STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245467	A. BUILDING _____ B. WING _____	05/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HENDRICKS COMMUNITY HOSPITAL	503 E LINCOLN STREET HENDRICKS, MN 56136

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 facility failed to ensure staff discarded personal protective equipment (PPE) prior to exiting a resident's room, and disinfect lift slings between multiple resident (R1, R2, R3, R4, and R5, R6, and R7), or perfom ongoing surveillance in accordance with Centers for Disease Control (CDC) and Centers for Medicare and Medicaid Services (CMS) guidelines for COVID-19. This had the potential to affect all 41 residents in the facility. Findings include: PPE Observation and interview on 5/12/20 at 8:54 a.m, outside of R1 and R5's isolation rooms identified an overbed table with SaniCloth, hand sanitizer wipes, gowns clipboard, thermometer and hand sanitizer. Three garbage cans contain were lined with red bags. Each bin was labeled isolation gowns, paper garbage, and linens and bagged personal items. NA-A stood in doorway of R5's room, and doffed gown and reaching out of room to place in the gown bin and place her gloves in the garbage. She identified that they were to stand within the threshold of the room and reach out to throw stuff in the appropriate bins. Observation on 5/12/20 at 9:41 a.m., identified NA-A exited isolation room R5 with a clear garbage bag with linens in her hand. She reached past the clean isolation supplies to the bin and threw the bag into the bin marked for linens. She remained standing outside of the room and doffed her gloves and gown, and sanitized her face shield. Observation on 5/12/20 at 10:45 a.m., of the PPE station outside R5's room identified a PPE door caddy was hung the outside of the entrance door. Two bedside tables were placed on the wall of R5's room entrance. The right table had a stack of black gowns stacked near the wall. Two white bins labeled trash and gowns were placed in front of the right table. The left table on the wall of the room entrance had alcohol-based hand sanitizer, a spray bottle, and a tub of Super Sani Wipes, and a roll of paper towels placed on it. A large grey bin labeled soiled linen sat front of the the left table. NA-D opened R5's room door and without removing her gown and gloves, exited the room. NA stood outside R5's door between the tables and bins untied the neck tie of the gown and waist, removed the gown, inverted the sleeves and removed the gloves, and discarded them in the appropriate bins. Without performing hand hygiene, NA-D sanitized the face shield with the Super-Sani Wipes. Without waiting the 2 minute dry-time, NA-D wiped the face shield with the paper towel and performed hand hygiene. NA-A exited R5's room and doffed PPE in the hallway. Interview on 5/12/20 at 10:50 a.m., NA-D identified she was instructed to remove the gown and gloves within the exit of R5's room. Face shields were to be wiped down with sanitizer wipes after exiting quarantined rooms. The shield was supposed to remain wet for 2 minutes before wiping the film off the face shield. Observation on 5/12/20 at 11:08 a.m., NA-A exited R1's room and doffed PPE in the hallway. Review of the Sani-wipes wipes manufacture's directions identified staff were to to remove all visible debris from surfaces to be disinfected The user was to use a clean germacidal wipe to wet the surfaces, ensure the surfaces remain wet for two minutes, then allow to air dry. SURVEILLANCE Review of the facility's January 2020, February 2020, March, 2020, and April 2020, Infection Control Monitoring report identified the reports include the following information: residents with infections, onset date of infections, the type of infection, the organism treated, and antibiotics prescribed. Infections were mapped out to identify where infections were located. The reports lacked information of when infections resolved, analysis of infections and actions taken to prevent further infection. Additionally, staff infections were not included in the infection reports. Interview on 5/12/20 at 12:200 p.m., with the infection preventionist (IP), registered nurse (RN)-A identified COVID-19 resident data was reviewed on a daily basis. All other infection data was reviewed on a monthly basis to identify trends and potential outbreaks in the facilty. Staff illnesses were tracked by the IP and and the human resources department, but were not compared with resident data to identify whether infections were transmitted between staff and residents. RN-A agreed staff illness should be reviewed and compared with resident illness data to identify potential transmission. Infections could be analyzed to identify potential causes of infection, to implement actions to prevent continued transmission, and reduce further instances of some infections and to identify breaks in infection control practices. Interview on 5/12/20, at 12:37 p.m., with the director of nursing (DON) identified facility infections were not actively logged on a daily basis, but symptoms of infection, but were reviewed within 72 hours by the IP, and herself. The facilty had few infections, but the DON agreed infection surveillance was to be ongoing, and should include review of staff illnesses and analysis of potential causes of infections to identify if additional infection control measures were needed. Interview on 5/12/20, at 1:18 p.m., with the administrator identified the facilty's infection data was incomplete and lacked evidence surveillance was ongoing. He agreed the IP records should include analysis of infections to identify potential causes or sources of infections and implement actions to improve infection control practices to prevent further infections in the facility. Review of the January 2020, Infection Prevention and Control Program policy identified it's purpose was to (1) maintain surveillance of the healthcare infection potentials, (2) identify and analyze incidents and caution of healthcare-associated infections, (3) develop and implement a preventative and/or corrective program to minimize infection hazards, (4) and supervise the program, and (5) act upon recommendations of the chief of staff, medical staff, facility departments and other hospital committees. The The infection control program established a committee. The committee was responsible to ensure a permanent record for all activities related to infection control were submitted to the medical staff and hospital governing board for review. The infection preventionist was responsible for supervising and implementing the infection control program, collecting and analyzing data, reporting infection control actions, and teaching and reinforcing infection control policies an procedures. The IP was to coordinate the employee heath program and the infection control program to assure adequate surveillance of infections in personal and maintenance of an effective infection control and prevention program. MULTI-USE EQUIPMENT Observation on 5/12/20 at 9:18 a.m., identified mechanical lift slings were draped over the lift. NA-B and NA-C entered R3's room with a lift and NA-C exited room at 9:20 a.m. with the lift and the lift sheet again draped over the lift. She used Sani-Cloth wipes to wipe down the surfaces of the lift. However, she did not clean the lift sheet in any way and it remained draped over the machine. Observation on 5/12/20 at 9:30 a.m., identified NA-A exited R2's room with the lift. The lift sheet was draped over the lift. NA-A used a Sani-Cloth to wipe down the lift but failed discard the lift sheet to be laundered. Interview on 5/12/20 at 9:43 a.m., with NA-A identified R2 and R3 had used the same transfer sling. Slings for the lifts were shared among the residents. The slings were not sanitized between resident uses and were cleaned once per week or when visibly soiled. Interview on 5/12/20 at 10:14 a.m., with LPN-A identified lift slings were shared between residents. They slings were to be cleaned once a week and if visibly soiled. No cleaning or disinfecting of the sheets was performed between residents. Interview on 5/12/20 at 10:34 a.m., with NA-C identified lift sheets were shared between residents. She had used the lift to transfer R3. The lift sheets were not cleaned between residents and were sent to laundry only if visibly soiled. She was unaware of any scheduled cleaning. Interview on 5/12/20 at 12:15 p.m., with RN-A, the infection preventionist identified lift sheets should not be shared between residents, however, the facility did not have enough slings for each resident to use. Interview on 5/12/20 at 12:40 p.m., with DON identified lift slings were shared between residents. The facility had no formal policy for cleaning slings. Mesh lift slings were laundered weekly as

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) they were a cloth mesh. Slings were to be cleaned between resident use. The DON agreed to appropriately clean and disinfect cloth slings, they must be laundered. No policy or procedure was in place regarding use of shared lift slings. Interview on 5/12/20 at 1:15 p.m., with the administrator identified he was unaware lift slings were not being cleaned between residents. His expectation was that staff would follow CDC recommendations.