STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245269	A. BUILDING _____ B. WING _____	05/08/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOOD SHEPHERD LUTHERAN HOME	1115 4TH AVENUE NORTH SAUK RAPIDS, MN 56379

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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure personal protective equipment (PPE) was worn consistently and handled in a manner to reduce the risk of cross-contamination by staff on 2 of 2 units observed (ACE, North Shore) during a complaint investigation and COVID-19 Infection Control Focused survey while staff were providing care for residents (R2, R3, R4). These findings had the potential to affect all residents residing in the facility, and staff. Findings include: R2's facesheet identified [DIAGNOSES REDACTED]. R2's quarterly Minimum Data Set (MDS), dated [DATE], identified R2 required extensive to total assistance with activities of daily living (ADLs). R3's facesheet identified [DIAGNOSES REDACTED]. R3's quarterly MDS, dated [DATE], identified R3 required extensive to total assistance with ADLs. During observation on 5/5/20, at 3:26 p.m. licensed practical nurse (LPN)-A exited R2's room, wearing gloves, blue disposable gown, surgical mask, and full face shield, shut R2's door with gloved hand on the door handle. While standing in the hallway, LPN-A doffed (took off) the gloves and disposable gown, and disposed of them into a designated personal protective equipment (PPE) garbage bin, using her foot to open. Without performing hand hygiene, LPN-A stood in the hallway, with her hands in her scrub shirt front pockets. LPN-A stated she did not perform hand hygiene because she was waiting to get keys from nursing assistant (NA)-A and was planning to re-enter R2's room and would wash her hands then. Without performing hand hygiene, LPN-A doffed her surgical mask and disposed into the same garbage bin. Still without performing hand hygiene, LPN-A opened the drawer of the isolation cart outside of R2's room with her bare hand, obtained a clean surgical mask, and donned (put on) the mask. Still without performing hand hygiene, LPN-A reached into her scrub pocket to retrieve a ringing portable phone. After a brief telephone conversation, LPN-A put the phone back into her pocket. LPN-A walked to R3's room. Nursing assistant (NA)-A exited R3's room into the hallway, wearing gloves, blue disposable gown, surgical mask, and full face shield. Without removing the gloves, NA-A pulled R3's door shut with gloved hand on the door handle, reached into his scrub pants front pocket, and grabbed the lanyard with keys hanging out of his pocket. Still with the gloved hand, NA-A handed the keys to LPN-A's bare hand. While holding the keys against her scrub top with her forearm, LPN-A performed hand hygiene with hand sanitizer from R3's isolation cart. During an interview on 5/5/20, at 3:41 p.m. registered nurse case manager (RNCM) stated she expected staff to perform hand hygiene upon doffing of PPE, and when exiting isolation rooms. During an observation on 5/5/20, at 3:59 p.m. LPN-A exited R3's room into the hallway, wearing gloves, blue disposable gown, surgical mask, and full face shield. Without removing the gloves, LPN-A pulled R3's door shut with gloved hand on the door handle. LPN-A doffed the disposable gown, then gloves, and disposed them into the PPE garbage bin. LPN-A performed hand hygiene with hand sanitizer, and donned new gloves. LPN-A doffed the mask, doffed the gloves, and disposed them into the PPE garbage bin. Without performing hand hygiene, LPN-A donned new gloves, and reached into her scrub pocket to retrieve the cordless facility phone. Without a mask on, LPN-A answered the phone. As she spoke, LPN-A donned a new mask. LPN-A was heard to instruct caller to call back in five minutes and she would bring the phone into a resident's room, so the resident could talk to the caller. NA-A explained the cordless facility phone is also for resident use. R4's facesheet identified [DIAGNOSES REDACTED]. R4 resided on North Shore unit where the resident were in quarantine due to other residents on the unit who had previously been diagnosed as positive for Covid-19 During an observation of the North Shore unit on 5/5/20, at 4:10 p.m. NA-B was sitting in a chair in R4's room, approximately four feet from R4's wheelchair, asking questions. NA-B wore a surgical mask, and was holding a face shield, in both hands, on his