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 _____	07/30/2020

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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview the facility failed to ensure staff utilized and removed personal protective equipment (PPE) in a manner to prevent the potential spread of infection for 5 of 5 residents (R2, R3, R4, R5, R7) who required isolation precautions. This practice had the potential to affect all 59 residents residing at the facility. The facility also failed to ensure communal blood glucose machines were disinfected between resident use for 2 of 2 residents (R7, R8) observed to have blood sugar checked. This practice had the potential to affect 5 residents residing on the unit who required blood sugar checks. In addition, the facility failed to ensure insulin pens were stored separately to prevent the cross contamination of blood borne pathogens in 1 of 2 medication carts on the first floor unit. Findings include: On 7/30/20, at 7:56 a.m. during the tour of the facility, registered nurse (RN)-A was observed standing at the medication cart, setting medications up. When approached RN-A was observed wearing a surgical mask but with regular reading/vision eye glasses. RN-A then locked the medication cart and did not put eye protection on when done dishing up the medications as she entered R1's room with medications and shut the door. -At 7:59 a.m. surveyor observed nursing assistant (NA)-A had come out of R1's room also wearing regular reading glasses and her goggles were observed fixed above her eyes on her forehead. -At 8:01 a.m. NA-A was observed go up and down the hallway still wearing her goggles on top of her head. -At 8:02 a.m. RN-A came out of R1's room, went into the linen closet and still not wearing goggles or a face shield. -At 8:04 a.m. NA-A was observed applying a gown and gloves outside R2's room which had a sign at the door STOP New admit Isolation Precautions x 14 days 7/19/20 to 8/2/20. After she applied the PPE, at 8:06 a.m. NA-A went into R2's room still with her goggles on top of her head as she carried R2's breakfast tray and set it on the bedside table next to R2's bed. At this same time licensed practical nurse (LPN)-A was observed by another surveyor going in and out of a resident's rooms on the second floor east side wearing a surgical mask but with regular reading glass. LPN-A did not have goggles or a face shield. -At 8:07 a.m. after setting the food tray on the bedside table NA-A pulled her goggles on top of her reading glasses as she stood at R2's bedside talking to R2. -At 8:09 a.m. after she had left the unit briefly, RN-A came back to the unit and was observed wearing a pair of goggles on top of her reading glasses. -At 8:10 a.m. NA-A was observed still wearing her goggles on top of her forehead as she put breakfast trays on the the bedside tables into R3's and R4's room which both had the Stop New admit Isolation Precautions signs at the doors. -At 8:12 a.m. NA-A was observed delivering breakfast to R5's room, still with her goggles on top of her forehead and did not wear proper PPE as she entered R5's room which had a stop sign at the door New Admit isolation precautions x 14 days 7/19/20 to 8/2/20. -At 8:14 a.m. NA-A was observed delivering breakfast to R6's room, still with her goggles on top of her head. -At 8:17 a.m. NA-A was observed applying a white plastic gown and gloves as she stood outside R7's room prior to entering R7's room which had a sign at the door Hospital return isolation precautions 7/24/20 to 8/7/20/20 x 14 days. Before she went into R7's room she pulled the goggles to cover her eye glasses then took a breakfast tray into the room. During the observation, NA-A was observed touching multiple things before she came to the door and was observed removing her gown, and putting the goggles on top of her forehead. NA-A then without washing her hands after doffing PPE, proceeded to pull R7's door shut, came to the hallway reached into the food tray carrier, shut the door then went down the hallway into the utility room with the garbage, then washed her hands before she came out into the hallway. At 8:19 a.m. NA-A continued to be observed going into R8's room with her goggles on top of her forehead and shut the door. At 8:22 a.m. NA-A came out of R8's room still with her goggles on top of her forehead. -At 8:35 a.m. RN-A was observed standing outside R4's room which had a sign Stop New admit Isolation Precautions and was re-directing R4 who was attempting to ambulate in her room without staff assistance. RN-A then grabbed a gown and as she entered the room in a hurry was observed applying the gown in the room next to R4. RN-A only applied right sleeve then continued to ambulate with R4 in the room as the left sleeve was hanging and her clothing touched R4's body and the loose gown portion was flying around. -At 8:37 a.m. surveyor intervened and cued RN-A to put on her gown properly. At this time RN-A stated she had not applied the gown properly because she had to get to R4 immediately because she was afraid R4 was unsafe. RN-A then applied the other sleeve and proceeded to assist R4 to the bathroom. At 8:38 a.m. NA-A was observed coming down the hallway still wearing her eye glasses and goggles on top of her forehead. When she approached R4's room, RN-A cued her to come into the room. -At 8:43 a.m. during a random observation, surveyor observed RN-A going into R8's room as she carried a pink multipurpose utility pencil box which contained diabetic supplies and a communal glucometer. RN-A set it on top of R8's bedside table without a barrier then cued R8 that she was going to check his blood sugar after she applied a pair of gloves. RN-A then took the glucometer out of the box applied a strip at the end then punctured R8's finger, obtained a drop of blood which she applied to the strip and got a reading of 234. RN-A then removed the strip from the glucometer, then with the same gloves used a alcohol wipe to clean the glucometer and put it back into the diabetic supplies box, closed it, then removed her gloves. RN-A then came out of R8's room and went to the medication cart which was in