STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245353	A. BUILDING _____ B. WING _____	05/21/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CAMILIA ROSE CARE CENTER LLC	11800 XEON BOULEVARD COON RAPIDS, MN 55448

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** - Some	**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 ensure employees were actively screened for signs or symptoms of infection prior to patient care on 1 of 1 dedicated units (3rd Floor) identified to have both COVID-19 positive and negative residents; and ensure personal protective equipment (PPE) was worn and implemented in a manner to reduce the risk of cross contamination and subsequent infectious spread. These findings had potential to affect 5 of 5 residents (R4, R5, R6, R7, R8) identified to be negative for COVID-19 and reside on the unit. Findings include: An untitled, undated listing was provided which outlined a section labeled, Negative COVID (3rd). This identified a total of five residents (R4, R5, R6, R7, R8) who resided on the 3rd Floor and whom were recorded as never having tested positive for COVID-19. Further, a Resident Bed List Report, dated 5/21/20, was provided which identified a total of 19 residents who were or had tested positive for COVID-19 and remained on the 3rd Floor. LACK OF ACTIVE SCREENING: An undated Centers for Disease Control (CDC) Key Strategies to Prepare for COVID-19 in Long-Term Care Facilities feature identified several steps which should be taken. This included, Actively screen anyone entering the building . for fever and symptoms of COVID-19 before starting each shift; send ill personnel home. On 5/21/20, at approximately 10:35 a.m. the 3rd Floor stairwell was observed immediately outside the unit. A large folding table was set up along with various PPE, thermometers and several binder(s) which contained various papers inside. There was signage displayed on the 3rd Floor entrance from the stairwell which directed only staff were to enter. On 5/21/20, at 11:06 a.m. housekeeper (HSK)-A was observed in the hallway of the 3rd Floor unit. HSK-A was dressed in PPE and going in and out of several resident rooms. HSK-A was interviewed at this time and explained the process for when they report to work. The staff use a dedicated entrance which enters from the outside of the building immediately into the stairwell where the staff report to the 3rd Floor. There were no other floor(s) or staff outside of the dedicated 3rd Floor staff allowed to use the stairwell since they had identified COVID-19 positive residents. HSK-A expressed the staff then check their own temperature using a thermometer and enter the unit to get dressed with PPE. HSK-A voiced there is nobody actively screening the staff for symptoms of COVID-19, however, added there used to be someone doing such activities when all the staff were using the main entrance before they had identified COVID positive residents in the building. HSK-A stated they had been doing a self-screening for a couple months now. Further, HSK-A stated she had no symptoms of COVID-19 and had recently tested negative for the infection. On 5/21/20, at 10:45 a.m. nursing assistant (NA)-A was observed coming out of a resident room on the 3rd Floor dressed in PPE which included a gown, face mask and eye shield. NA-A was interviewed and explained the process for when they report to work which included using the dedicated stairwell entrance and reporting to the 3rd Floor station outside the unit. NA-A stated the staff then check their own temperature and sometimes a nurse will be there to ask questions of them including if they developed symptoms of COVID-19 since their last shift. This had been the process for reporting to work since the COVID started here. On 5/21/20, at 11:01 a.m. NA-B was observed leaving a resident room on the 3rd Floor dressed in PPE. At 12:09 p.m. NA-B was interviewed and explained the staff working on the 3rd Floor use a separate entrance which enters the building through the stairwell. They then report up to a station outside the 3rd Floor where they take their own temperatures and record them on a sheet which is kept right outside the door of the unit. NA-B explained they thought someone then checks the sheet later in the day and keeps track of temperatures, but she was not sure. Further, NA-B voiced if she felt ill or found herself to have a temperature she would report it to the nurse before caring for patients. When interviewed on 5/21/20, at 12:28 p.m. registered nurse (RN)-A stated the staff report to the station outside the 3rd Floor in the stairwell and check in which includes checking their own temperature and then writing it down on a notebook. RN-A verified nobody's there to oversee this process which had been the procedure since the facility had it's first COVID-19 positive resident on 4/19/20. On 5/21/20, at 1:00 p.m. the facility' infection control nurse (RN)-B was interviewed. RN-B explained the 3rd Floor staff were able to report through the main entrance or report directly to the station outside the unit through the dedicated stairwell entrance. The staff then are to take their own temperature and record it on the