STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245445	A. BUILDING _____ B. WING _____	08/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SHAKOPEE FRIENDSHIP MANOR	1340 THIRD AVENUE WEST SHAKOPEE, MN 55379

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)
E 0013 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Develop Emergency Preparedness policies and procedures.** Based on interview and document review the facility failed to prepare policies and procedures to activate a contingency staffing plan. The facility also failed to address staffing needs for hazards deemed significant based on the facility's all hazards risk assessment as part of their emergency preparedness plan of CFR 483.73(a)(1)(2). This deficient practice had the potential to affect all of the 44 residents. Findings include: On 8/5/20, at 9:58 a.m., the facility infection preventionist (IP) was asked what the facility's plan was should they develop a surge in numbers of staff absences due to COVID-19 exposures and illness. IP responded that she was thankful the facility has not had an issue with staffing and did not feel that going forward staffing would be an issue. IP admitted there was not a plan in place should a staffing shortage occur at their facility. IP stated that she had spoken with a case manager from(NAME)County and was told at that time, she could contact the county and they would attempt to assist with their staffing shortage, should that develop. IP stated that this was not written and there was not a policy developed in regards to a surge in staff absences. IP also stated they do not use agency staffing and facility had not made any contacts with outside agencies for assistance if a staff shortage in their facility occurred. Review of the facilities COVID-19 processes and procedures found no documentation stating the facility had any type of contingency staffing plan.
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 COVID-19 infection control measures were followed when proper hand hygiene was not performed during direct cares. Further, the facility failed to clearly identify rooms that required the use of personal protective equipment (PPE) for entry due to COVID-19 isolation. This had the potential to affect all 46 residents in the facility. Findings include: On 8/5/20, at 11:30 a.m. nursing assistant (NA)-B was observed in room and assisted a resident to use the toilet. NA-B donned gloves, placed a 2 wheeled walker in front of the resident, and positioned a wheelchair at the bathroom doorway. NA-B cued R1 to stand and use the walker, performed peri care, raised clothing, turned and asked R1 to sit in the wheelchair. NA-B doffed gloves, wet a paper towel, applied soap to hands, washed for 2 seconds, rinsed for 5 seconds, shook water off hands vigorously, and used a clean paper towel to dry hands. NA B then handed R1 a wet paper towel to clean her hands and turned the water faucet off with a bare hand. At 11:35 a.m. NA-B was interviewed and confirmed he had infection control and hand hygiene training. NA-B stated hands should be washed with soap and water for 15 seconds. When asked, NA-B stated during observation by the surveyor, he washed his hands for approximately 10 seconds. On 8/5/20, at 12:14 p.m., RN-A was interviewed and stated the hand hygiene policy should indicate proper hand washing was 20 seconds. RN-A further stated staff training consisted of a video that directed staff to wash hands for 20 seconds. RN-A stated her expectation would be for staff to wash with soap and water for 20 seconds. A previous interview with RN-A at 9:50 a.m. indicated no hand hygiene audits were completed to verify staff washed their hands for the appropriate amount of time. The provided facility policy, Hand Hygiene for all Healthcare Workers, dated 2/15/19, indicated the routine hand washing procedure includes washing hands for at least 15 seconds, as well as use a clean paper towel to turn off the faucet. The provided facility policy, Prevention and Control of Coronavirus (COVID-19) Disease, updated 7/27/20, indicated Prior to entering and exiting the unit and resident room, HCP must perform hand hygiene by washing hands at least 20 seconds with soap and water or applying alcohol-based hand sanitizer. The policy further directed Ongoing staff education on proper hand hygiene, and Observe staff-hand hygiene, putting on and taking off PPE and during care. On 8/5/20, at 10:24 a.m. A room on the 400 wing was observed to have a personal protective equipment (PPE) cart outside the room door. No signage was visible on the door or near the room to indicate the level of of precautions or appropriate PPE to don for safe entry into the room. At 10:25 a.m. NA-A was interviewed and stated the resident in the room was on precautions due to the roommate who had tested positive for COVID-19. NA-A stated the needed PPE was in the cart outside the door, and usually the presence of the cart was an indicator to wear PPE when staff entered a room. If NA-A saw a cart, she would just assume the resident was on precautions. NA-A further stated normally there would be a sign to indicate the level of precautions, but with COVID it is not used. At 10:46 a.m. licensed practical nurse (LPN)-A was interviewed and stated residents with carts outside rooms were on isolation precautions. LPN-A stated she has not seen signs posted to indicate the type of precautions for the room. When asked how staff would know if the resident was on precautions, LPN-A stated, I think with the cart, people know. At 10:55 a.m., the dedicated Covid unit was observed with PPE carts present in hall outside resident rooms. Signage posted outside the unit indicated Stop and Do not enter. No signs indicated the level of precautions and what PPE was required to wear for safety beyond that point. At 12:14 p.m., RN-A was interviewed and stated they have a sign See Nurse Before Entering Room, but hadn't put it up on rooms currently on isolation precautions. RN-A stated they do not post isolation precautions on the resident door due to privacy concerns. The provided facility policy, Prevention and Control of Coronavirus (COVID-19) Disease, updated 7/27/20, indicated to ensure isolation carts with isolation signs are centrally located near residents in isolation to put on and off PPE.

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.