STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245496	A. BUILDING _____ B. WING _____	04/24/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MINNEOTA MANOR HEALTH CARE CENTER	700 NORTH MONROE STREET MINNEOTA, MN 56264

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.** Based observation, interview, and document review, the facility failed to cancel all group activities, appropriately screen residents for all signs and symptoms, and actively screen staff at the point of entry to the facility in accordance with Centers for Disease Control (CDC) and Centers for Medicare and Medicaid Services (CMS) guidelines for COVID-19. Additionally, the facility also failed to ensure and personal protective equipment (PPE) including glove use and hand hygiene was performed appropriately. This had the potential to affect all 41 residents in the facility. Findings include: SCREENING Interview on 4/23/20 at 9:00 a.m., with laundry aid (L)-A identified staff enter the facility through the South entrance of the facilty. Staff screened themselves for potential signs and symptoms of COVID-19 before entering the facilty by taking their own temperature. If two staff members were present, staff would screen each other. If staff entered the facilty alone, they would take their temperature and answer the screen questions, then enter the building to find another another staff to sign they were symptom free. Interview on 4/23/20 at 9:15 a.m., with housekeeper (H)-A identified staff entered the building at the South entrance. Staff were to take their own temperature, then enter the building to find a staff member to screen them. If they had identified symptoms or a temperature they were to not enter the facilty and call the director of nursing (DON) for further instructions. Interview on 4/23/20 at 10:00 a.m. with registered nurse (RN)-A identified when there were multiple staff entering the facility at the same time, staff screened each other before entering the building at the South entrance. If no staff members were present, staff took their own temperature, answered the questions on the screening papers, donned a mask, and entered the building to have another staff verify no COVID-19 symptoms were present. Staff were instructed to not enter the building if they had a temperature or other symptoms and notify the DON. Interview on 4/23/20 at 11:30 a.m., with NA-A identified she entered the building around 8:30 a.m. through the south entrance. Before entering she performed hand hygiene and donned her facemask, and took her temperature. She answered the questions and brought the slip with her into the facilty to have a nurse verify she had no symptoms. Observation on 4/23/20, at 1:30 p.m., identified visitors entered the building at the main entrance. A table and two-way radio were placed in the entrance. The door was locked. A sign directed persons entering to call on the two-way for assistance. The entryway opened into a large area with offices and a large desk. Three wings branched from the entry way. Residents resided in the front section of the North, South, and West Wing. The South entrance of the facilty was the entrance connected to the assisted living. The assisted living was connected to the facility in the South Wing by a short corridor. The South Wing contained resident rooms, a beauty shop, conference room, and a small nurse station. The 4/3/20, COVID-19 Eyes-on Screening Tool for Employees identified staff were to use hand sanitizer before completing the COVID-19 screening process. Staff measured their temperatures and signed the screening tool which meant they were verifying absence of fever, shortness of breath, or presence of a cough or sore throat. Staff were to hand the tool to the first person seen in the facilty. The person was to ask the questions on the form and sign no symptoms were visualized. The form was placed in a basket at the main nurse desk at the entrance of the facility. Observation and interview on 4/23/20, at 10:45 a.m. of the resident's COVID-19 screening process with activity aid (A)-A identified she measured resident temperatures, pulse and oxygen saturation daily at 10:00 a.m. If a resident had an elevated temperature, she would notify the nurse. The record was given to the nurse to review. The nurse was responsible for checking for physical symptoms of COVID-19. She could not recall specific training she had for gathering assessment data since she was not a NA or a licensed nurse. Review of the resident's 4/13/20 through 4/19/20,COVID-19 screening record identified resident temperatures, pulse and oxygen saturation were recorded daily at 10:00 a.m. The record contained a week's worth of data. Physical symptoms