back of a questionnaire which asks several questions about COVID screening. The staff do not complete a new form each time and when they record their temperature they are attesting they are symptom free and have not been directly exposed to someone with COVID-19. RN-B explained this process should be happening everytime they come through the building. RN-B provided and reviewed the questionnaire / temperature log(s) with the surveyor as follows: HSK-A had no recorded questionnaires and/or temperature logs present; NA-A had a single form present labeled, COVID-19 Screening Form, which was signed by a nurse as being completed on 5/21/20; NA-B had no recorded questionnaires and/or temperature logs present; and, RN-A had an undated screening form present which had a temperature record flowsheet outlined on the back. This identified a total of 19 days RN-A had worked along with her recorded temperature(s), however, a total of 15 of the recorded days had only her initials present under the column labeled, Nurse. There were no other documents or evidence provided demonstrating these employees had been actively screened in accordance with CDC guidance to help prevent the spread of COVID-19. RN-B verified the above findings and stated the staff without any completed questionnaires and temperature logs weren't following procedure. RN-B expressed he felt nurses and NA staff could take their own temperature as it was standard practice, however, acknowledged he had not done any competency training on them or the other staff to ensure they were doing it correctly and consistently. This was important to do as they shouldn't be working if they have any symptoms which could be related to COVID. Further, RN-B voiced he had not been included on the weekly calls offered by the State agency (SA) for COVID; rather was getting needed information from those calls through the administrator. RN-B stated he was unaware the screening process for staff should be actively completed. A provided COVID-19 Screening Policy and Procedure, dated 5/11/20, identified the policy applied to employees, visitors and volunteers of the facility. A section labeled, COVID - 19 Screening Process, directed anyone entering the facility would be screened for symptoms and known or suspected COVID-19 exposure. The policy outlined, Screening will be documented and completed once a day upon arrival . (and) . Screening should be done near the initial entrance. Further, the policy outlined screening indicators would be documented and immediately reviewed with an agency nurse as staff . should not determine on their own if a symptom is relevant or not. However, the policy lacked dictation or guidance on how to ensure active screening was completed. PPE USE: On 5/21/20, at 11:06 a.m. housekeeper (HSK)-A was observed in the hallway of the 3rd Floor unit going in and out of several resident rooms (Rm. 311, 312, 314) with various cleaning supplies. HSK-A was dressed in PPE which consisted of a source control face mask, clear eye wear, a green-colored cloth gown and shoe coverings. HSK-A was interviewed and explained she had just completed cleaning three different resident rooms along with a shared bathroom using a bleach and water solution. HSK-A expressed she was unsure if the residents inside the rooms were COVID-19 positive adding, I don't know that. HSK-A explained they report for their assigned shift(s) and don (apply or put on) their PPE which then remains on for the entirety of their shift. HSK-A verified they go room to room to room wearing the same PPE (despite COVID-19 status) except they change their gloves between each place. This had been what they were instructed to do when the first COVID-19 case was identified approximately a month prior. Further, HSK-A stated she had no active symptoms of COVID-19. On 5/21/20, at 10:45 a.m. nursing assistant (NA)-A was observed to enter a double resident

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
	245353	A. BUILDING _____ B. WING _____	05/21/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CAMILIA ROSE CARE CENTER LLC	11800 XEON BOULEVARD COON RAPIDS, MN 55448

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** - Some	(continued... from page 1) room (one resident identified as COVID positive 4/21/20; the other identified as COVID negative) while wearing visible PPE which included a green-colored gown, face mask and eye shield. NA-A closed the door to provide care and moments later, NA-A opened the doorway and assisted a resident (identified as COVID negative) to walk out of the room and down to the dining room. NA-A then proceeded to the serving window in the dining room, ordered a plate of food for the resident and then sat down with her at a table and assisted her to eat. When interviewed on 5/21/20, at 12:18 p.m. NA-A explained the staff report to the floor for work and change into their PPE which included the dark green gowns, face mask and eye shield. NA-A verified he had not changed his PPE, except gloves, since the beginning of his shift earlier that morning and expressed this was the process all 3rd Floor staff were following since the COVID started here approximately a month prior. Further, NA-A