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 _____	04/15/2020

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 implement a comprehensive infection control program to include the Centers for Medicare and Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) COVID-19 Long-Term Care (LTC) Facility Guidance for all LTC facility personnel to cancel group activities. This had the potential to affect 12 residents (R4, R5, R7, R8, R9, R10, R11, R12, R13, R15, R16, and R17) who participated in a group activity. In addition, the facility failed to develop and implement a comprehensive infection control program with established protocols and monitoring to ensure tracking and trending of [MEDICAL CONDITION] and bacterial illnesses and infections in the facility for R1, R2 and R18 and this had the potential to affect all 40 residents who resided in the facility and staff and visitors. Findings include: On 4/13/20, at 12:32 p.m. three residents (R4, R5, R17) were observed in the first floor dining room. R4 and R5 were seated at opposite far ends of a rectangular table that was approximately 5 feet long and 2 1/2 feet wide. R17 sat on a chair between the two, away from the table approximately one foot. The approximate distance between R4 and R17 was 3.5 feet, and between R5 and R17 it was 4.5 feet. A white board in the dining room listed coffee at 2:00 p.m. and BINGO at 2:30 p.m. At 1:55 p.m. R4 and R5 R4 and R5 were seated at opposite far ends of a rectangular table that was approximately 5 feet long and 2 1/2 feet wide. R9 and R8 were seated at a table across from each other with three bingo cards in front of each of them. Activities director (AD) entered the dining room at 1:57 p.m. and wore a mask and gloves R10 entered the dining room and went to sit with R4 and R5, but AD stated the chair at that table was wet so AD redirected R10 to the next table over. At 2:10 p.m. R5 left the dining room and went to the nursing station and passed within 3 feet of R9. R8 stood up and walked over to the bingo table and handled items on it. R8 coughed and did not cover his mouth. R11 walked in the dining room, R15 arrived by wheelchair to the dining room and passed closely to R9. R12 entered and wanted to sit in the middle of the table near R9 but AD placed him at the end of the table and stated he needed be further away from R9. R16 arrived with a motorized wheelchair and situated himself at a table, R7 soon sat down at the same table. AD began to served snacks and beverages. AD spoke with R11 and put her left arm behind R11's back as if to pat R11 on her back. AD moved a chair with her right hand that was ungloved. She then continued to serve food with ungloved hand that had touched the chair and handled other items that included the lemonade jug, the hot water spigot, and a tea bag. Additional residents arrived that included R15, R12, R7 and R13. During an interview, at 2:18 p.m. AD was asked if she was aware that CMS has given guidelines to cancel group activities. AD responded her administrator said they could continue with the current arrangement. AD described the schedule of their group activities. The group that was present on 4/13/20, was the Tuesday and Wednesday BINGO group. Other activities were much smaller and in the small dining room or lobby. AD indicated in the small dining room, they played table tennis with five people; did crossword puzzles and played Jeopardy with five or six residents. This was the largest activity of the week. AD stated the administrator provided updates about COVID-19 and said the activities were okay unless it hit closer to home. Then they would have to be further apart and only half of the residents would be able to participate. On 4/14/20, at 2:24 p.m. the administrator reported he was aware of the guidance from CMS to cancel group activities and had planned to implement procedures to do so. The administrator reported he had not canceled groups activities at this time, as he was busy. The administrator had not delegated the responsibility to another staff person. On 4/14/20, at 2:37 p.m. the director of nursing (DON) reported he was aware of the guidance from CMS to cancel all group activities. DON reported they continued to hold group activities at the facility to discourage residents who wanted to leave the facility grounds. DON reported residents were distanced six feet away during groups. DON deferred to the administrator for further information. At 2:42 p.m. the administrator arrived in the dining room and he said, We are wrapping up BINGO right now. The administrator stated he would meet with each of them later. A few residents asked, Why do we have to end BINGO? The administrator answered, I will be available for questions later. CMS Quality, Safety Oversight (QSO) Memo 20-14-Nursing Home (NH), dated 3/13/20, under additional guidance directed facilities to, 1. Cancel communal dining and all group activities, such as internal and external group activities. CMS COVID-19 Long Term Care Guidance dated 4/2/20, directed nursing homes should immediately ensure they comply with all CMS and CDC guidance related to infection control. R1's orders, dated active as of 4/16/20, listed [DIAGNOSES REDACTED]. R1's orders revealed an order, dated 4/10/20, Document on resident's respiratory status and temp (temperature) q (every) shift every shift. On 4/14/20, at 2:40 p.m. RN-A reported R1 was tested for COVID-19 due to a request he made after he watched a television program about COVID-19. RN-A explained staff did not use special precautions for R1, even though staff were to wear a face mask and universal precautions because R1 had been tested for COVID-19. RN-A explained R1 ate in his room but left his room for to smoke a few times a day. RN-A reported R1 had [MEDICAL CONDITION] and did not exhibit any respiratory symptoms and staff monitored his temperature every shift. On 4/14/20, at 2:45 p.m. the nursing assistants on R1's unit (NA)-A and NA-B reported they were not aware of any resident who were on precautions. NA-A reported she heard R1 went to the hospital and had a test for COVID-19 but was not aware of the results. On 4/14/20, at 4:06 p.m. R1 was observed in his room. There was no sign on or near the room to indicate precautions were necessary and no additional person protective equipment (PPE) was noted outside or near the room. R1 reported he was tested for COVID-19 and did not know the results yet. R1 reported he coughed up dark sputum, was tired, ached and he felt ill. R1 reported staff did not monitor his condition. R1 reported he was stayed in his room and went outside to smoke three times a day and wore a mask while outside the room. At that time, RN-A entered the room with gloves and a N 95 face mask on. RN-A did not wear a gown or eye protection. RN-A used an ear thermometer with a cover on it to take R1's temperature and reported it was 99.4 degrees F. R1 reported that was high for him. RN-A removed his gloves, removed the cap for the ear thermometer and sealed the bag of thermometer covers. RN-A then left the room and washed his hands in the resident shower and bathroom down the hall. On 4/14/20, at 4:12 p.m. NA-A and NA-B transferred R19 from his wheelchair and into his bed with a sit to stand mechanical lift. Both NA's wore gloves. NA-A and NA-B rolled R19 in bed to remove his pants and soiled incontinence brief. NA-A wiped R19's bottom. NA-A and NA-B then applied a clean incontinence brief and R19's pants. NA-A and NA-B used the sit to stand lift to transfer R19 back into his wheelchair. NA-A gathered the garbage with the soiled gloves and incontinent briefs. NA-A then washed her hands in bathroom, it was noted the water ran for five seconds. NA-A then handed a beverage mug to R19 before she left the room and took garbage to utility room. NA-B sanitized her hands. NA-A reported she washed her hands for five seconds in the bathroom. NA-A reported she was supposed to wash her hands for twenty seconds. NA-A did not offer an explanation why she did not wash her hands as trained. R1's medical record revealed an elevated temperature of 99.4 degrees F on 4/14/20. There was no evidence of an assessment, full set of vitals taken, symptom monitoring, and/or self isolation put in place. R2's medical record revealed an elevated temperature of 99.0 degrees F on 4/10/20. There was was no evidence of an assessment, full set of vitals taken, symptom monitoring, and/or self isolation put in place. R18's medical record revealed an elevated temperature of 99.1 degrees F on

