| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245293 | A. BUILDING _____ B. WING _____ | 05/05/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| HOPKINS HEALTH SERVICES | 725 SECOND AVENUE SOUTH HOPKINS, MN 55343 |

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) |
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| F 0880<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Many | **Provide and implement an infection prevention and control program.**<br><br>Based on observation, interview, and document review, the facility failed to ensure all staff entering the facility were being actively screened for the prevention and potential transmission of COVID-19. This had the potential to affect staff and all 60 residents currently residing in the facility. Finding include: On 5/4/20, at 7:45 a.m. the survey team entered the facility through the main front doors which were unlocked. Upon entering there was a hand sanitizer station by the second doors and to the left was a table which had a sign that directed visitors to be screened. On the table were several documents with COVID-19 information and a clipboard with COVID-19 questionnaires. On the table was a thermometer. At this time, a housekeeping staff was standing by the cleaning cart, across from the front desk, but never offered to obtain temperatures from the surveyors. The surveyors took their own temperatures and answered the questions before the administrator came. -At 7:52 a.m. the administrator re-checked the surveyors temperatures before bringing the surveyors to the conference room by the front door. During the entrance conference the administrator stated the facility had 16 confirmed cases with COVID-19 and all cases were in one unit except for the pending cases. In addition, the administrator stated the facility had multiple staff with confirmed COVID-19, and staff were returning back to work, after being cleared. On 5/4/20, at 7:59 a.m. the activities coordinator (AC)-B was observed to enter the building through the back door and went into an office located on the back service hallway. -At 8:00 a.m. AC-B was observed to clock in across from the nursing station before she approached the nursing station where registered nurse (RN)-A stood by the medication cart. RN-A took AC-B's temperature. AC-B then approached the clipboard located at the nursing station and completed the screening questions before RN-A signed off on it. -At 8:01 a.m. the health unit coordinator (HUC) was observed to enter the building through the back door and went immediately into an office located on the service hallway and never came out. -At 8:02 a.m. the social service coordinator came into the building through the main entrance and went past the front receptionist desk down the long hallway with resident rooms before she arrived at the nursing station 1 East. As she approached the nursing station RN-A checked her temperature and the social services coordinator proceeded to complete the screening questions before RN-A signed off. -At 8:04 a.m. the HUC was observed to come out of the office and clocked in, then went back to the office briefly and was then observed to carry a lunch bag to the employee break room. -At 8:05 a.m. the HUC was observed to exit the break room and returned to the office. -At 8:09 a.m. the activities director (AD) was observed go past resident rooms before she approached 1 East nursing station to get screened. When she approached the nursing station RN-A was not in the area and she stood there to wait for RN-A to come back. At 8:11 a.m. RN-A came out of the dining room and was observed to check AD's temperature and then AD completed the screening questions before RN-A signed off. -At 8:15 a.m. the HUC and AC-A both approached the nursing station and AC-A was observed to stand by the HUC as she checked her temperature which the thermometer said was 95.2 degrees. The HUC then rechecked it twice and got a reading of 94.4 degrees and the last time it said low. Both staff laughed and the HUC stated she would re-check it when she got to the front desk. As AC-A left the nursing station, the HUC was noted to be sniffling under her mask as she cleared the 1 East desk before she went to the front desk at 8:18 a.m. -At 8:20 a.m. the director of maintenance (DM) was observed to enter the building through the back door and was observed standing outside the office in the service hallway as he took his helmet off. -At 8:29 a.m. the DM was observed to key in the code at the back entrance door and exited the building. -At 8:31 a.m. the DM re-entered the building, cleansed hands with hand sanitizer and was then observed to come down the service hallway towards the nursing station. -At 8:33 a.m. the DM approached the nursing station and before he was screened he was observed go past the desk to the right and turned the hallway light on where resident rooms were located. The DM then approached the nursing station and checked his temperature - the thermometer reading indicated, Your temperature is low. The DM then stated he had checked his temperature before he left his home and it was 98.3 degrees. He then stated I rode my bike to work as he completed the screening form located on the clipboard at the nursing station before AC-B signed off for him. -At 8:37 a.m. the AD stated she had entered the building through the main entrance and verified she had not been screened at the front. On 5/4/20, at 9:08 a.m. when asked about staff screening, RN-B stated usually when reporting to work she came through the back entrance and two staff were supposed to screen each other and sign off as the screener. RN-B stated there was no staff designated to screen staff and at times she had observed staff enter the building through the main entrance and were allowed to come down all the way to 1 East past resident rooms before they were screened, which she did not think was appropriate. On 5/4/20, at 9:20 a.m. when asked about staff screening, nursing assistant (NA)-A stated we use the thermometer to check our temperature and we screen each other and if the nurse is not there we screen ourselves and the other staff will sign for you so we can work. The nurse is not always there as she or he is doing something with the residents and we just do it. NA-A stated he entered the building through the back entrance usually. On 5/4/20, at 9:33 a.m. AC-B stated she usually came into the building through the back entrance and before I clock in I have to have someone witness me taking my temperature and I sign off for other people and they sign for me. We do the symptom screening and then someone will sign off. When there is no one at the desk I will go down the hallway to find someone and usually you will find someone. On 5/4/20, at 10:03 a.m. RN-A stated he entered the building through the back door. When asked who would screen him, RN-A stated he would be screened by anybody at the desk and this did not matter if it was a nurse or not and they would screen and sign off for each other. When asked if staff knew what to look for when screening each other, RN-A stated all the staff knew and no one was allowed to go to the floor until they were screened and they had to wait at the desk. RN-A further stated when staff came through the main front entrance the staff would have to come down to the 1 East nursing station past resident rooms to be screened if no one was at the front. On 5/4/20, at 10:20 a.m. when asked who reviewed the screening forms after they were completed, the facility administrator stated the Corporate nurse reviewed the forms. The administrator stated usually he scanned them and if any recommendations he would follow up with the staff with education and would mark it in the form. During a review of the Facility COVID-19 Screening Tool for staff dated 5/3/20, through 5/4/20, it was revealed 4 out of 23 staff did not have a screener signature and one employee had screened herself on 5/4/20.<br><br>On 5/4/20, at 7:20 a.m. AC-A was observed to enter the building through the back door of the facility as this surveyor was waiting to enter the building. On 5/4/20, at 7:59 a.m. the social services coordinator entered the facility through the front main entrance door and was not screened. -At 8:06 a.m. the activities director (AD) entered the facility through the front main entrance door. She was not wearing a mask and was not screened. -At 8:20 a.m. the DON entered the facility through the front main entrance, was not wearing a mask and was not screened and did not request to be screened before she went to her office, which was located a few doors from the main entrance past the table with screening information. On 5/4/20, at 10:35 a.m DON was interviewed and stated that her expectation was for employees to be screened when they come to work and if they go out to lunch, they need to be screened again upon their return to the facility. She also said she expects staff to be screened by a nurse or management staff that had been trained specifically for COVID-19. The facility Pandemic Preparedness and Response policy dated 3/23/20, directed for staff monitoring the facility was to Follow CDC/DPH |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0880<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Many | (continued... from page 1)<br>recommendations regarding staff screening process for each pandemic. The infection preventionists will determine in consultation with the pandemic committee, how the screening will be implemented should the need arise . |