the hallway, and cleansed her hands using hand sanitizer. RN-A then took the multipurpose utility box and put it in the medication cart and continued with the medication pass. -At 8:45 a.m. RN-A left the medication cart briefly then came back with a container of Medline Micro-Kill One wipes. RN-A was observed opening the medication cart, took one wipe out and cleaned the outside of the multipurpose utility box. When asked if she had cleaned the glucometer she stated she had cleaned the glucometer with an alcohol wipe in R8's room. When asked who the glucometer was used for checking blood sugars, she stated I have to be honest this glucometer is for everyone here in the unit. -At 8:51 a.m. RN-A was observed pulling one wipe from the Medline Micro-Kill One container then reached for the middle medication cart drawer to open it. As the drawer was open, surveyor observed a container of several insulin pens belonging to R1, R3, R5, R7 and R8 that were stored together without separation from each other. RN-A then picked R8's [MEDICATION NAME]pen, cleaned the outside of the flex pen, primed it with two units then went to R8's room and gave the insulin. At 8:53 a.m. RN-A came back to the medication cart and was observed to store R8's insulin [MEDICATION NAME] inside the container with the other resident's pens with no barrier which allowed the pens to touch each other. -At 8:52 a.m. NA-A was observed still wearing her goggles on top of her forehead as she came out of R4's room. NA-A wore only the surgical mask with eye glasses. -At 8:56 a.m. RN-A and surveyor reviewed the container with the insulin [MEDICATION NAME] and the following was revealed and verified by RN-A: -R7's and R1's one [MEDICATION NAME] each of [MEDICATION NAME] and [MEDICATION NAME]-R3's [MEDICATION NAME] Flextouch pen insulin -R5's [MEDICATION NAME]-R8's [MEDICATION NAME] Kwikpen insulin When asked how the [MEDICATION NAME] were supposed to be stored in the medication cart, at 9:00 a.m. RN-A stated this is how we keep them. -At 9:01 a.m. NA-A came out of R7's room with her goggles on top of the forehead as she went down the hallway past R9, who was being wheeled to his room by the receptionist who was wearing eye glasses and a surgical mask. The receptionist did not have on goggles or a face shield as she went into R9's room as she assisted him. -At 9:06 a.m. RN-A came out of R7's room still wearing the gown and gloves she had on in the room as R7 was on isolation precautions. RN-A then took the lid off the Medline Micro-Kill One container, grabbed one wipe and was observed to clean the outside of the pink multipurpose utility pencil box which contained diabetic supplies while still wearing the PPE from R7's room. As RN-A was cleaning the box, NA-A approached her and told her she was

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) leaving the floor. RN-A with PPE on still approached the medication cart where the surveyor was standing at, then removed her gown and gloves, went down to the nursing station and washed her hands. When asked if she had cleaned the glucometer after using it in R7's room, RN-A stated I cleaned the glucometer with an alcohol wipe in the room and the outside of the box I cleaned it with germicidal wipe, as observed by surveyor. On 7/30/20, at 1:56 p.m. to 2:01 p.m. housekeeping staff and NA-B were observed both on the second floor by the entrance door both wearing surgical masks but no eye protection in the hallway. On 7/30/20, at 9:21 a.m. during an interview, R10 stated there was a concern at the facility of staff not wearing PPE and not using it properly. R10 stated staff were able to leave the facility and would go about their life but when they came back they did not wear the PPE to protect them from Covid. R10 also stated I have pictures of staff not wearing the PPE properly which she showed the surveyor. R10 further stated They have not been telling us to wear the masks until today because you are here they are telling us to wear the masks when they are not even themselves wearing them properly. Sometimes they let people come in from the back door up here without masks and no screening is happening when they come up here. On 7/30/20, at 10:00 a.m. LPN-A was still observed wearing her regular reading eye glasses. When asked about eye protection LPN-A left the nursing station and went into the PPE supply room and came out wearing a pair of goggles. On 7/30/20, at 10:10 a.m. the director of nursing (DON) stated They have been trained with new admits they are to wear proper PPE when going into the room. All the new admits have up to 14 days isolation precautions which is posted at the door and they are to wear a mask, gown and goggles or face shield. We have been auditing it. When asked about storage of insulin [MEDICATION NAME] in the medication cart, the DON stated They should be kept in bags in the top drawer of the cart not together and separate baggies in the cart. When asked about how staff was supposed to clean a communal glucometer between residents, the DON stated if they are using the one glucometer for all residents they should be cleaning the glucometer with the purple top wipes and following the manufacturer's guidelines. When asked about use of eye protection for the staff when providing direct care and/or when in resident rooms, the DON stated They are supposed to have a face shield or goggles. Their eye glasses are not proper PPE. The facility Glucometer Infection Control Guidance policy dated March 2014, directed staff the following: 3. Disinfect the exterior surfaces of the glucometer after each use, even if there is no visible blood or soil following the manufacture's direction. 4. Use an EPA -Registered disinfectant effective against HBV, HCV, [MEDICAL CONDITION].5. Use the products as directed by the manufacturer. Thoroughly wipe the surface with the wipe. The label on the wipes will include a timeframe for how long the product must remain on the equipment to be effective. a. For example, PDI Sani Cloth Plus (red top) Germicidal Disposable Wipes -treated surface must remain visibly wet with the product for 2 minutes to be effective against HBV, HCV, [MEDICAL CONDITION].