STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245332	A. BUILDING _____ B. WING _____	04/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE ESTATES AT EXCELSIOR LLC	515 DIVISION STREET EXCELSIOR, MN 55331

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 ensure staff utilized and removed personal protective equipment (PPE) in a manner to prevent the potential spread of infection. In addition, the facility failed to ensure hard touch surfaces were cleaned properly between uses. This had the potential to affect all 36 residents currently residing in the facility along with all staff and approved visitors at the time of the COVID-19 Focused Infection Control Survey. Findings Include: Memory care unit: On 4/30/20, at 8:26 a.m. registered nurse (RN)-A stated there were 7 residents currently who had confirmed COVID-19 in the unit. RN-A stated the residents were isolated in their rooms and staff assisted them. As this surveyor went down the hallway, it was observed that outside multiple rooms garbage containers were located right next to a cart with clean PPE outside rooms 102, between 105 and 107, and 110 and 108. On 4/30/20, during continuous observations from 8:29 a.m. to 9:54 a.m. several staff including RN-A, nursing assistant (NA)-A, RN-B and social service coordinator were observed to apply PPE and went into rooms 102, 104, 105, 107, 108 and 110 several times. All staff during the observations came out of the room's wearing the same PPE and were observed take it off outside the room next to the clean PPE. In addition, during the same observation NA-A, RN-A and RN-B were observed to come out of rooms 108, 104, 105 and 110 carrying the food trays, after assisting residents with breakfast, and would set the trays on the table outside the room or on top of the clean PPE carts and never disinfected the hard touch surfaces after. On 4/30/20, at 9:14 a.m. when asked if there was enough PPE to use and available at the facility, RN-A stated we are being told when we come to work we are to use the same gown the entire time and I just don't feel comfortable doing that because I don't know if I will touch my face when re-using it. On 4/30/20, at 9:20 a.m. when asked if there was enough PPE available, NA-A stated she did not feel comfortable either when she re-used the gown and she was afraid if she re-used the gown she would contaminate her scrubs in the process and would get sick herself or cause other residents to get sick who were not sick. NA-A explained that she was taking care of both COVID and non-COVID residents in the unit. On 4/30/20, at 9:33 a.m. during a random observation when RN-A went to open the door to go into room [ROOM NUMBER], the action of opening the door caused the air to move and a disposable yellow gown hanging on a hook by the door to the right side was observed to come unhooked and flew through the air, landing on RN-A's face shield as she entered the room. When surveyor asked about the gown, RN-A stated the staff had been asked to re-use disposable gowns and this was the reason the gown was hanging there. RN-A further stated she did not feel comfortable to re-use disposable gowns because it had been used in a room with a confirmed case and she did not like this practice. Main unit: On 4/30/20, at 10:05 a.m. clean PPE carts with garbage containers next to each other were observed outside rooms 117, 125, 126, 127 and 129. In addition disposable and washable gowns were observed hanging on hooks by the door entrances in rooms 117, 118, 125, 126 and 127. -At 10:16 a.m. NA-C was observed to grab a disposable gown off the hook and donned it after applying gloves. The licensed practical nurse (LPN)-A applied a clean gown off the cart. Both staff went into room [ROOM NUMBER] and shut the door. -At 10:25 a.m. NA-C came out of the room and was observed to remove gloves, then untied her gown and hung it back on the hook by the door. LPN-A came out of the room still wearing the gown and as she came to the hallway NA-C pushed the garbage container right in front of the clean PPE cart for LPN-A to dispose or her gown. After LPN-A threw the gown in the garbage can, NA-A moved the can back to the left of the clean PPE cart and both staff went around the corner and washed their hands. On 4/30/20, at 10:27 a.m. when asked if there was enough PPE available to use, LPN-A stated we have enough but I prefer not to re-use the gowns LPN-A further stated staff were to re-use the disposable gowns and that was the reason, in some rooms, staff were hanging the gowns to re-use during their shift. On 4/30/20, at 11:41 a.m. NA-A stated after breakfast that morning when she came out of resident rooms, after assisting residents with breakfast, she acknowledged setting the trays on the floor. NA-A explained that she did this because she did not want to set them on top of the clean PPE cart. NA-A stated there was no other place to set the trays after leaving the room and that was why she would set the tray down, stand over the tray as she removed her PPE in the hallway then would carry the tray to the dining room before she washed her hands. NA-A stated the garbage containers that PPE was disposed in were always set this way next to the clean PPE, this is how it's always been. I think we should remove the PPE in the room and not the other way. On 4/30/20, at 11:48 a.m. to 11:51 a.m. a tour of the facility was completed with the director of nursing (DON) who verified the findings. She acknowledged the garbage containers and clean PPE carts were not supposed to be next to each other. The DON stated moving forward the staff will be removing PPE in the rooms before they come out in the hallway, as there were still other residents who were coming in and out of their rooms. The DON verified the gowns hanging on hooks in rooms blew around when the room doors were opened. DON also stated a cart was going to be added in the hallway for staff to use for placing meal trays after coming out of resident rooms.

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.