STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245189	A. BUILDING _____ B. WING _____	05/21/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SOUTHVIEW ACRES HEALTHCARE CENTER	2000 OAKDALE AVENUE WEST SAINT PAUL, MN 55118

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0726 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.** Based on interview and document review, the facility failed to ensure all direct care staff received appropriate orientation and informtion to provide care to meet resident needs. This had the potential to affect all 21 residents on the 3rd floor east COVID-19 unit. Findings include: On 5/19/20, at 10:03 a.m. NA-B confirmed NA-A and NA-B picked up the 5/14/20, night shift through an agency after receiving an email regarding staffing struggles of long term care facilities. NA-B stated they were supposed to be given paperwork to complete upon arrival, but never received any paper work. NA-B stated the three staff working that night on the 3 east unit were all from the emergency staffing program. There were two NAs and one RN. NA-B stated the NA from the prior shift did not have any care plans and they received no report from that NA. NA-B stated she did not receive information on how to transfer each resident nor did she receive care guides. NA-B also stated they were given login information to PCC (the electronic health record-point click care) but never received education on how to access the EHR (electronic health record). NA-B stated they (NA-A and NA-B) told the charge nurse, but she did not help them get on PCC. NA-B stated they did not check vitals because they did not get instructions on how to do them in this facility; the charge nurse told them they should have done the vital signs but the new nurse that came to help them at 2 am told the NAs to not check vitals. On 5/19/20, at 11:32 a.m. NA-A described coming to work her first shift at the facility. NA-A stated when she arrived at the facility, the staff at the front desk gave her a manilla envelope that included PPE. NA-A stated she was brought into an elevator and asked staff what kind of unit she would be working on, to which the staff replied, COVID. Once on the unit, NA-A met the NA who had worked the prior shift. This NA started to give report before leaving for the night. NA-A asked if there was a care plan she could review, and the NA from the prior shift stated they did not have that, and proceeded to tell NA-A the resident names, and how she had been transferring each person. NA-A found a piece of s[REDACTED] paper and started writing down how the NA who had worked the prior shift said she had been transferring people. NA-A looked around the unit, and found a nurse brain (structured report sheet with resident information used to direct care) that had a little more information about each resident. NA-A said she was working with NA-B and RN-C, who were also both new to the facility. NA-A said nobody showed them a care plan, or how to chart anything in the medical record. NA-A stated she did safety checks on the residents, and did checks and changes of residents' incontinence briefs with NA-B, and wrote the times and details of what was done for each resident on a piece of paper since they did not know how to document in the official record. NA-A had observed mechanical lifts on the unit, but the NA from the prior shift giving report did not mention using any of them, so NA-A did not know why they were there or if they should be used for anyone. On 5/19/2020, at 11:34 a.m. RN-C stated she picked up two shifts through an emergency staffing program. RN-C worked a shift the previous week on the memory unit at this facility and worked the 5/14/20, night shift. RN-C stated she received a packet with PPE and paper work and was told to complete the paper work during the shift or the next day. At the beginning of that shift the RN who had worked the prior shift gave RN-C some instruction on medication pass and together they completed a narcotic count. RN-C stated she had access to PCC and brief tutorial on how to document vital signs and COVID charting. RN-C stated she took the envelope with the paperwork when she left her first shift. RN-C also stated the RN who worked the shift prior to RN-C was from an agency and did not seem to know what he was doing. RN-C reported receiving a very brief report and the RN who had worked the prior shift just said, this person is ok, this person is ok, this person will probably die, this person will probably die. RN-C further stated, There were no regular staff on my shift, so it was the blind leading the blind. RN-C stated they attempted to get assistance, but the charge nurse was not helpful. I did not know their policies and procedures. I kept trying to get a hold of her (the charge nurse) and she was not helping. On 5/19/2020, at 12:54 p.m. RN-D confirmed working as building charge the 5/14/29, night shift. RN-D stated she had worked with agency staff previously, but this was a new process. RN-D stated not being aware that the agency staff were coming because their names were not on the staffing list. RN-D stated this was her first experience with this type of staff and normally any new staff, even temporary staff, would have had orientation. That night NA-A and NA-B were assigned the 3 east unit. RN-D escorted them to the floor and explained that it was a COVID unit. PPE was provided and they were introduced to RN-C. RN-D stated she told the previous shift staff to not just leave but help give an orientation to the new temp staff. On 5/19/2020, 3:22 p.m. the director of nursing (DON) stated the use of pool or agency staff was new as of 3 weeks ago. Temporary staff should receive a packet by the screener which would include their PCC login, a welcome letter, building charge phone number, location of AED (automated external defibrillator), and [MED]gen and medication rooms. The packet also included a PCC tutorial. The DON also stated care plans were available in PCC and care guides were on paper for the NAs to use. The nurses have brain boards on paper which would include instructions such as altered diet or fluids. On 5/21/2020, at 2:20 p.m. the DON stated new staff were given a checklist that should be completed with a mentor. This included agency and temporary staff. The mentor could be the nurse/NA that they were getting report from or the nurse/NA or building charge during their shift. The DON further stated it (orientation) would take between 30 to 45 minutes depending on the staff experience and there was 15 minutes for NAs and 30 minutes for nurses built into the schedule to do this orientation. The DON verified and stated the expectation was to have the checklist completed and any questions answered. In an emergency situation some of the items on the checklist could be completed during the shift. The Southview Acres Orientation Packet included a Welcome Form dated 5/15/20, that noted an On-Unit Orientation Checklist which would highlight what staff needed to know about the unit. The Welcome Form directed new staff to review the On-Unit Orientation Checklist with the nurse who was giving report, and return the completed On-Unit Orientation Checklist to the building charge nurse or clinical manager on the unit. The Welcome Form required that all residents have a COVID assessment completed every shift, including temperature and [MED]gen saturation levels, found in the electronic medical record (eMR). The Welcome Form directed staff to ask for help if they needed it. The Welcome Form also included login information for the computers and eMR. The Welcome Form noted there was a building charge that could be called if staff needed assistance, supplies, or had questions. The Orientation Packet included a Quick Start Training Guide for the eMR, and an undated On-Unit Orientation Checklist. The On-Unit Orientation Checklist had check boxes for the new employee to check in each area whether they felt confident, felt familiar but desired review, or were unfamiliar. There were check boxes for each mentor to complete that they reviewed and/or demonstrated for the new employee, and whether the new employee demonstrated correct procedure.
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 follow recommendations for the use and re-use