lap. After approximately three to four minutes, without performing hand hygiene, NA-B donned the face shield and walked out of R4's room. When interviewed on 5/5/20, at 4:16 p.m. NA-B indicated he was instructed to wear the face shield at all times, especially when in direct contact with residents. NA-B stated, I just get so hot. During the interview, perspiration was observed dripping down the inside of NA-B's face shield, from his forehead. NA-B stated he knew he shouldn't have taken his face shield off, especially in a resident's room, but was uncomfortable. During an observation on North Shore unit on 5/5/20, at 4:36 p.m. NA-C walked several feet in the hallway to where a group of staff were gathered with two residents. NA-C was wearing a surgical mask and carrying a face shield in her hands. When NA-C reached the group, she donned the face shield. When interviewed on 5/5/20, at 4:38 p.m. NA-C stated she had been in the charting room, had taken the face shield off, and put it back on when she came out into the hallway. NA-C stated she has been instructed to wear the faceshield at all times, but stated, It's so hot. During an interview on 5/5/20, at 4:45 p.m. registered nurse (RN)-B stated staff were expected to wear the face shields at all times. During an interview on 5/6/20, at 8:29 a.m. the assistant director of nursing (ADON) stated clinical staff had been completing audits of staff for several weeks, observing proper use of PPE and infection control practices. ADON stated staff seek answers to questions they have regarding situations that arise, and stated she had received several phone calls last weekend from staff with questions about specific scenarios, seeking direction. Review of the facility's Donning and Removing PPE (Droplet Precautions) audits, Hand Hygiene Audit, Donning and Removing PPE (Gown and Glove) audits, Assisting Residents with Hand Hygiene Audit, Hand Washing audits, and Extended Use of Facemask Audit, revealed numerous completed audits of numerous staff, from 3/30/20 through 5/6/20. The audits included documentation of opportunities for re-education of staff when needed. When interviewed via telephone on 5/6/20, at 11:09 a.m. the director of nursing (DON) and the ADON stated the expectation of staff included performing hand hygiene when doffing PPE, and all staff performing direct care were to be wearing face shields. DON stated there was no process in place for disinfecting the cordless facility phone that was shared by staff and residents. DON stated they would be consulting with the Infection Control Assessment and Control (ICAR) program and COVID case manager about doffing of PPE in resident's room versus in the hallway, and staff using goggles for eye protection rather than full face shields, for staff comfort. Review of the facility's policy, Transmission Based Precautions, revised 4/21/20, included, when removing PPE, remove gown and gloves, and perform hand hygiene. Review of the facility's policy, Extended Use of Eye Protection, dated 3/30/20, directed, Employee should take care not to touch their eye protection. If they touch or adjust their eye protection, they must immediately perform hand hygiene. Further, Employee should leave patient care area if they need to remove their eye protection. Review of the facility's policy, Extended Use of Facemask, revised 4/6/20, directed, If facemask is touched or adjusted immediately perform hand hygiene. Review of the facility's policy, Cleaning Procedure with suspected and positive COVID-19, dated 4/21/20, indicated, If shared equipment is unavoidable, nursing staff will clean shared equipment when it leaves the residents room. Based on observation, interview and document review, the facility failed to ensure personal protective equipment (PPE) was worn consistently and handled in a manner to reduce the risk of cross-contamination by staff on 2 of 2 units observed (ACE, North Shore) during a complaint investigation and COVID-19 Infection Control Focused survey while staff were providing care for residents (R2, R3, R4). These findings had the potential to affect all residents residing in the facility, and staff. Findings include: R2's facesheet identified [DIAGNOSES REDACTED]. R2's quarterly Minimum Data Set (MDS), dated [DATE], identified R2 required extensive to total assistance with activities of daily living

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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