STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245438	A. BUILDING _____ B. WING _____	**03/11/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TALAHI NURSING AND REHAB CENTER	**1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304**

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 -** Few	**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 proper handwashing and glove use was implemented when preparing water cups. This had the potential to affect all 59 residents in the facility. In addition, the facility failed to ensure proper cleaning of a nebulizing machine was completed for 1 of 4 residents (R4) noted to have nebulizers at their bedside. Findings include: Water glasses: During an observation on [DATE], at 2:33 p.m. nursing assistant (NA)-A was observed to be filling water glasses with ice without using proper gloving and hand hygiene. NA-A was not wearing gloves when she reached into the ice bucket, grabbed the metal scoop that was lying on the ice and scooped ice into large water cups. NA-A proceeded to fill the cups with water and placed on the cart and touched the tops of the cups to position them. NA-A was interrupted by a resident who requested the TV remote. NA-A grabbed the remote, walked toward the TV and turned it on then returned to the water area. NA-A turned on the water and ran water over her fingers but did not use soap to wash hands nor did NA-A apply gloves. NA-A continued to fill water cups from the second shelf of the cart when a cup of ice tipped over. NA-A grabbed some paper toweling, picked the ice cubes from the floor with towel in left hand and used the right hand in a sweeping motion to clear the ice from the cart into the paper towel. NA-A shook ice out of the towel into the sink and disposed of the paper towel in the garbage. NA-A ran water over her hand, but did not use soap to wash hands nor did NA-A apply gloves. NA-A continued to fill the remainder of the water cups and organized the cups by touching the tops of the cups with bare hands. NA-A rinsed the first stack of cup covers, shook off excess water and proceeded to place on top of the water cups. The second stack of covers were also run under water and shook off excess water. NA-A paused and appeared to remove a hair from the covers. The second stack was rinsed again, shook off and then placed on the water cups. NA-A proceeded to secure the covers by pressing down on the covers with ungloved hands. A third stack of covers were rinsed and placed on remaining water cups then pressed down with ungloved hands. During an interview on [DATE], at 2:33 p.m. NA-A stated she'd often completed the task of filling the water cups and had never worn gloves during the process. During an interview on 3/11/20, at 8:08 a.m. registered nurse (RN)-A stated the expectation was for staff to wear gloves when scooping ice and filling water cups. Further, RN-A stated she would expect staff to wash hands with soap after handling a TV remote or cleaning up spilled ice. During an interview on 3/11/20, at 10:21 dietary manager (DM)-A stated staff was expected to wear gloves when filling water cups. Further, DM-A stated expectation was to wash hands after handling TV remote or cleaning up spilled ice. During an interview on 3/11/20, at 11:22 a.m. director of nursing (DON) stated all staff were trained on hand hygiene upon hire and annually. Nebulizer: R4's admission record indicated [DIAGNOSES REDACTED]. R4's physician orders [REDACTED]. R4's record lacked evidence of capacity to self administer medications. During a walk through of the facility, around the noon hour, R4's nebulizing machine was at bedside, still assembled with liquid in the medicine cup. During an interview on 3/11/20 at 12:10 p.m. RN-A stated the nurse that dispensed the nebulizer was responsible to wash the nebulizing machine after every use. RN-A confirmed R4's nebulizing machine had not been cleaned after being used and that R4 was currently out of the facility receiving [MEDICAL TREATMENT]. During an interview on 3/11/20, at 12:16 p.m. RN-B stated R4 was not able to self administer medications and it was the responsibility of the nurse that dispensed the medication to pull apart the chamber and wash it after every use. After observing the still assembled nebulizing chamber with liquid in the medicine cup, RN-B stated this is incorrect. RN-B confirmed R4 was currently out of the facility at [MEDICAL TREATMENT]. During an interview on 3/11/20, at 12:20 p.m. DON stated nebulizing machines were to be cleaned between uses. A facility policy issued on 8/15 directed to cleanse nebulizer mask, reservoir with water and allow to air dry.

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