| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **245439** | A. BUILDING _____ B. WING _____ | **06/22/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **CATHOLIC ELDERCARE ON MAIN** | **817 MAIN STREET NORTHEAST MINNEAPOLIS, MN 55413** |

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<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | **Provide and implement an infection prevention and control program.**<br><br>Based on observation and interview, the facility failed to ensure staff wore the appropriate personal protective equipment (PPE) and failed to ensure staff doffed (removed) PPE and place into appropriate receptacles according to Centers for Disease Control (CDC) and Centers for Medicare and Medicaid Services (CMS) guidelines for mitigating transmission of COVID-19. This had the potential to affect all residents on the transitional care unit. Findings include: Observation on 6/22/20, at 1:20 p.m., identified housekeeper (H)-A who removed trash on 2nd floor of the long term care unit. She was in the resident hallways and did not wear a face shield or goggles. She identified staff were not required to wear eye protection unless they went into a quarantined room. Observation and interview on 6/22/20, at 2:28 p.m., registered nurse (RN)-A was in the hallway of the 2nd floor long term care unit. He did not wear eye protection. RN-A identified all staff were required to wear a face shield or goggles when they went into every resident room. Staff were not required to wear eye protection in the hallways. Observation and interview on 6/22/20, at 1:59 p.m., with registered nurse (RN)-B identified she was in the hallway of the transitional care unit (TCU) and did not wear eye protection in the hallways and her respirator mask was around her right upper arm. RN-A identified staff were to wear eye protection when in direct contact with residents and when they provided care. There were three residents on quarantine in the TCU, Resident (R2) tested positive for COVID-19 and was asymptomatic. Observation on 6/22/20, at 2:26 p.m., of nursing assistant (NA)-A who exited R2's room, wore a gown, surgical mask and prescription eye glasses. She did not wear a face shied. NA-A exited the room and removed her gown in the hallway. NA-A draped the gown over her arm and carried it across the hallway and placed it in the soiled utility room linen bin. NA-A identified R2 was on quarantine status. NA-A said, gowns were hung on the inside of the doorway and used for an entire shift. At the end of the shift, gowns were removed from the rooms and placed in the soiled utility rooms to be laundered. Quarantined rooms had a blue sign on the door. PPE carts were not placed outside the rooms. Staff acquired PPE supplies from the soiled utility room. Staff wore face shields or goggles when they provided care to residents. NA-A identified she wore glasses while in the room. She had not worn a face shield and had not changed her mask prior to her exit from the room. Interview on 6/22/20, at 2:35 p.m., with RN-C identified staff were expected to wear eye protection at all times because there were several residents on quarantine status in the TCU. Interview on 6/22/20, at 5:00 p.m. with RN-D identified gowns were reused for a shift and stored in resident rooms. Staff were to bag the gowns prior to their exit of the room to transport to the soiled utility room for to be laundered. Interview on 6/22/20, at 3:57 p.m., with infection preventionist (IP)-A and the director of musing (DON) identified direct care staff were expected to wear a surgical mask and face shield. The exception to this would be if staff charted behind the nurse desk. Housekeeping staff were expected to wear a face shield and surgical mask while on the resident units. Gowns were reused in quarantine rooms and were changed at the end of each shift. IP-A expected staff to doff gowns and place them into clear trash bags to transport to the soiled utility room for laundering. |

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.