STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245433	A. BUILDING _____ B. WING _____	**04/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SYLVAN COURT	**112 ST OLAF AVENUE SOUTH CANBY, MN 56220**

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.** Based on observation, interview and document review, the facility failed to ensure staff were actively screened at the point of entry in accordance with Centers for Disease Control (CDC) and Centers for Medicare and Medicaid Services (CMS) guidelines for COVID-19. This had the potential to affect all 47 residents in the facility. Additionally, the facility failed to maintain appropriate infection control practices for mechanical lift slings between multi-resident-use for 1 of 6 residents (R1) and hand hygiene after personal cares for 1 of 1 resident (R1). Findings include: SCREENING Observation on 4/8/20 at 9:00 a.m., identified the entrance to the facility was located on the north side of the building. The entrance was composed of a glass exterior entry door, a small entrance area, and an interior door opening into the facility. The exterior door was locked and signs were posted at the entrance restricting visitors and directed people to enter through the adjacent clinic entrance. A thermometer and binder sat on a table placed in the entryway. Interview on 4/8/20 at 10:00 a.m., licensed practical nurse (LPN)-A identified staff enter the building at the front entrance on the north side of the building and self- screen for signs and symptoms of COVID-19 before entering the facility. Staff were to take their own temperatures and complete the questionnaire. If they had symptoms or a temperature, staff were to notify the nurse inside the facility. Interview on 4/8/20 at 10:05 a.m., with housekeeper (H)-A identified staff were to enter the facility through the north entrance take their own temperature and record it in the log located in the front entrance. If they had symptoms, they were to notify the nurse in the facility and refrain from work. Interview on 4/8/20, at 10:05 a.m., with nursing assistant (NA)-A identified staff enter through the front entrance of the facility and screen themselves for COVID-19 symptoms prior to entering the building. A thermometer and sign-in sheet were on a table at the front entrance. Interview on 4/9/20 at 8:42 a.m., with the director of nursing (DON) identified The DON was unaware staff needed to be actively screened at the point of entry by another staff person prior to being allowed into the facility to prevent potential exposure of COVID-19 to all residents. Review of the 3/16/20, Temperature Checks for Staff COVID-19 Symptom Screening policy identified staff were to take their temperature at the beginning and end of their shift and record the information in the binder in the facilty's designated entry. All staff were to self-monitor for symptoms on an ongoing basis and notify their manager for further direction if symptoms were identified. INFECTION CONTROL Observation on 4/8/20, at 10:10 a.m., identified a total lift with a (mesh fabric) sling hanging hanging on the hand grips. NA-A brought the left into R1's room. NA-A placed the sling under R1. NA-B hooked the sling onto the lift and transferred R1 onto the commode. Once R1 finished toileting, R1 was assisted off the commode. NA-A donned gloves and assisted R1 with personal hygiene care. R1 was lowered into her wheelchair. Without removing the gloves, and performing hand hygiene, NA-A positioned the wheelchair under R1 using the wheelchair handles. R1 was lowered into the wheelchair. While wearing the same contaminated gloves, NA-A detached the sling loops from the lift and placed the contaminated sling onto the lift. While wearing the same gloves used to perform peri cares, NA-A moved R1's personal belongings and placed them on R1's table tray. NA-A removed her gloves and without performing hand hygiene, donned a new pair of gloves, emptied the commode, and disinfected the commode. NA-B used a disinfectant wipe to disinfect the lift's hand grips and control panel. NA-B removed the lift and mesh sling from the room and placed the lift into the storage area with the contaminated mesh sling. Interview on 4/8/20 at 10:20 a.m., with NA-B identified sling was used for 4 other residents and was not laundered after transferring R1 between use. Interview on 4/8/20 at 10:35 a.m., with NA-A identified staff were to perform hand hygiene before and after resident cares and after removing gloves. She had not removed her gloves after performing R1's personal care because R1 had no bowel movement. 4 residents used the sit to stand lift for transfers. Residents did not have dedicated lift slings. The sling was used multiple times during the day for the 4 residents. The same sling had been used for all 4 residents. The slings were only laundered washed when they became visibly soiled. NA-A had asked management about having dedicated slings to use for the residents and was told there was not enough slings for each resident. Interview on 4/9/20 at 9:28 a.m., with the infection control preventionist (ICP) identified she expected staff to follow appropriate hand hygiene after removing gloves. Gloves should be removed and hand hygiene performed after provision of person care and before touching high contact areas and equipment shared between residents. The ICP agreed slings needed to be appropriately laundered between multi-resident use. Interview on 4/9/20 at 8:42 a.m., with the director of nursing (DON) identified she expected staff to follow infection prevention policies and procedures during the above observations. Staff were to remove gloves and perform hand hygiene after performing personal care and touching high touch areas and equipment used between residents. The slings were not dedicated equipment to each resident. There was no policy or procedure in place for routine laundering of mesh slings. Review of the 7/11/18, Hand Hygiene Policy and Procedure identified hand hygiene was to be performed after contact with a patient's intact skin, body fluids or excretions, and mucous membranes if hands were not visibly soiled. Hand hygiene was to be performed after contact with contaminated surfaces, objects, medical equipment in the immediate vicinity of the patient. Hand hygiene was to be performed after removing gloves. There was no policy or procedure related to laundering mesh slings between resident use.

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