were not included on the document. Interview with registered nurse (RN)-C identified resident's temperatures, pulse and oxygen saturation were measured daily at 10:00 a.m. The charge nurse reviewed them daily when they were completed. If a resident developed a temperature or was observed to have symptoms, the nurse would document the information into the electronic medical record and notify the infection prevention nurse, or director of nursing (DON) for further instructions. Absence of COVID-19 assessment of symptoms were not documented in electronic medical record (EMR), and nursing did not formally check each resident daily for symptoms. Nurses and NAs were in resident rooms frequently every shift, and if symptoms were identified by chance rather than formal assessment, the NAs were expected to notify the charge nurse, infection preventionist, or the DON. GROUP ACTIVITY Observation on 4/23/20, at 9:40 a.m., of the beauty shop identified it was a small room located in the South wing of the facilty. Residents sat within close proximity facing one another The hair dryer sat by the entrance of the room. R1 was seated by the sink in the beauty shop. Nursing assistant (NA)-A was setting R1's hair. R2 was seated under the hair dryer facing R1. R1 and R2 were not wearing source control masks. NA-A was improperly wearing her source control mask as it was pulled down under her chin. At 10:00 a.m., R2 was assisted back to her room. R1 was seated under the hair dryer and R3 was now seated by the sink, NA-A was setting R3's hair in rollers. R1 and R3 were not wearing source control masks. R1 left the beauty shop. At 10:10 a.m, NA-A assisted R4 into the beauty shop to set her hair. R3 sat under the hair dryer. R3 and R4 were not wearing face masks. Observation and interview at 10:00 a.m., of the beauty shop identified NA-A assisted residents setting their hair. NA-A's facemask was pulled down underneath her chin. The director of nursing (DON) entered the room and spoke to NA-A. NA-A pulled the mask up over her mouth and nose and without performing hand hygiene, continued to set R3's hair. At 10:10 a.m. NA-A's face mask was underneath her nose. At 10:30 a.m NA-A identified she had pulled her facemask under her chin. Face masks were required to be worn to cover their nose and mouth while assisting residents with their hair. Hand hygiene was to be performed before and after setting hair, and after sanitizing the beauty shop. Interview on 4/23/20 at 11:30 a.m., with NA-A identified the beautician was not permitted to come to the facilty during the COVID-19. NA-A worked only in the beauty shop two days per week for a couple of hours each visit and assisted residents to set their hair on their bath days. In order to get all residents who wanted their hair set done in a few hours, she set one resident's hair while another sat under the hair dryer. The residents were not required to wear face masks in the beauty shop. HAND HYGIENE, PPE, AND GLOVE USE Observation and interview on 4/23/20 at 10:05 a.m., of collection of soiled linen from the facility's soiled utility rooms identified laundry aid (L)-A entered the north wing with a linen cart wearing gloves. While wearing gloves, L-A opened the soiled utility room door, opened the laundry bin lid, leaned into the bin, removed unbagged soiled linen from the soiled utility room linen bin, replaced the lid, and put the linen into the laundry cart. Without removing gloves and performing hand hygiene, L-A opened the tub room door, opened the soiled linen bin. There was no linen in the bin. L-A exited the tub room and without removing gloves and performing hand hygiene, pushed the linen back to the laundry room to sort linen. Without donning a gown, L-A leaned into the linen cart and removed a soiled linen bag. L-A opened the bag and emptied it into the soiled linen cart in the laundry room. A piece of linen fell into the wrong bin and L-A reached into the bin to retrieve it. L-A's uniform was in contact with the soiled linen bin. Observation of the soiled linen room during that time identified there was no PPE in the soiled linen area of the laundry room. L-A stated gloves were located by the sink near the washing machine and a gown was hanging on the other side of the door between the clean and soiled linen areas. L-A verified she had not donned a gown to sort soiled

