STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245435	A. BUILDING _____ B. WING _____	04/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KNUTE NELSON	420 12TH AVENUE EAST ALEXANDRIA, MN 56308

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, interview and document review, the facilty failed to implement a comprehensive infection control program to include recommended COVID-19 staff health screening procedures. This deficient practice had the potential to affect all 75 residents residing in the facility and all facility staff. Findings include: During observations on 4/3/2020, at 2:25 p.m. on the counter of the east nurses station, a clear plastic container was observed, which held homemade masks, thermometer, gloves, bottle of sanitizer and a binder labeled Employee Temp Log rested on top of the counter. The log included spaces for date, time, name, temperature and any respiratory symptoms. - at 2:30 p.m. nursing assistant (NA)-D was observed wearing a winter coat, with no mask on, and walked down the entire hallway of the Pines unit toward the nurses station. At the nurses station, NA-D removed her coat, obtained a clean mask from the clear plastic container on top of the counter and placed it on her face, covering her nose and mouth. NA-D and NA-E, who was seated at the nurses station, proceeded to walk down the hallway to entered room [ROOM NUMBER], and closed the door to assist a resident with cares. NA-D was not observed to have had her temperature taken, symptoms screening of illness or hand hygiene completed prior to assisting with resident cares. -a 2:33 p.m., NA-D exited room [ROOM NUMBER], walked to the nurses station, and stated do you want to take my temperature or do you want me to do it to licensed practical nurse (LPN)-A. NA-D replied you can, while NA-D filled out the information in the binder located on the counter, LPN-A took NA-D's temperature of 97.3, NA-D recorded her temperature in the binder and was instructed to wash her hands by LPN-A. - at approximately 2:34 p.m. NA-F walked up to the east nurse station from the Pines unit entrance area, with a mask on her face covering her nose and mouth area. NA-F was not observed to have her symptoms screening done, temperature taken or hand hygiene completed prior to assisting with resident cares. - at 2:35 p.m. NA-G entered the building at the east hallway entrance, walked down the Pines unit hallway, no mask on her face, stopped to talked to LPN-A and proceeded to walk down the entire length of the east hallway to the nurses station. At that time, NA-G indicated she had not had her temperature taken and had not been screened for symptoms of illness before she entered the Pines unit. - at 2:36 p.m. NA-G took her own temperature, filled out the log in the binder, cleaned the thermometer off with a alcohol wipe, cleaned her hands with sanitizer and proceeded to go out to the floor to assist residents with cares. -at 2:37 p.m. NA-F was up at the nurses station filling out the information in the employee temp log binder, when LPN-A walked up to her and proceeded to take her temperature of 97.8. NA-F proceeded to recorded the results of her temperature in the temp log binder. LPN-A did not ask NA-F regarding any possible symptoms. On 4/3/2020, at 1:46 p.m. LPN-A stated the facility nurses were to screen each employee at the beginning of each shift, which included taking the employee's temperature and asking about any respiratory symptoms. LPN-A stated the usual practice for staff symptom screening at the beginning of each shift was for the individual staff to complete the log prior to working on the floor, wash their hands, put on a mask, have their temperature taken by the nurse, and be asked if they had any respiratory symptoms. On 4/3/2020, at 2:13 p.m. NA-E indicated she felt she could either screen herself for symptoms or have the nurse complete the symptom screening and temperature check that was needed prior to the beginning of each shift. On 4/3/2020, at 2:56 p.m. NA-F confirmed she did not have her symptom screening done prior to starting her shift, and indicated either the nurse would take her temperature and record it in the binder at the nurses station or she would. NA-F indicated she would usually come to work through the locked unit because that was where she parked and indicated staff could enter through any door of the building. NA-F indicated she forgot to get screened because a co-worker had asked for help with a resident. On 4/3/2020, at 3:05 p.m. NA-G confirmed she did not have symptoms screening done prior to helping residents on the floor and came in the building through the east door of the facility. NA-G indicated when staff arrive to work, they entered the facility through any door of the building, and then reported to any of the 4 nurses stations in the building. NA-G indicated at the start of each shift, staff were to sign the binder at the nurses station with their name, the day/time, any respiratory symptoms they had, take their