STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245460	A. BUILDING _____ B. WING _____	**06/18/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
JONES HARRISON RESIDENCE	**3700 CEDAR LAKE AVENUE MINNEAPOLIS, MN 55416**

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 implement proper screening of staff members to prevent the spread of COVID 19. This had the potential to affect all 100 residents in the facility. Further, the facility failed to properly disinfect shared equipment between resident use on the 300 unit. This had the potential to affect 13 out of 100 residents in the facility. Findings include: On 6/18/20, at 9:20 a.m., Staff member (S)-A was interviewed and stated all visitors were screened upon entry. S-A further stated staff members enter through the front entrance, proceed down the elevator and were screened prior to punching in at the time clock located on the lower level. At 9:23 a.m., an unidentified person, later identified as S-B, entered the facility, was not screened, entered the coffee shop, ordered coffee, then proceeded to enter the elevator to go downstairs. S-A confirmed the person was an employee of the facility. At 9:30 a.m. S-B was interviewed and stated upon entrance to the facility, she will go down to the staffing office to get her temperature taken before she punched in at the time clock. S-B further stated she was not asked questions or screened for COVID 19 symptoms or recent exposure risks. At 9:35 a.m. the director of nursing (DON) was interviewed and stated staff that enter the facility at times other than shift change are screened at the staffing office on the lower level and have a temperature and symptom check. The DON further stated staff screening results were not recorded and records were not kept for review. At 9:38 a.m., staff member C, Staffing Coordinator, was interviewed and stated at the time of the screening process she will take the staff member's temperature and will let them know if it is ok to punch in. Staff member C further stated no other screening was performed and no further screening questions are asked. At 10:46 a.m. Registered Nurse (RN)-A, Infection Control Nurse was interviewed and stated the great majority of staff are screened at a station by the time clock at shift change. RN-A further stated it would be expected that the Staffing Coordinator, would screen staff, take their temperature and screen for COVID 19 symptoms. The facility policy titled COVID 19 dated 3/18/20, indicated prior to entry all staff will be required to complete screening processes (i.e., screening questions, and assessment of illness). On 6/18/20, at 10:02 a.m., Licensed Practical Nurse (LPN)-A was observed to exit a resident room on the 300 unit with a cart that had equipment to monitor vital signs. LPN-A performed hand hygiene, donned gloves, wiped uniform protector and face shield with disinfectant cleaner, doffed gloves. LPN-A then donned clean gloves, entered a room with the cart, assessed resident's temperature and oxygen saturation, and documented on a clipboard on the cart. LPN-A was then observed to doff gloves, exit room, don gloves, wipe down gown and face shield with disinfectant cleaner, doff gloves and perform hand hygiene. LPN-A then donned clean gloves and wheeled cart into another room and proceeded to assess the resident's vital signs. At 10:18 a.m., LPN-A was interviewed and stated she cleaned the cart and vital sign equipment when she was done with the assessments for all residents. LPN-A further verified she used the thermometer and oximeter on each resident and stated all staff wipe the vitals cart at the end of their shift. At 10:50 a.m., RN-A was interviewed and stated all staff had training on infection prevention. RN-A further stated it would be her expectation that shared vital sign monitoring equipment would be cleaned between residents.

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