verified they used the same PPE, and did not change it before helping COVID positive and negative patients adding he was not aware of any PPE shortage in the facility. On 5/21/20, at 11:01 a.m. NA-B was observed in a double resident room (one resident identified as COVID-19 positive 4/21/20; the other identified as COVID-19 negative) changing bed linens. NA-B was dressed in visible PPE which included a dark green-colored gown, face mask and eye shield. NA-B left the resident' room and proceeded to walk down the hallway when she stopped to help R3 (COVID-19 positive) reposition her sweater while wearing the same PPE she just changed linens in while in another COVID-19 positive resident room. NA-B then proceeded to enter a non-resident room which was closed with white signage present which read, PLEASE KEEP DOOR CLOSED AT ALL TIMES. At 11:23 a.m. NA-B was observed in the dining room wearing the same PPE as she had been observed in just prior. NA-B was seated immediately next to R2 (identified as COVID-19 positive on 4/21/20) and assisting her with cues and prompts to eat her served lunch meal. When interviewed on 5/21/20, at 12:09 p.m. NA-B stated she was responsible to help both COVID-19 positive and negative residents on the 3rd Floor. The staff used a list to help know whose positive and negative, however, it changed hourly sometimes. NA-B explained the staff report to the floor for their shift and put on PPE which included the dark-green gowns, face shields and masks. The PPE was then kept on all day until the end of their shift when they removed everything and it was laundered. NA-B stated the only time they change their PPE was if it became visibly soiled with stool or other bodily fluid and verified they do not change the PPE in-between COVID-19 positive and negative residents. NA-B acknowledged she had been in a resident's room changing bed linens just a little while ago (when observed at 11:01 a.m.) and stated the resident whose linens were being changed was COVID-19 negative, however, she remained in the PPE used on COVID-19 positive residents. NA-B reiterated they remain in the same PPE all day after their shift starts and just changed gloves on a room-to-room basis. This had been the process the floor staff had been doing for maybe two months to her knowledge. On 5/21/20, at 12:28 p.m. registered nurse (RN)-A was interviewed. RN-A explained the staff were instructed to apply their PPE at the start of their shift and leave it on until the end of the shift unless it became visibly soiled or after two or three times wearing the same items. RN-A verified the same staff whom were dressed in PPE were helping both COVID-19 negative and positive residents without changing their PPE and expressed that was a concern adding, I completely agree with what you're (surveyor) saying. RN-A stated the staff should likely be changing their PPE before helping COVID-19 negative person(s) as not doing so presented a risk of passing it on. On 5/21/20, at 1:00 p.m. the facility' infection control nurse (RN)-B was interviewed. The staff on 3rd Floor had recently started using the green colored re-washable gowns as prior they were just using rain gear and they felt this was a better option. RN-B verified there were no COVID-19 positive patients outside of the 3rd Floor and stated most of the 3rd Floor resident had tested positive for [MEDICAL CONDITION], however, there were approximately seven or so whom had never tested positive. RN-B expressed they would not have enough PPE supplies for staff to change each time they went from a positive COVID-19 resident to a negative resident and added, This one is definitely a challenge. RN-B reiterated they had implemented dedicated staffing to help reduce the number of people being exposed to positive and negative COVID-19 residents, however, there was just not enough PPE, particularly gowns, to keep changing them out. RN-B explained the facility had taken several steps to secure more gowns, however, their provider was on back order so they were left with the current supply. Further, RN-B acknowledged it was not OK to keep the same PPE on while going from COVID-19 positive to negative patients, however, they felt they had no choice given the PPE shortage. On 5/21/20, at 2:40 p.m. the administrator, director of nursing (DON), assistant administrator and RN-B were interviewed. They explained the facility had been conducting ongoing, frequent testing of the 3rd Floor residents to determine COVID-19 positive and negative residents. The staff were instructed to apply their PPE and leave it on until the end of their shift as the lack of supplies limited their ability to change it in-between residents. There had been steps taken to order more PPE and they had reached out to the State Emergency Operations Center (SEOC) and local health coalition for more, however, there were just no gowns to be had. Further, they acknowledged the risk of not changing PPE, including spreading [MEDICAL CONDITION] to others, and voiced they would look at different strategies to resolve the concern. A facility' transmission based precautions and/or PPE policy was requested, however, none was provided.