log and O2 sats (oxygen level) from 5/1/20, through 5/28/20, indicated 15 of 26 days of documented temperatures and 13 of 26 days of documented O2 sats (oxygen saturation level, a measurement of blood oxygen) (R2 was out of the facility in the hospital from 5/18/20 to 5/20/20). R3's temperature log and O2 sats from 5/1/20, through 5/28/20, indicated 17 of 28 days documented temperatures and 13 of 28 days of documented O2 sats. R1's temperature log and O2 sats from 5/1/20, through 5/28/20, indicated 23 of 28 days documented temperatures and 15 of 28 days of documented O2 sats. R4's temperature log and O2 sats from date of admission 5/21/20, through 5/28/20, indicated 6 of 8 days documented temperatures and 5 of 8 days of documented O2 sats. R5's temperature log and O2 sats from 5/1/20, through 5/28/20, indicated 24 of 28 days documented temperatures and 16 of 28 days of documented O2 sats. The current CDC guidance is to monitor all residents daily for signs and symptoms of COVID-19. The facility policy AHCA (American Health Care Association)/NCAL (National Center for Assisted Living) Interim Guidance: Accepting Admissions from Hospitals During COVID-19 Pandemic dated 3/24/20, identified guidance for accepting hospital admission when there are no COVID-19 cases in the long term care (LTC) facility. For a situation where COVID-19 cases are widespread in the surrounding community and the resident tested negative for COVID-19, the resident should be monitored for fever and respiratory symptoms every shift and limit contact with other residents. The facility policy Infection Prevention and Control-Addendum: COVID-19 Coronavirus dated 3/27/20, indicated the facility would collaborate with State and Federal guidelines follow recommendations from CDC. The policy indicated surveillance of residents would include temperature and O2 sats daily. Hospital return precautions: When observed on 5/28/20, at 12:13 p.m. a stop sign on the doorway of R2's room indicated, hospital return precautions 5-20 to 6-3. When interviewed on 5/28/20, at 12:15 p.m. NA-A stated the sign on R2's door meant

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.

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 1) the resident would be in quarantine for fourteen days and staff were supposed to protect themselves. NA-A stated he should gown and glove if he needed to go into R2's room. There was no isolation cart with PPE outside the room. NA-A stated he would have to go down the hall to get some PPE if needed and he had been educated on how and when to use PE. When interviewed on 5/28/20, at 12:25 p.m. LPN-A stated the sign posted on R2's door indicated the resident was on hospital return precautions. LPN-A also stated that hospital return precautions meant that they would check the resident's temperature, oxygen saturations (O2 sats) and respiratory status every shift. LPN-A stated the resident had the right to come out of the room, but the staff were supposed to encourage the resident to stay in the room as much as possible. When observed on 5/28/20, at 12:28 p.m. R2 carried a tray out of his room to the tray cart without wearing a mask. NA-A grabbed the tray from R2 and suggested R2 return to his room. When observed on 5/28/20, at 12:31 p.m. R2 walked down the hallway past LPN-A without wearing a mask. LPN-A did not talk to R2 and did not suggest R2 return to his room or wear a mask. When observed on 5/28/20, at 1:36 p.m. R2 was out of room without wearing a mask. LPN-A reminded R2 to wear mask, but allowed R2 to continue to walk in hallway heading away from his room. R2 did not have a mask with him and did not immediately return to room to retrieve one. During an interview on 5/28/20, at 1:14 p.m. NA-D was wearing goggles and a mask, and explained he was supposed to wear his goggles and mask throughout his shift. When asked what the new admission signs meant, NA-D stated he was not sure about signs describing certain residents as newly admitted to the facility and being on new admit precautions; but he thought it meant staff should stop and be aware that the residents were new, and watch the residents more because staff did not know them as much. When observed on 5/28/20, at 1:24 p.m. registered nurse (RN)-A was wearing a mask and goggles. RN-A stated the new admits were quarantined and staff were always supposed to wear a mask and goggles. RN-A also stated they asked newly admitted resident to wear a mask while staff were in the room working with them. RN-A added that she thought staff were supposed to wear gloves if they were going to have contact with the new resident, and a gown if there was one available. RN-A stated the resident rooms did not have hand sanitizer inside them, but did have soap and water for hand washing. When observed on 5/28/20, at 1:36 p.m. R4's room door had a new admit sign on it, and a box of gloves balancing on the hand rail in the hallway just outside the door. The sign did not direct staff on any precautions, but to, CHECK WITH NURSE BEFORE ENTERING in all capital letters. R9 and R10's rooms had the same sign, but no gloves outside either door. R11's room had the new admit sign and gloves on the hand rail outside the door. None of these newly admitted residents' rooms had gowns outside the room for staff to wear. When interviewed on 5/28/20, at 2:01 p.m. The DON stated they were placing residents in quarantine for fourteen days after admission from the hospital. DON also stated they ask residents to remain in their room for fourteen days. The DON also stated the residents tested negative for Covid-19 in the hospital and the