STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245366	A. BUILDING _____ B. WING _____	08/19/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CHRIS JENSEN HEALTH & REHABILITATION CENTER	2501 RICE LAKE ROAD DULUTH, MN 55811

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 0880 **Level of harm -** Immediate jeopardy **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 implement appropriate COVID-19 infection control practices related to the appropriate utilization of personal protective equipment (PPE) when providing personal care and treatment to residents; and failed to quarantine 2 of 2 residents (R1, R2) who had recently returned from hospitalization s as recommended, in order to minimize or contain the spread of COVID-19. These practices resulted in an immediate jeopardy (IJ) due the potential risk for widespread outbreak of COVID-19 with the potential to affect all 133 residents residing in the facility, and all staff. The immediate jeopardy began on 8/1/20, when it was determined the facility had begun re-using one to two plastic infection control gowns per room, per resident, per day, for all staff entering a resident room to wear regardless if contaminated during the provision of cares; and when the facility failed to ensure quarantined residents remained in their rooms during the 14 day hospital return per the Centers for Disease Control and Prevention (CDC) COVID-19 guidelines even though the facility currently had an outbreak of COVID-19 within the facility. The executive director, administrator, director of nursing (DON) and the infection control nurse were notified of the IJ at 4:20 p.m. on 8/14/20. The IJ was removed on 8/19/20, but noncompliance remained at the lower scope and severity level of F: widespread which indicated no actual harm with potential for more than minimal harm that is not IJ. Findings include: On 8/13/20, at 12:30 p.m. upon entrance to the facility, the executive director stated the facility currently had twelve residents who had tested positive for COVID-19 and an additional resident test result was pending. Between 8/1/20 and 8/13/20, twelve of twenty-seven residents tested positive for COVID-19. Eleven of the twelve positive residents resided on the Birch unit; one resided on the Elm unit. The Birch and Elm units were currently under quarantine due to having had COVID-19 positive residents residing on those units. On 8/13/20, at 2:20 p.m. when asked about infection control precautions, unit manager (UM)-A stated plastic reusable gowns hung on a hook in the entrance of each resident room on the Elm unit. UM-A stated the staff were to don the gown when entering the resident room, provide care or assistance to the resident, then doff the gown when exiting the room and hang it back up on the same hook for the next staff member to use when entering the resident room. UM-A stated all staff had their own goggles which they stored in Tupperware containers in their break room when not on shift. Personal Protective equipment (PPE) On 8/13/20, at 1:57 p.m. a staff member on the Birch unit was observed to enter room [ROOM NUMBER]. Upon entrance to the room the staff member removed a gown from a hook just inside the door to the room. The staff member then put her arms into the sleeves of the gown and pulled the gown, which was already tied at the neck, over her head touching the gown to her face. In addition, R3's room was located on the Elm unit which was a quarantined unit due to another resident, who resided on the unit, having tested positive for COVID-19. R3 required transmission-based precautions for a 14 day period due to a potential exposure to the COVID-19 illness. Precautions included the staff to wear a mask, eye protection and a gown when entering R3's room. R3 did not exhibit any acute respiratory symptoms and was not COVID positive. During observations on the Birch unit on 8/14/20, at 7:56 a.m. trained medication aide (TMA)-A entered room [ROOM NUMBER] wearing a gown. Upon entrance to the room TMA-A removed a gown from a hook inside the door and placed it on over her gown. When leaving the room, TMA-A removed the gown and placed it back on the hook inside the room. -At 8:03 a.m. an unknown nursing assistant (NA) was observed removing a gown by pulling it over her head with the neck still tied and hung it on a hook outside the nurses station. The NA then took the gown back off the hook and placed it over her head, again with the neck still tied. -At 8:06 a.m. NA-D entered room [ROOM NUMBER], removed a gown from a hook in the room and pulled it over her