temperature, and washed their hands before working with residents. On 4/3/2020, at 3:13 p.m. NA-D confirmed she did not have a symptom screening done prior to helping residents on the floor. NA-D indicated when she arrived to work she wore a mask, washed her hands, had her temperature taken and was asked about respiratory symptoms. NA-D stated she had recorded the information in the book at the nurses station when she signed in for her shift. NA-D indicated sometimes she would take her own temperature and tell the nurse. NA-D indicated another co-worker from the day shift needed help with a resident and she was no screened for symptoms prior to providing resident care. NA-D indicated staff could enter through any door they wanted when they came to work. On 4/3/2020, at 2:29 p.m. registered nurse (RN)-A, with a coat on, entered the entrance of the Maples unit, no facemask on, walked down the hallway to the nurses station, and entered the medication (med) room. RN-A returned to the nurses station with a facemask on, opened up the binder located there, checked her temperature and signed the binder. -at 2:30 p.m. nursing assistant (NA)-A, NA-B, and NA-C all entered the entrance of the Maples one shortly after each other, with their coats on, without facemask's on, walked down the hallway and entered the med room. Each one returned to the nurses station with a facemask on and RN-A checked their temperatures and asked if they had any symptoms of respiratory illness. On 4/3/2020, at 1:10 p.m. housekeeper (H)-A stated she had recently received instruction to check her temperature at the nurses station and to answer the set of questions related to the presence of a cough, shortness of breath, or a fever located in the binder each time she arrived at work. H-A stated she checked her own temperature when she arrived, answered the set of questions and then started working. H-A stated she completed this task independently and confirmed no staff were present to oversee the screening process. H-A stated she always entered the facility via the Pines unit, walked down the hallway to the nurses station and confirmed there was not a screening station set up at the entrance of the building. On 4/3/2020, at 2:35 p.m. RN-A stated she always entered the building through the entrance to the Maples unit and walked down the hallway past the nurses station to the med room to apply her facemask, checked her temperature and signed the binder indicating she had no symptoms of respiratory illness. RN-A confirmed there was not a screening station set up at the entrance of the building and indicated staff had the ability to enter each entrance of the building. On 4/3/2020, at 2:56 p.m. NA-A stated she always entered the building through the Maples unit entrance and proceeded to the nurses station to be screened by a nurse. NA-A confirmed there was not a screening station present at the entrance. NA-A stated there were several entrances for staff to enter the building when they arrived to work. On 4/30/2020, at 2:58 p.m. NA-B stated she entered the Maple unit entrance and had RN-A screen her for signs of respiratory illness. NA-B confirmed there was not a screening station present at the entrance. On 4/30/2020, at 3:04 p.m. NA-C stated she entered the Maples unit entrance and had RN-A screen her for signs of respiratory illness. NA-C confirmed the facility had not set up a screening station at the entrance. On 4/30/2020, at 3:04 p.m. infection preventionist (IP) stated staff could enter through any entrance of the building and were screened at one of the nurses station by a nurse. IP stated it was expected staff were evaluated for presence of fever, cough or shortness of breath. IP stated if there was not a nurse present at the nurses station, staff had the option of walking down to the short stay unit where her office was located and she would screen them at that

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245435	A. BUILDING _____ B. WING _____	**04/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KNUTE NELSON	**420 12TH AVENUE EAST ALEXANDRIA, MN 56308**

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	(continued... from page 1) location. IP confirmed the facility had not been screening employees at the entrance of the building and confirmed screening occurred at each of the nurses station in the facility. On 4/30/2020, at 3:31 p.m. the director of nursing (DON) stated it was expected staff were screened by a nurse for the presence of fever and respiratory symptoms prior to beginning their shift and prior to providing resident cares. The DON stated staff were not trained to screen themselves, and confirmed the facility lacked screening procedures at any of the entrances into the building. Review of the facility titled COVID-19 Action Plan, and dated 3/25/2020, revealed the facility would screen all staff at the entrance of the facility for symptoms of respiratory illness (shortness of breath, cough or fever) and screen temperature before the start of any shift.