STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	05/01/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE ESTATES AT BLOOMINGTON LLC	9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420

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 ensure a clean shower environment for 1 of 1 residents (R3) reviewed for infection control practices with a potential to affect the 25 residents who used the 300 A shower room for bathing. In addition 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 residents to properly screen 1 of 3 residents (R3) for signs and symptoms of COVID-19, upon return from a scheduled appointment or leave of absence (LOA). The facility also failed to encourage 2 of 3 residents (R3, R5) to wear a facemask when out of their rooms, upon return from a LOA. This had the potential to affect 37 of 54 residents in the facility that were able to leave their rooms. Findings include: R3's quarterly Minimum Data Set (MDS) dated , 3/17/20, identified R3 was cognitively intact, and required minimal assistance for most activities of daily living (ADL's). The MDS further identified R3's [DIAGNOSES REDACTED]. R3's care plan dated 4/4/29, identified R3 was independent with ADL's, would ask for assistance with self cares and bathe weekly as scheduled. R3's care plan further indicated R3 was leave of absence (LOA) non-compliant and R3 would be screened upon return from LOA to check for signs and symptoms of COVID-19 and temperature would be taken upon re-entry. Environment When interviewed on 4/30/20, at 12:05 p.m. R3 stated the 300 A shower room had dirty bandages on the floor beside the tub last seen with R3's bath a few days ago, Monday, I think (4/27/20). During observation on 4/30/20, at 12:22 p.m. several dirty 4 inch by 4 inch gauze bandages and several 4 inch by 2 inch adhesive bandages noted with either dried bloody or serous (clear or yellow watery) drainage seen on the floor next to the tub in shower room [ROOM NUMBER] A. When interviewed on 4/30/20, at 12:32 p.m. nursing assistant (NA)-A stated the NAs were responsible to clean the shower room after each use. When interviewed on 4/30/20, at 12:39 p.m. housekeeper (H)-A stated the NAs clean the shower room after each use and housekeeping cleans and disinfects the shower room once a day on each day shift. When interviewed on 4/30/20, at 1:10 p.m. director of housekeeping verified and stated, There should not be dressing there on the floor. Housekeeping does a deep clean every morning. Director of housekeeping further stated the NA that assisted the resident would clean the room after use. Director of housekeeping was observed to pick up some of the dirty dressings with bare hands and left two adhesive bandages on the floor. When interviewed on 4/30/20, at 1:13 p.m. registered nurse (RN)-A stated when the shower room was observed, The dressings are not supposed to be on the floor. The nurse is supposed to remove the dressing before the shower to assess the wound. RN-A further stated if the NA removed the dressing in the shower room, they should throw them in the trash. When interviewed on 4/30/20, at 2:29 p.m. the director of nursing (DON) stated, The NAs clean the shower room after each resident and housekeeping does a daily deep clean. The leader of housekeeping does a quarterly deep clean. DON further stated the shower room should be looked at daily since the nurses go in there to do skin checks and was not sure how long those dirty bandages had been there. When asked for the shower room daily cleaning procedure, the facility provided a Seven Step Daily Resident Bathroom Cleaning list. The list included: dust mop floor, clean and sanitize sink (inside/outside/under/around/pipes) and tub, and damp mop floor. Monitoring During observation on 4/30/20, at 7:30 a.m. R3 entered the facility via wheelchair and did not stop to be screened prior to entrance to the nursing unit. When interviewed on 4/30/20, at 12:10 p.m. R3 stated, When I went to clinic this morning, I had to ask staff for a mask and the nursing assistant gave me one. R3 further stated the facility had arranged the medical transportation for the clinic appointment today and was not screened or had temperature taken upon return to the facility. When interviewed on 4/30/20, at 1:48 p.m. RN-B stated (R3) did go out to the [MEDICATION NAME] clinic that morning. (R3) goes out every two weeks. The nurse from nights would have taken the temperature and either documented in PCC (point click care-the electronic health record) or on the log that is for before the day person at the front desk comes in. RN-B verified and stated, Oh, she is not on this list. I hope the night nurse put in in PCC. When interviewed on 4/30/20, at 1:54 p.m. receptionist stated the shift started today at 9:00 a.m. and if a temperature was not listed on the log at the front, it would be on the log at the nurse's station. When interviewed on 4/30/20, at 2:03 p.m. RN-B confirmed the last temperature listed for R3 in PCC was 4/29/20, at 10:44 p.m. and stated, The overnight nurse was still here when (R3) got back. I got (R3's) temp at breakfast like 8:30 a.m. I just have not charted it yet. On 4/30/20, at 2:15 p.m. R3 was observed to wheel self in her wheelchair, held cigarettes and went toward the smoking area. No facemask was observed. R5's annual Minimum Data Set (MDS) indicated R5 was cognitively intact, independent with locomotion and had a [DIAGNOSES REDACTED]. Resident continued to go out of LOA despite education as to why this was not advisable. Resident continued to be non complaint with facility LOA policy and regularly did not sign out/in and will often not notify nursing staff he was leaving. Resident has been non compliant with COVID-19 monitoring when he returns to the facility (he will refuse to have his temperature taken) Care plan instructed staff to provide education regarding risks for LOA during Covid -19 pandemic, upon R5's return they were to screen for signs and symptoms and R5's temperature was to be taken upon return from LOA. Care plan did not address R5 should self isolate for 14 days after an LOA, or wear a facemask while out of the facility and while in the facility but out of his room . On 4/30/20, at 8:11 a.m., R5 came out of the 300 hallway on electric scooter headed toward the nurses desk. R5 stated he had been out to smoke. R5 did not have a facemask. Registered nurse (RN)-A was at the nurses station but did not remind R5 to put a face mask on when out of his room. On 4/30/20 at 9:33 a.m. the director of nurses (DON) stated that all staff were to encourage residents to wear face masks but there were many residents who were non-complaint. The DON stated if a resident refused to wear a mask staff were to document it in the medical record. On 4/30/20, at 11:28 a.m. R5 at the nurses station using the portable phone without a face mask. Unknown female staff member asked R5 how long he would be and R5 stated twenty to forty minutes. Staff member did not remind R5 to wear a face mask. On 4/30/20, at 11:35 a.m. R5 finished with the phone. RN-C sat at the nurses station. RN-C did not remind R5 to wear a face mask. No one was observed to clean the portable phone. On 4/30/20 at 11:42 a.m. R5 stated he hated to reuse the surgical masks because they get damped and could not be cleaned R5 stated they got one a week. R5 discussed cloth masks and he stated he would wear a cloth mask if he had one. RN-B who was present, did not encourage R5 to put the surgical mask on. When interviewed on 4/30/20, at 2:29 p.m. DON stated, Absolutely everyone is screened when they come back (from an appointment or LOA). The nurse typically will do the screening. DON further stated the temperature would be in PCC or on the daily temperature log. The facility policy Coronavirus (COVID-19) dated 4/24/20, identified reasonable steps to minimize exposure to respiratory pathogens, identify symptoms, and provide appropriate care. The policy indicated residents should be educated on the risks of leaving the facility and that they would be screened upon return to the facility. The policy further indicated if movement and/or transport is necessary, the resident was to wear a facemask.

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.