staff would screen those residents for signs and symptoms of Covid once a day. The DON further stated staff should be donning (putting on) full PPE before entering those rooms, each room should have an isolation cart outside the room and staff should be using droplet precautions. The DON further stated residents should have a mask on if they come out of their room. On 5/28/20, at 2:36 p.m. the DON clarified they don't place an isolation cart outside of resident rooms who are on hospital admit precautions, rather staff, should just mask and use eye protection. Current MDH guidance for residents admitted to a congregate living setting from a hospital with no clinical concerns for Covid-19 indicated residents should be placed in observation and monitored for signs and symptoms of Covid-19 for 14 days after admission. All recommended PPE should be worn during care of residents under observation, when PPE supplies allow. At minimum, facemask's and eye protection should be worn by staff during care. Cloth face coverings are not considered PPE. Lift cleaning: On 5/28/20, at 12:51 p.m. an EZ Way Smart Lift, labeled #5, was observed in the first floor east hallway. The full body lift had a bag hanging off the lift, with no cleaning wipes in the bag. An EZ Way Smart Stand, labeled #2, was also observed in this hallway, with no wipes in the bag attached to the stand. At 12:56 p.m. on the first floor west hallway an EZ Way Smart Lift, labeled #3, did not have wipes in the attached bag. On 5/28/20, at 1:00 p.m. NA-C pushed an EZ Stand from the 2 East/West unit into the 2 East unit and into R3's room. Once in the room NA-C donned (put on) gloves. R3 was sitting in a wheel chair. NA-C positioned the EZ stand in front of R3 and connected the sling. R3 placed his hands on the grab bars. NA-C then secured the safety belt around R3, used the EZ stand to transfer R3 off the chair onto his/her bed, where NA-C assisted R3 to lie down. NA-C pushed the EZ stand out of room and positioned it against the wall in the hallway. NA-C did not clean the EZ stand lift. On 5/28/20, at 1:37 p.m. NA-D was observed bringing the EZ Way Smart Lift #3 into R8's room before closing the door. At 1:43 p.m. NA-D brought lift #3 out of R8's room, did not clean the lift, and stored it against the wall in the hallway for the next use before going down the hallway to wash hands at the nursing station. On 5/28/20, at 1:47 p.m. NA-D brought the EZ Way Smart Stand #2 into R7's room, and closed the door. At 1:53 p.m. NA-D brought stand #2 back out of R7's room, and pushed it down to R4's room. NA-D did not clean the lift, but knocked on R4's door, and alerted staff inside the room that the stand was outside the door when they needed it. NA-D then washed hands at the nursing station. At 1:58 p.m. NA-D was asked about cleaning the mechanical lifts and stands. NA-D stated cleaning occurred at the end of the shift, usually by the nursing assistants. When asked where the cleaning supplies were kept, NA-D looked inside the bags on the lifts in the hallways, and commented how there were no cleaning supplies in the bags, where the cleaning wipes were sometimes kept. NA-D stated he probably could call someone to find more wipes if he needed them, and thought housekeeping might help with locating new wipes. At 1:59 p.m. staff inside R4's room opened the door and brought EZ Way Smart Stand #2, which had not been cleaned since the previous use, inside R4's room to use. On 5/28/20, at 1:44 p.m. NA-C stated he would usually sanitize the lifts after each use but the facility did not currently have anything to clean the lifts. NA-C also stated he used three different lifts on the East wing and did not clean any of them and would have to go back and clean them later. On 5/28/20, at 1:48 p.m. NA-B stated staff were supposed to wipe the lifts down after every resident. NA-B also stated she helped NA-C transfer R6 back to bed but did not clean the Hoyer lift because there were no wipes in the bag on the lift. NA-B stated normally there was a container of wipes stored with the equipment to clean it. On 5/28/20, at 1:50 p.m. three lifts were on the second floor East wing (two Hoyer lifts and one EZ Stands) . None of the lifts had wipes stored with them. On 5/28/20, at 1:55 p.m. NA-B stated in his mind the EZ stand lift in the second floor East wing (that was used on R3 and not cleaned) was clean and ready to be used on a resident because it should have been cleaned after it was last used. On 5/28/20, at 1:59 p.m. LPN-A stated lifts in the hallways were clean and ready to go because the NA's wipe them down after they are used. On 5/28/2020, at 2:01 p.m. the DON stated lifts should be washed between residents, but the facility was currently out of the purple top disinfectant wipes. The DON also stated the housekeepers are mixing up a bleach water mix that they should be using on the lifts. On 05/28/2020, at 2:39 p.m. housekeeper (H)-A stated the housekeepers make up a solution from pre-made concentrated solution about once a week and stored in the locked cabinet in the utility rooms on each unit. H-A also stated they cannot leave the solution out because they do not want the residents to have access to it. H-A stated the staff are supposed to spray the equipment after each use and she used it to clean all the restrooms and common areas. The EZ Way Floor Lift & Stand Cleaning Guide from the manufacturer revised 8/14/18, recommended a standard germicidal spray, Sani-Wipe, or similar product. The cleaning guide did not have a recommendation for how often or when to clean the mechanical lifts and stands.