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) linen because gowns were only worn to handle linen from residents who were placed on transmission based precautions. L-A agreed she had worn the same gloves to collect linen from each wing and had not removed her gloves and performed handy hygiene after handling unbagged linen and before entering the tub room. L-A only changed her gloves and performed hand hygiene after she collected all the linen from the wings and sorted the linen. Observation on 4/23/20 at 12:05 p.m., housekeeper (H)-B exited R5's room. Without removing her gloves and performing hand hygiene, HA-B entered R6's room and cleaned high-touch surfaces. Without removing gloves and performing hand hygiene, H-A grabbed the dust mop handle and dusted the floor, and placed the dust mop on the cart. HA-B removed her gloves and without performing hand hygiene, donned a new pair of gloves and entered R7's room. When H-B completed cleaning R7's room, she exited the room. Without removing gloves and washing hands, H-B pushed the housekeeping cart out of the resident area. Interview on 4/23/20 at 1:15 p.m., with H-A identified gloves were to be removed and hand hygiene performed between cleaning resident rooms. Floors were to be mopped daily. H-A was the only housekeeper working, and had not mopped the floors because the facilty was short of help. When there was only one staff, sometimes corners had to be cut. H-A ensured all high touch areas were wiped in each room, and in the hallways. Interviews on 4/23/20 at 3:30 p.m. with infection preventionist nurse (RN)-A, registered nurse (RN)-B, and the DON identified staff were expected to follow the facilty policy for hand hygiene and glove use. RN-A stated laundry was not required to wear a gown when sorting soiled laundry. The DON was responsible for oversight of the infection prevention program, but department managers were responsible for each department's infection prevention practices. She was not sure what the appropriate practices were for laundry while handling soiled linen. RN-A, RN-B, and the DON agreed laundry staff's clothing had potential to become contaminated while handling soiled linen. The DON, RN-A, and RN-B agreed source masks should cover the nose and mouth and were not to be under the chin when providing care for residents. The DON identified residents in the beauty shop were placed six feet apart, and verified residents were provided source control masks to wear when in confined areas. She felt because no symptoms of COVID-19 were present in the facilty, residents were able to continue having their hair set in the beauty shop. Most staff were screened prior to entering the facilty, only a few entered the facilty at odd times where they would need to enter the facilty to have their COVID-19 symptom screening completed by another staff. All staff donned masks prior to entering the building, and would not enter the building if they were ill. The DON identified staff were very careful and conscientious, and were doing everything they needed to prevent bringing COVID-19 into the facility. RN-A stated all resident temperatures, pulse and oxygen saturation were measured daily at 10:00 a.m. by an activity staff member. Nursing staff screened residents for symptoms of COVID-19 when they entered their rooms every shift. Staff only documented COVID-19 symptoms if symptoms were present, however the activities aide was responsible for formal assessment per observation above. Staff were in contact with residents multiple times daily and multiple times every shift, and were expected to report presence of signs and symptoms of COVID-19 to the nurse immediately so an assessment could be completed. There was no mention how the facility assured the activity aide would be an appropriate choice to perform resident assessments for COVID-19 or how she was trained. An interview with the administrator on 4/23/20 at 2:00 p.m. identified residents were permitted to use the beauty shop. An NA worked a couple of hours two days per week to assist residents to set hair. Residents would not wear source masks in the beauty shop and were in a confined area but felt they were appropriately distanced. The faciltiy was expected to follow Centers for Medicare and Medicaid (CMS) and Centers for Disease Control (CDC) guidelines for COVID-19 infection prevention practices. Review of the 8/13/19, Interdepartmental Meeting agenda identified housekeeping and laundry staff were to handle, store, process, and transport contaminated linens to prevent the spread of infection. Staff were to use universal precautions for all potentially contaminated laundry. The agenda made no mention of what PPE was to be worn. A policy was requested for PPE use and handling of soiled linen. No policy was provided. The 3/27/19, Hand Hygiene policy identified the facilty was to complete hand hygiene according to evidenced-based practice. There was no specific mention in the policy what those steps were. A policy for glove use was requested. No policy was provided.