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

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 1) of personal protective equipment (PPE) including face masks. This had the potential to affect all 162 residents residing in the building. Findings include: The CDC website https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/decontamination-reuse-respirators.html indicated that filtering facepiece respirators (FFRs) such as the KN95 are considered one time use products and there are no manufacturer authorized methods for FFR decontamination before reuse. The CDC furthers indicated only respirator manufacturers can reliably provide guidance on how to decontaminate their specific models of FFRs. In the absence of manufacturer's recommendations, crisis standards of care decontamination recommendations would include Ultraviolet germicidal [MEDICAL CONDITION], vaporous hydrogen peroxide and moist heat. On 5/18/20, at 2:23 p.m., housekeeper (H)-B stated education was provided on PPE including when and how to use it. H-B also stated she would take the mask (KN95 - filtering facepiece respirator) home, wash it in soapy water and let it air dry. On 5/18/20, at 2:33 p.m. nursing assistant (NA)-C was observed wearing a KN95. NA-C stated education was provided on how and when to use PPE. NA-C also stated he would take the mask home every day and wash it with water, antibacterial soap and a little bleach and then hang to dry. NA-C stated he was only given one mask and that sometimes he used wipes to clean the mask as well. On 5/18/20, at 2:57 p.m. housekeeper (H)-A was observed wearing a KN95 mask. H-A stated he had been working at the facility for a couple weeks now, and had been given two KN95 masks. H-A described taking the mask home after use, washing it in lukewarm water and letting it air dry after washing. H-A said if black spots showed up on the mask, it was no longer good. When asked what the black spots were, H-A stated it meant the filter was no longer catching anything, and needed to be replaced. On 5/18/20, at 3:00 p.m. registered nurse (RN)-E was observed wearing a KN95 mask. RN-E stated she took the face mask home and washed it using laundry detergent and water. RN-E also stated she was not sure how long this mask was good before needing to replace it. On 5/18/20, at 3:05 p.m. NA-D was observed wearing a KN95 over a cloth mask. NA-D stated she took the mask home every shift and washed it with soap. On 5/18/20, at 3:13 p.m. registered nurse (RN)-A was observed wearing a KN95 mask and faceshield. RN-A stated he had a KN95 mask, and was told he could wash it. RN-A described keeping the mask in a bag when not in use, and stated he had not washed the mask yet. On 5/18/20, at 3:21 p.m. RN-F was observed wearing an N95 mask. RN-F stated he had his own supply of about 10 N95 masks which he cycles through. RN-F also stated that other staff were taking their masks home and washing them. On 5/18/20, at 3:32 p.m. RN-G was observed wearing a KN95 mask. RN-G stated she took her mask home and cleaned it. RN-G carried two zip lock baggies, one labeled clean and one labeled dirty she used to carry them. On 5/19/20, at 3:22 p.m. director of nursing (DON) stated the facility had enough KN95 masks for 100 percent of the staff and that staff took them home and washed them. The KN95s are considered washable. We did print the manufacture guidelines which state hand washable and air dry. If there is discoloration then they can be replaced. The guidelines state black dots will develop when it is time to replace. On 5/21/20, at 3:50 p.m. DON stated, I have read on the CDC (Centers for Disease Control and Prevention) website that it is up to the building administration to decide the best way to preserve PPE. When asked for policy on how to maintain the KN95 masks, the facility provided at print out of a web page dated 4/15/20, titled, Difference Between N95 Masks (versus) KN95 Masks. The website was https://electroguides.com, a website that compared information on the Internet about different products, and compiled the information together in one place. The printed web page stated as a KN95 mask got old, the carbon fibers would to leave their color, and the mask will get black color clots on the inner side of the mask. This was a sign that the mask had worn out and needed to be replaced. The web page also stated KN95 masks were made up of washable cotton material, and could be washed by hand. The facility gave each staff member a bag with their KN95 mask, and on the bag were the following instructions, This is your KN95 mask. You must wear it during your shift. Use 2 hands to ensure it is snug around your face. Hand washable/air dries. Ask Questions. Store in white bag when not in use.