head with the neck already tied. -At 8:12 a.m. NA-E removed a gown from a hook inside a resident room, put the gown on in the hallway while talking to another staff member and returned to the room where the gown had been. Upon leaving the room, NA-E pulled the gown, still tied at the neck over his head and hung it back on the hook in the room. -At 8:16 a.m. registered nurse (RN)-A stopped at the entrance to room [ROOM NUMBER], removed a gown from a hook in the room and pulled it over her head. Upon leaving the room, RN-A pulled the gown back over her head and placed it back on the hook. -At 8:20 a.m. NA-E stated the gowns were being shared by staff throughout the day and were changed out on the overnight shift. When asked about education related to donning and doffing PPE, NA-E stated staff were probably not doing it correctly. Shortly thereafter, UM-B stated she had been on the floor all day the previous day. UM-B stated she had seen some of the staff pulling gowns on and off over their heads and stated she had educated those staff members as to the correct way to don/doff a gown. -At 8:19 a.m. NA-A was observed on the Elm unit, pushing a mechanical standing lift into R3's room. Upon entering the shared resident room, NA-A grabbed one of two, unlabeled gowns that were hanging side by side on hooks just inside the entrance of the room. With ungloved hands, NA-A proceeded to don the gown by grabbing the outside of the gown, threading her arms into the sleeves, and tied the gown ties to secure it at the neck and waist. NA-A stated the gowns hanging were to be shared and worn by all staff who entered the room and that the night shift changed the gowns every night. R3 was lying in bed. NA-A applied gloves, and assisted R3 to a seated position on the edge of the bed, applied the lift sling around R3's waist, positioned straps around R3's calves, fastened the waist lift straps to the lift and proceeded to stand R3 up. NA-A wheeled R3, in the mechanical stand, into the bathroom and onto the toilet. NA-A obtained an unlabeled wash basin from an unidentified closet and filled the basin with wash water. While R3 was seated on the toilet, NA-A washed R3's upper and lower body and dressed R3. Throughout the cares, and with the same gloved hands, NA-A was observed to grab her gown several times and pull it up over her shoulders, as it kept sliding down off her shoulder. While applying R3's pants and shoes, NA-A's gown brushed up against R3's bare feet and calves. Once dressed, NA-A stood R3 up with the mechanical stand and provided perineal care. During the perineal care, NA-A's gown came into direct contact with R3's bare hip. Following the cares, NA-A assisted R3 into her wheelchair. With the gown on, NA-A removed R3's wet, urine soiled, bed linens and placed them into a bag, tied the bag, and rinsed the wash basin and returned it to an unidentified closet. The soiled linen and basin were not noted to have direct contact with NA-A's gown. Neither the basin nor closet were labeled with a resident's name or bed. NA-A verified the gowns and basin were not labeled to identify for which resident they were to be used. When asked, NA-A confirmed the supplies could get mixed up and used for either resident but it was common knowledge that the closet closest to the door belonged to bed one except in one room on the Birch unit were it was just the opposite. NA-A stated she was unaware of any closets having been marked or identified with a resident name. NA-A stated the wash basins were disinfected one time weekly on the resident's bath days. -At 8:59 a.m. the regional nurse consultant stated the facility was using reusable gowns to conserve on their PPE. The regional nurse consultant stated the facility had a non-COVID related outbreak a few months prior and had received direction to re-use gowns, however, had not clarified the use of re-useable gowns during a COVID-19 outbreak. The regional nurse consultant stated the facility had been stockpiling reusable gowns and were utilizing them throughout the building. The regional nurse consultant stated the facility had a mixture of disposable and re-usable gowns but they were trying to conserve. She further stated the health department had supplied the facility with gowns. The nurse consultant stated the gowns were used throughout the day and were changed out on the overnight shift or when soiled. She stated the staff should not be donning and doffing the gowns by leaving them tied and pulling them over their heads and stated the

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.

