STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245485	A. BUILDING _____ B. WING _____	04/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
JOHNSON MEMORIAL HOSP & HOME	1290 LOCUST STREET DAWSON, MN 56232

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 faciltiy failed to ensure staff implemented appropriate personal protective equipment when handling soiled linens for 1 of 1 observation during a COVID-19 Focused Infection Control Survey. This had the potential to affect all 55 residents residing at the facility. Findings include: Observation on 4/15/20 at 10:00 a.m., identified laundry aid (L)-A entered the River Road Wing through the double door entrance wearing gloves. L-A pushed the covered soiled linen cart to the soiled utility room and opened the door. Upon entry, L-A lifted the lid off the gray soiled linen container with her gloved hands and leaned over and into the container to retrieve the soiled linen. L-A's clothing on her torso, arms, and armpits contacted the walls and rim of the container She was not wearing a gown, and the linen was not bagged. L-A exited the soiled utility room and placed the soiled linen into collection cart in the hallway. Without removing her gloves and performing hand hygiene, had opened the door of the soiled utility room replaced the lid onto the soiled linen bin and left the room. Without removing the gloves and performing hand hygiene, she touched the handle of the linen collection cart and pushed it to next soiled utility room on the River Road wing soiled linen room to collect soiled linen. Interview on 4/15/20 at 10:10 a.m., with L-A identified she donned her gloves in the laundry room before coming to the floor to collect soiled linen. L-A collected linen from four soiled utility rooms located in the River Road and Prairie Lane units at the facility. L-A would wear the same contaminated gloves to collect all soiled linen from all the utility rooms in the facility. She agreed she had not worn a gown to collect the linen. L-A and her body and clothing was in contact with the container which held unbagged, soiled linen. L-A had to lean into the soiled linen container to reach the linen at the bottom. She used the same gloves to collect all soiled linen before returning to the laundry room. There were no gloves, gown, or hand sanitizer on the linen cart. L-A was unsure if there were gloves in the soiled utility rooms or if she was supposed to wear a gown when collecting soiled linen in the units. Laundry staff were expected to wear a gown while handling, sorting and washing soiled linen in the laundry room. Hand hygiene was performed before and after donning and doffing gloves. Gloves were to be removed and hand hygiene performed after handling soiled linen. After L-A had retrieved the soiled linens, she would launder those items, folding, hanging and redistributing the laundered linen throughout the facility. Interview on 4/15/20 at 12:00 p.m., with the infection control preventionist (ICP) identified laundry staff were expected to remove gloves and perform hand hygiene after handling soiled linen and before touching high-touch objects such as door handles to prevent cross contamination and transmission of infections. If there was potential for staff to contaminate clothing while handling soiled linen, staff were to don a gown to handling soiled linen. The 9/20/18, Infection Control-Linen 12.0 policy and procedure identified linen was to be handled in a way to prevent contamination with dirty linen. Once linen was removed from the resident room it was considered dirty. Linen was to be placed in placed in clear plastic bags and marked with the resident's name. Contaminated linen was not to come into contact with uniforms or the environment. Review of the November 2018, Hand Hygiene policy and procedure identified staff were to perform hand hygiene even when gloves were used. Staff were to wash hands after removing personal protective equipment (PPE), and after contact with contaminated objects and surfaces.

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