STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245452	A. BUILDING _____ B. WING _____	05/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
EPISCOPAL CHURCH HOME OF MINNESOTA	1879 FERONIA AVENUE SAINT PAUL, MN 55104

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 follow proper precautions regarding personal protective equipment (PPE) while assisting a resident to eat, according to current COVID-19 guidelines for 1 of 1 residents (R10). The facility also failed to ensure proper infection control procedures were followed for hand hygiene and glove use during housekeeping and meal tray collection duties in order to prevent and or decrease the risk of transmission and spread of infectious diseases including COVID-19 by staff for 6 of 18 residents (R7, R8, R9, R11, R12, R13). Findings include: R10's quarterly Minimum Data Set ((MDS) dated [DATE], included, severe cognitive impairment with [DIAGNOSES REDACTED]. R10's MDS indicated R10 required extensive assistance with activities of daily living (ADL's) and required set up help only with eating. During an observation on 5/12/20, at 12:30 p.m., nursing assistant (NA)-C was observed seated at a dining room table next to R10. There was a plate of food in front of R10. There was a different plate of food in front of NA-C. NA-C's surgical mask was pulled down below her chin and NA-C's eye goggles were on top of her head. NA-C was observed to be assisting R10 in eating with her left hand, while NA-C was using eating herself with her right hand from the toher plate of food During an interview on 5/12/20, at 12:38 p.m., licensed practical nurse (LPN)-A stated, staff eat and assist residents at the same time all the time. During an interview on 5/12/20, at 2:29 p.m., the director of nursing (DON) indicated a staff member was observed a week or so ago eating themselves while at the same time assisting a resident. The DON educated the staff member, and stated, on the spot to not feed herself and a resident during COVID-19 due to the risk of transmission or spread of infectious diseases including COVID-19. The DON indicated staff development was completing more education on this topic as she went around the facility performing other education. The DON was unable to provide education materials or sign in sheets to indicate staff received the education. During an observation on 5/12/20, at 1:11 p.m., housekeeper (H)-A placed the housekeeping cart in front of R13's room and entered R13's room without first performing hand hygiene. H-A donned gloves, grabbed a toilet brush and cleaned the toilet. H-A came out of R13 room to the cart where H-A removed the gloves and disposed of them on the cart. During observation on 5/12/20, at 1:16 p.m., H-A first, without performing hand hygiene, opened the cart, grabbed cleaning solution, donned gloves, and went into R12's room and cleaned the bathroom. H-A came out of R12's room to the cart where H-A removed gloves and disposed of them in the cart trash. During an observation on 5/12/20, at 1:20 p.m., H-A first, without performing hand hygiene, went into R11 room, donned gloves, and cleaned the bathroom. When interviewed on 5/12/20, at 1:23 p.m., H-A verified she did not wash her hands or utilize hand sanitizer prior to entering R11, R12, and R13's rooms. H-A verified education provided to H-A indicated hand hygiene should be performed prior to donning gloves, after the removal of gloves, and in between resident rooms. R7 was admitted from the hospital on [DATE], for complications related to hip prosthesis. R8 was admitted from the hospital on [DATE], related to cartilage calcification of the knee. R9 was admitted from the hospital on [DATE], for aftercare following joint replacement surgery. On 5/12/20, at 12:55 p.m. NA-A pushed a cart through the hallway to collect room trays. NA-A knocked on R9's door, entered to pick up the room tray from lunch, and brought the tray back to the cart. NA-A continued to pick up room trays from R8's room, and then from R7's room, without performing hand hygiene between rooms. On 5/12/20, at 2:15 p.m. the DON stated staff should perform hand hygiene between each room that they enter, and added that was why there was hand sanitizer affixed to the walls at the door to each room. The DON stated staff had all been educated on the hand hygiene expectations, and the administrator explained that staff development was present throughout the building to perform hand hygiene audits, and trained staff as problems were found. The Foam In/Foam Out policy dated 3/10/20, required staff to use foaming cleanser upon entry to each room prior to contact with patient, and to use the foaming cleanser upon exiting the room after contact with the patient. The policy notes that hand sanitizers containing foaming cleanser were mounted to the wall outside each patient room. The Hand Hygiene policy reviewed 3/20 required staff to perform hand hygiene after touching blood, body fluids, secretions, excretions, and contaminated items, whether or not gloves are worn; immediately before and after gloves are removed; and when otherwise indicated to avoid transfer of microorganisms to other elders, personnel, equipment and /or the environment.

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