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 1) department heads and unit managers were responsible for monitoring how staff were donning and doffing the PPE. -At 9:01 a.m. NA-B was observed on the Elm unit going from room to room delivering breakfast trays to the residents in their rooms. NA-B was observed to remove a shared gown off the hook from inside a resident's room. The neck ties of the gown were tied, therefore NA-B slipped the gown over his head and threaded his arms into the gown sleeves. NA-B applied gloves and entered the resident room to deliver the tray that another NA handed to him from the hallway. NA-B placed the tray on the over bed table, set up the meal, removed the gown, hung it back up on the doorway hook with the ties remaining tied. NA-B removed and discarded his gloves, and utilized hand sanitizer. NA-B was observed to repeat this process in three additional resident rooms, on the Elm unit. Throughout the observation, NA-B was not noted to secure the gown at his waist, rather the gown flowed freely when on. On 8/14/20, at 12:23 p.m. NA-C was observed standing next to and leaning over R4's bed to take his meal tray off the bedside table. NA-C wore a mask and face shield as required, however, was not wearing a gown. NA-C's uniform brushed up against R4's bed while she was speaking to R4. NA-C utilized hand sanitizer and exited the room. When asked, NA-C stated she thought she should have put on a gown before entering R4's quarantined room, but was not sure as the facility staff was not good at informing staff about that stuff. R4's clinical record revealed R4 had been hospitalized from [DATE] - 8/11/20, therefore was required to be on 14 day transmission based precautions and isolated to his room due to this recent hospitalization and subsequent return to the facility. Precautions included the staff were to wear a mask, eye protection and a gown when entering R4's room and in-room isolation. R4 did not exhibit any acute respiratory symptoms and was not COVID positive. On 8/14/20, at 3:33 p.m. NA-C stated she also worked at another facility and at that facility, she would apply a new gown each time she entered a resident room and discard the gown in the garbage. NA-C stated at this facility, the staff were using the same gowns all day with multiple people. NA-C asked, What if one of the staff have COVID-19 and now I am contaminated by using their gowns. I think it is so gross. NA-C also stated she had worked a couple of hours this shift before someone stopped her and told her she also needed to be wearing goggles. NA-C stated, They (staff) are so poor at explaining stuff. NA-C also stated she worked at this facility very part time, and prior to today, had not worked in a long time. Quarantined residents R2 had been hospitalized on [DATE] through August 7, 2020, and required 14 day transmission based precautions and in-room isolation for a 14 day period due to her recent hospitalization . Precautions included the use of a mask, eye protection and gown when entering R2's room. R2 did not exhibit any acute respiratory symptoms and was not COVID positive. On 8/13/20, at 12:24 p.m. ward clerk (WC)-C verified R2 was hospitalized [DATE] through August 7, 2020 and was under 14 day quarantine following the hospitalization . On 8/13/20, at 1:27 p.m. R2 was seated in a wheelchair in the main hall near the nurse's station. R2 had a cloth face mask on that covered her mouth, however the mask was not covering her nose. A staff member was observed to pass R2 and gave her a verbal reminder to pull her mask up over her nose. R2 replied the mask made it difficult for her to breathe. The staff member instructed R2 to remain in her room if she could not wear the mask properly. On 8/14/20, at 7:45 a.m. R2 was observed self-propelling in the facility hallways on Spruce unit. R2 had a cloth face mask on, however, the mask did not cover R2's nose. Several staff were observed to walk past R2, however, none of the staff directed R2 back to her room. -At 11:40 p.m. R2 was observed self propelling her wheelchair in the hallway on the lower level of the facility near the kitchen area. R2 was wearing a cloth mask over her mouth, however, the mask did not cover her nose. -At 3:33 p.m. R2 was observed in the main hallway of the first floor near the nurse's station, seated in her wheelchair. R2 was not wearing her face mask rather was holding it out, away from her face. Two staff members were observed to pass by her, but did not redirect R2 to put her mask on properly or to return to her room. R1 had been hospitalized [DATE] through August 13, 2020, therefore was on 14 day transmission-based precautions and in-room isolation. Precautions included the use of a mask, eye protection and gown when entering R1's room. R1 did not exhibit any acute respiratory symptoms and was not COVID positive. On 8/13/20, at 2:40 p.m. R1 was observed to be outside the facility's first floor dining area between the Elm and Birch units, near to two other residents. All three residents were seated in wheelchairs about two to three feet apart from each other smoking. When done smoking, R1 re-entered the facility through the dining room door and wheeled himself through the dining area, hallway, turned onto the Spruce unit hallway, touched the elevator button, and entered the elevator in order to return to his room on the second floor. R1 stated he had just returned from the hospital that morning. Upon reaching the second floor, R2 propelled himself down the hall, past the dining area and nurse's station and to his room. On the door of R2's room was a sign that indicated he was on enhanced respiratory precautions. R1 was observed to wear a face mask when not smoking. -At 2:47 p.m. licensed practical nurse (LPN)-A stated enhanced respiratory precautions indicated R1 was under a 14 day quarantine following a hospital return that morning. LPN-A stated when staff entered the room they were to wear a gown, gloves and face mask. LPN-A was