STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245578	A. BUILDING _____ B. WING _____	07/28/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BETHANY RESIDENCE AND REHABILITATION CENTER	2309 HAYES STREET NORTHEAST MINNEAPOLIS, MN 55418

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 facility failed to follow Centers for Medicare and Medicaid Services (CMS) and Centers for Disease Control (CDC) guidelines to appropriately implement preventive measures to prevent the spread of COVID-19. The facility also failed to monitor for signs and symptoms of COVID-19 for 3 of 6 residents (R1, R2, R3) reviewed for monitoring practices. Additionally, the facility failed to establish facility wide infection prevention and control policies (IPCP) including standards, policies and procedures that were current and based on national standards for undiagnosed respiratory illness and COVID-19. This had the potential to affect all 36 residents who resided at the facility. Findings include: CLOTH FACE COVERINGS Current Minnesota Department of Health (MDH) guidance Contingency Standards of Care for COVID-19: Personal Protective Equipment (PPE) for Congregate Care Settings dated 6/15/20, directs HCP (health care providers) with face to face contact with COVID negative residents; HCP are to wear surgical mask, eye protection and to perform hand hygiene. On 7/28/20, at 10:40 a.m. activities director (AD)-A was observed in a resident room. AD-A had a cloth face covering on and stood one foot away from the resident while they had a conversation. The resident did not have a mask on. During interview on 7/28/20, at 10:55 a.m. AD-A stated they had visited with the resident and assisted with Skype. AD-A stated while at work they need to have goggles and a mask on. AD-A stated it was acceptable to use the cloth face covering and had used one since the facility implemented the mask requirement several months ago. AD-A stated they had a cloth mask for work use and a separate one for community use. AD-A was not aware of any PPE shortages. On 7/28/20, at 12:55 p.m. nursing assistant (NA)-A was observed to sit next to a resident in the dining room and assist with the meal. NA-A had on a cloth face covering. The resident did not have a face mask on. During an observation and interview on 7/28/20, at 12:58 p.m. NA-A left the dining room and walked down the hallway to answer a call light. NA-A entered a resident room and exited. NA-A confirmed they had worked the day shift that day and provided resident care. NA-A had been instructed to use a cloth face covering and took it home and washed it every day. NA-A stated if they needed a surgical mask they could get one at the front desk. NA-A stated the director of nursing (DON) had provided education on PPE but could not recall when the last education was. On 7/28/20, at 1:02 p.m. nursing assistant (NA)-B and nursing assistant (NA)-C were observed to enter a resident's room with a mechanical lift device. NA-B had a cloth face covering on. NA-C had a surgical mask on. NA-B and NA-C assisted the resident into bed using the lift, assisted the resident with peri-care and repositioning then exited the room. During interview on 7/28/20, at 1:23 p.m. NA-B stated the facility provided the cloth face covering they had on. NA-B had not been notified if they needed to switch to the surgical masks. NA-B stated sometimes the charge nurse provided education on PPE but couldn't remember when the last education had been. During interview on 7/28/20, at 3:45 p.m. facility administrator was observed to have a cloth face covering on. Administrator stated staff were required to wear a cloth face mask and goggles or face shield while at work. Administrator was not aware the CDC guidelines had changed from crisis to contingency standards. Administrator stated they had adequate supply of PPE so all staff could wear a surgical mask. Facility memo dated 5/25/20, titled Staff PPE Utilization indicated staff shall at all times utilize the following: -Faceshield or approved goggles. These should be cleaned as needed throughout the day. -Masks, reusable and cloth masks. Staff will wear cloth masks at all times while in the facility. This MDH/CDC requirement is for source control and for the protection of the resident and other staff members. Cloth masks should be reused and washed between shifts. Masks should be worn at all times when others are present, including offices and other spaces while around co-workers. Facility policy titled Personal Protective Equipment- Using Face Masks, undated, directed staff to wear a mask when providing treatment or services to a patient and the use of a mask is indicated. The policy lacked instructions specific to COVID-19 precautions. DISINFECTING OF SHARED MEDICAL EQUIPMENT Current recommendations from the MDH Long Term Care (LTC) Toolkit dated 6/5/20, directs LTC facilities to disinfect surfaces with an Environmental Protection Agency (EPA)-registered disinfectant with a label indicating effectiveness against human coronavirus or emerging [MEDICAL CONDITION] pathogens. High-touch surfaces include but are not limited to: door handles, railings, light switches, remotes, phones, call buttons, medical equipment (lifts, thermometers, pulse oximeter), etc. During interview on 7/28/20, at 9:17 a.m. registered nurse (RN)-A who worked on first floor stated the facility practice was to check all resident's temperature every day. They had shared vital signs equipment which was disinfected between uses. RN-A showed surveyor the sanitizing wipes in a white container with red top by the nurses station. The container label indicated Sani-Wipe: no rinse sanitizing multi-purpose towel with an EPA registration number of 9480-13 and reorder number of P . The label further indicated this product is recommended for use in retail food establishments where the prevention of cross contamination between treated surfaces is its primary importance. During interview on 7/28/20, at 9:39 a.m. RN-B who worked on second floor stated the facility cleans all shared equipment such as vital signs equipment and transfer devices with the sanitizing wipes. RN-B picked up a white container with red top at the nurses station and indicated this was the one they used. This container had the same label as first floor: The container label indicated Sani-Wipe: no rinse sanitizing multi-purpose towel with an EPA registration number of 9480-13 and reorder number of P . During observation on 7/28/20, at 1:23 a.m. NA-C who worked on second floor was observed to exit a resident room and clean the resident transfer lift with wipes located at the nursing station from the container label indicated