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

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 _____	**04/15/2020**

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	(continued... from page 1) 4/11/20. There was no evidence of an assessment, symptom monitoring, and/or self isolation put in place. R18's medical record revealed evidence R18 had been hosptalized on [DATE], and had respiratory concerns. RN-B and RN-C were interviewed on 4/14/20, at 3:30 p.m. and described the procedure to check temperatures and chart. They agreed if a temperature was taken, it would be documented in the vitals part of the medical record. They described if a resident had a temperature above the resident's usual, but not greater than 100 degrees Fahrenheit (F), the next shift nurse would check it again and if it was still higher than average, they would do an assessment. If the resident's temperature still remained higher than the usual, the resident would then have additional monitoring for 72 hours. RN-B stated that he did not complete routine vitals on residents in response to guidance to prevent the spread of COVID-19. RN-C stated that routine vitals were done on new admissions daily for six weeks and that those that received antibiotics had their temperature taken every shift. RN-C agreed they did not do routine temperatures checks related to COVID-19 precautions. Review of the facility's Infection Control Surveillance tracking revealed: March 2020 monthly tracking had no residents with any illness and/or infection symptoms identified with onset of in March. April 2020 monthly tracking had one resident R5 listed with onset of symptoms of low O2 saturations, shortness of breath upon exertion, and wheezes in lungs, with onset date of 4/8/20. The April tracking also revealed an antibiotic was started on 4/8/20, and a chest x-ray taken for R5. The tracking did not reveal any evidence of the results of the x-ray nor any follow up with monitoring and/or self isolation. R18's, R2's, and R1's fevers were not identified on the April tracking form. Infection Preventionist (IP) on 4/15/20, at 12:40 p.m. verified on the March and April 2020 surveillance tracking the data indicated for the residents' illnesses and infections. IP stated no resident had any signs or symptoms of COVID-19 in the facility. IP stated checking the residents' temperatures daily had been spotty and he would need to put in an order into PCC for each resident to ensure their temperatures were taken daily. IP stated he had not fully implemented the infection control program regarding tracking and analyzing of residents' illnesses and infections. IP stated he went to each nurse station and looked at the 24-hour report for the residents; however, had not yet integrated the signs and symptoms of residents' illnesses onto the illness and infection tracking spreadsheet; and planned to. IP stated staff were trained to wash their hands for 20 seconds and staff were aware of the 6 feet physical distancing between residents. IP stated he had not completed any audits of staff washing their hands. IP stated he and the administrator had previously talked regarding communal dining and activities for the residents; however, had not yet canceled them before yesterday. Facility policy Infection Prevention Surveillance dated 10/30/17, indicated, Surveillance data is collected and analyzed on an ongoing basis . The policy also indicated, Cohorting of residents and staff may be considered as appropriate. Cohorting is used for the most epidemiologically significant organism.