asked why R1 was off the unit if he was supposed to be quarantined and stated the nurses manager had just spoken to him about leaving his room after he returned to the unit after smoking. On 8/14/20, at 9:08 am. the regional nurse consultant stated when a resident returned from the hospital they were placed under quarantine for 14 days and staff were to treat them as if they were positive for COVID-19, wearing a mask, gloves and gown when providing care. She stated residents were educated upon return from the hospital and should not be leaving their rooms. -At 9:52 a.m. the regional nurse consultant stated all of the residents except one who had tested positive for COVID-19 had resided on the Birch unit prior to moving to the designated COVID-19 unit. On 8/14/20, at 12:15 p.m. R1 was again observed seated in his wheelchair in front of the first floor activity office door. R1 wore a face mask. R1 stated he was waiting for the activity director to return as she had purchased his cigarettes and he needed them. There were no staff members present. The social worker was asked to assist and was observed to have a brief conversation with R1 in the hall. R1 then turned to go to the elevator. R1 stated the social worker told him she would get his cigarettes for him, but he was to return to his room because he was supposed to be quarantined. R1 self-propelled to the elevator to return to the second floor. -At 3:45 p.m. the director of nursing (DON) stated new admissions and residents who returned from the hospital were placed on a 14 day quarantine and were to remain in their rooms. The DON stated the staff were directed to wear a face shield, mask, gown and gloves when entering into a quarantined/isolation room. The DON stated the staff tried to keep R2 in her room, but she was non-compliant. The DON verified the staff were aware R1 and R2 were under quarantine and were expected to redirect a resident under quarantine/isolation back to their room if they were out and about within the facility. The DON verified allowing R1 and R2 to come out of their rooms and wheel throughout the facility was an infection control concern due to the potential of spreading COVID-19 if they were to test positive for the illness. The DON verified the staff did reuse gowns in quarantined resident rooms and confirmed the gowns were not disinfected between use but were replaced daily. The DON also confirmed additional COVID-19 test results were pending. The DON confirmed the gown hooks, and closets in shared rooms, were not labeled to identify which resident it belonged to rather the hook or closet closest to the door was meant for the resident in bed one which was by the door and the other was for bed two, the bed by the window. In regard to residents who required two staff for cares the DON stated that was up to the staff going into the rooms. The DON confirmed there was a potential [MEDICAL CONDITION] could be spread to staff and other residents based on the current staff practices. The DON further stated she was not aware of any shortage of PPE in the building and stated, we have been pretty well stocked. An Email letter sent to the families and residents of the facility, dated August 8, 2020, indicated the facility was following all guidance from federal, state and local health officials to limit the spread of the COVID-19 virus within the facility. A facility policy titled, Infection Prevention and Control COVID-19, revised 7/23/2020, indicated upon identification of symptoms there would be strict adherence to the use of standard, contact and droplet precautions. The policy indicated residents with known or suspected COVID-19 should be placed in a private room but indicated room sharing might be necessary if there are multiple residents with known or suspected cases. In the event of an outbreak the policy outlined the following: Place residents in private rooms on standard, contact and droplet precautions, PPE to include gloves, gowns and masks. The CDC recommendations recommended healthcare workers wear a gown to protect skin and prevent soiling or contamination of clothing during resident-care activities when contact with blood, body fluids, secretions, or excretions was anticipated. Remove the gown and perform hand hygiene before leaving the resident's room, and to not reuse gowns, ever for repeated contacts with the same resident. Disposable gowns should be discarded after use. Residents may remove their face mask when in their rooms but should put it back on when around others or leaving their room. Any reusable PPE must be properly cleaned, decontaminated, and maintained after and between uses. All new admissions and hospital returns should be quarantined in room for 14 days following admission. The immediate jeopardy that began on 8/1/20, was removed on 8/19/20, when the facility implemented an infection control plan to minimize the spread of COVID-19 which included procedures for the appropriate use and reuse of PPE by facility staff and procedures to ensure staff encouraged the appropriate use of face masks by residents when outside of their room for source control, encouraged resident social distancing, and limited resident wandering between designated hot (facility COVID cohort area), warm

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 2) (facility quarantine area) and cold units within the facility. The plan also included identification of additional separate smoking areas to accommodate each unit of the facility to ensure residents within the 14-day quarantine period, residents residing on a hot unit and residents residing on units not requiring quarantine restrictions did not travel through a unit with a different hot, warm or cold designation to reach their smoking area and limited potential exposure to each other. Staff were provided education regarding the infection control procedures and the facility established a daily auditing plan for PPE usage and 14-day quarantine in relation to smoking and source control.