Sani-Wipe: no rinse sanitizing multi-purpose towel with an EPA registration number of 9480-13 and reorder number of P . NA-C stated these were the wipes they used to clean shared equipment between uses. During interview on 7/28/20, at 2:41 p.m. facility administrator provided a product print out. The document review indicated the wipes the facility used to clean shared medical equipment were sanitizing wipes, not a hospital grade disinfectant. The product website indicated it is effective for food borne pathogens and [MEDICAL CONDITION]. Administrator stated the wipes the facility used, Sani-Wipe: no rinse sanitizing multi-purpose towel with an EPA registration number of 9480-13 and reorder number of P were not listed on the Environmental Protection Agency (EPA)'s list of disinfectants for use against [DIAGNOSES REDACTED]-CoV-2. Administrator had not been aware the wipes were not appropriate. Administrator said they had struggled since March of this year to get enough disinfectant supplies. Administrator stated had not yet reached out to the community and/or regional resources such as MDH, local public health or health care coalition for assistance. COVID-19 MONITORING Current recommendations from the MDH Long Term Care (LTC) Toolkit dated 6/5/20, directed to actively screen all residents for fever and respiratory symptoms of illness at least daily. Twice daily is best practice. Actively monitor all residents for fever (>100.0 F or subjective) and symptoms of COVID-19 (shortness of breath, new or change in cough, sore throat, muscle aches). If positive for fever or symptoms, screen each shift and implement Transmission-Based Precautions. Chart all clinical measurements and symptoms for each resident. R1's face sheet indicated an admission date of [DATE], and primary [DIAGNOSES REDACTED]. One time a day for COVID-19 infection prevention and surveillance. Active daily monitoring by licensed nurse, document in Point Click Care (PCC facility electronic health record). R1's medication administration record (MAR), progress notes (PN), and vitals section (VSS) for 6/1/20, through 7/28/20, lacked documentation of daily temperatures. Documentation in R1's MAR, PN and VSS from 6/1/20, through 7/28/20, indicated 5 out of 58 days had documented temperatures. R2's face sheet indicated an admission date of [DATE], and primary [DIAGNOSES

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) REDACTED]. R2's MAR and PN lacked documentation of active screening for respiratory symptoms. Documentation in R2's MAR, PN and VSS from 7/2/20, through 7/28/20, indicated 19 out of 22 days had documented temperatures. R3's face sheet indicated an admission date of [DATE], and primary [DIAGNOSES REDACTED]. R2's orders section included an order for [REDACTED]. R2's orders section lacked an order to actively screen for fever and respiratory symptoms of illness at least daily. However, on 7/28/20, an order was entered. R3's MAR and PN lacked documentation of active screening for respiratory symptoms. R3's MAR, PN and VSS from 6/25/20, through 7/28/20, indicated 29 out of 34 days had documented temperatures. During interview 7/28/20, at 3:45 p.m. DON stated daily COVID symptom monitoring is expected for all residents and temperature is to be taken daily and documented in PCC. DON puts an order in PCC so it triggers for nursing staff to complete. DON stated would correct the order. Facility memo titled COVID-19 Surveillance and Testing dated 6/8/20, indicated if COVID-19 was identified in the building, staff were to monitor each resident for symptoms including fever, cough, shortness of breath or difficulty breathing once each shift and to track signs and symptoms. A policy for resident surveillance and monitoring was requested and not provided. INFECTION PREVENTION AND CONTROL POLICIES (IPCP) Infection Control Policy and Procedure Manual, provided by the director of nursing (DON), did not reflect current CMS, CDC, and MDH standards for addressing COVID. Some sections were dated from 2018, some from 2017, and some with no date. There were two table of contents from different corporate structures, two different Infection Preventionist policies, and the surveillance section was specific to Illinois for reportable diseases. On 7/28/20, at 11:13 a.m., DON stated he had not updated policies and procedures. He said, yes, I've been thinking for awhile that I should maybe I should revise them. He agreed that some were out-of-date and did not reflect current COVID related infection prevention measures. Current standards from the Minnesota Department of Health's Contingency Standards of Care for COVID-19: Personal Protective Equipment for Congregate Care Settings, dated 6/15/20, directs long-term care (LTC) facilities to have all staff wear surgical masks when having face-to-face contact with residents. As well as staff with face to face contact with residents to wear eye protection at all times. The facility's Interim Guidance and Policy and Procedure for PPE's and Management of COVID 19 (undated) noted use of N95 masks or respirators with known or suspected COVID 19 residents. The policy also noted the use of cloth masks for staff. The facility's Key Response Guide to COVID19 Situation (undated) noted staff should wear a gown and face/eye shield if a resident was coughing or potential splash precaution was needed. It further stated if COVID 19 was in facility, staff would use N95 respirator. Resident would not need airborne isolation but placed in a private room. There were no facility policies that identify any droplet or contact precautions. SURVEILLANCE AND PREVALENCE MONITORING On 7/28/20, at 11:10 a.m., administrator produced line listing of test results. Data in the line listing included name, date of testing, and testing results for all residents and staff who have been tested . There was no prevalence or surveillance data nor was the data aggregated or analyzed. The data had not been presented to Quality Assurance Performance Improvement (QAPI) group. The last QAPI met in February and was scheduled to meet in November. The administrator stated normally, they meet quarterly but have not met because of COVID. He has had not met with the Medical Director but did send him e-mails. The administrator did not have house-wide surveillance of other organisms/infections within the facility. Facility document titled, Standards and Guidelines: Facility Testing Plan for COVID-19, revised 7/6/2020, noted that during an outbreak there would be weekly QAPI meetings with Medical Director and a root cause analysis of any new cases. When there is not an outbreak, there would be monthly QAPI meetings to review COVID 19 strategies.