STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245610	A. BUILDING _____ B. WING _____	09/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ST GERTRUDES HEALTH & REHABILITATION CENTER	1850 SARAZIN STREET SHAKOPEE, MN 55379

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 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to report an allegation of staff to resident abuse to the State Agency (SA) within two hours of the allegation for 1 of 3 residents (R3) reviewed for allegations of abuse by a staff member. Findings include: R3's quarterly Minimum Data Set (MDS), dated [DATE], noted R3 had a Brief Interview Mental Status (BIMS) score of 14 out of 15, indicating her memory and cognitive abilities were intact. The MDS indicated R3's relevant medical [DIAGNOSES REDACTED]. The MDS further indicated R3 required extensive assistance by staff for bed mobility, transfers, toileting, and hygiene. R3's care plan, dated 1/9/20, and edited 5/11/20, identified R3 as a vulnerable adult needing assistance to stay safe in the community because of her progressive supranuclear opthonoplegia. R3's care plan further directed the facility to report and investigate any allegations of suspected abuse. During an interview on 9/9/20, at 10:30 a.m., registered nurse (RN)-A reported R3 told nursing assistant (NA)-C the night aid was a little rougher than usual when rolling her in bed to change her adult incontinence product. RN-A further stated this led to bruises in R3's inner thighs. RN-A reported this incident to RN-C, who asked RN-A to write a summary of the incident. RN-A's written statement, dated 8/25/20, indicated R3 reported to RN-A the night aide was too rough when rolling R3 to change her adult incontinent product in bed. RN-A further wrote R3 had bruising bilaterally to her inner thighs with a small dark bruise and two smaller light green/blue bruises on the right inner/mid-thigh and 2 small, light green/blue bruises on the left inner thigh. RN-A reported to RN-C and the director of social services (DSS). R3's progress note, dated 8/25/20, indicated RN-A notified the assistant director of nursing (ADON)-B and the DSS about the incident on 8/25/20. During an interview on 9/10/20, at 10:47 a.m., ADON-B verified R3 reported to her the night aide handled her roughly when the aide turned R3. ADON-B confirmed if a resident complained about being handled roughly, it would be reported to the SA. ADON-B confirmed R3's allegation was not reported to the SA. During an interview on 9/10/20, at 2:45 p.m., the director of nursing (DON) verified the expectation was all allegations of abuse be reported immediately to the SA. The online Facility Reported Incidents (FRI) listing was reviewed on 9/10/20, and lacked any evidence of R3's allegation of abuse, which was reported to ADON-B on 8/25/20. The facility Abuse Prevention Plan, dated 1/22/20, identified the facility would contact the Minnesota Department of Health (MDH) immediately upon receiving a report of possible abuse.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to thoroughly investigate an allegation of staff to resident abuse for 1 of 3 residents (R3) reviewed, each who had alleged staff to resident abuse. Findings include: R3's quarterly Minimum Data Set (MDS), dated [DATE], indicated R3's memory and cognitive abilities were intact. The MDS indicated R3's relevant medical [DIAGNOSES REDACTED]. The MDS further indicated R3 required extensive assistance with bed mobility, transfers, toileting, and hygiene. R3's care plan, dated 1/9/20, and edited 5/11/20, identified R3 as a vulnerable adult needing assistance to stay safe in the community because of her progressive supranuclear opthonoplegia. R3's care plan further directed the facility to report and investigate any allegations of suspected abuse. During an interview on 9/9/20, at 10:30 a.m., registered nurse (RN)-A reported R3 told nursing assistant (NA)-C the night aide was a little rougher than usual when rolling her in bed to change her adult incontinence product. RN-A further stated this led to bruises in R3's inner thighs. RN-A reported this incident to RN-C, who asked RN-A to write a summary of the incident. During an observation on 9/9/20, at 3:30 p.m., R3 pointed to her inner thighs and rubbed her hands on her legs, from upper inner thigh to lower inner thigh, stating this was where she was hurt. There were no signs of bruising on either thigh. There was also no evidence of bruising on either arm. During an interview on 9/9/20, at 3:25 p.m., with R3 and her family (F)-A in R3's room, R3 was alert and oriented. F-A stated the facility called to inform them R3 had bruising that occurred at night when staff were changing R3's adult incontinence product. F-A stated R3 said most staff were good but one or two were rough. R3 interrupted the F-A and stated one or two staff were not rough and the rest of the staff were rough. R3 further stated the night aide grabbed her thighs to turn her. R3 reported she told NA-C about the incident the morning after it happened. During an interview on 9/10/20, at 1:29 p.m., NA-C stated she clearly remembered the day R3 reported being handled roughly by the previous night shift's nursing assistant. NA-C stated the bruises looked fresh. The bruises on the right leg looked like well-defined fingerprints and the left leg was one big bruise. NA-C stated she had worked with R3 for six months and this was the first time R3 complained about anything. NA-C further stated this was the first time she had seen bruising on R3's legs. During an interview on 9/10/20, at 2:02 p.m., RN-A stated R3's bruises were not present two days before RN-A was informed about them. When RN-A observed the bruises on 8/25/20, the ones on the right were purplish and the ones on the left were more faint and yellowish. The facilities investigative documents, dated 8/25/20, included written statements from NA-C, RN-A, and RN-C's notes from her interview with R3. RN-C's interview note with R3, dated 8/25/20, noted R3 told RN-C, last night the girl bruised me. NA-C and RN-A's notes both reported R3's allegation the night aide was rough and bruised her. The investigative file failed to include a review of the schedule to determine who had worked with R3 the night before, interviews with potential alleged perpetrators (AP), or other staff who worked the night shift with potential AP. The investigative file indicated the facility only interviewed two other residents, who were independent with cares; the facility failed to interview residents who required extensive assistance with activities of daily living. R3's progress note, dated 8/25/20, stated R3 reported bruising happened overnight during changing of R3's adult incontinence product and repositioning in bed. The progress note indicated RN-A notified the assistant director of nursing (ADON)-B and the director of social services about the incident on 8/25/20. During an interview on 9/10/20, at 10:47 a.m., ADON-B verified R3 reported to her the night aide handled her roughly when the aide turned R3. ADON-B verified she did not interview any night shift staff or attempt to identify an AP as she believed R3's bruises were old and she did not know which night the bruising happened. During an interview on 9/10/20, at 2:45 p.m., the director of nursing (DON) verified the expectation was all allegations of abuse be thoroughly investigated. The facility policy Abuse Prevention Plan, dated 1/22/2020, identified the facility would investigate all allegations of abuse. It further stated measures would be taken to identify the source of alleged abuse.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** Based on observation, interview, and document review, the facility failed to ensure staff were wearing face masks and eye protection to reduce likelihood of COVID-19 transmission within the facility, which could affect all 96 residents. Findings include: On 9/9/20, the following observations were made at the identified times: - At 8:05 a.m., Wellness Coordinator (WC)-D entered the building then proceeded to the desk, was screened, donned a surgical mask and proceeded down 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** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) hallway. WC-D did not have eye protection even though he went to resident care areas. - At 11:00 a.m., registered nurse (RN)-B wore a surgical mask but her face shield was hanging on her arm near the second floor nursing desk. - At 11:00 a.m., licensed practical nurse (LPN)-B wore a surgical mask but had no eye protection near the second floor nursing desk. - At 11:15 a.m., WC-D wore a surgical mask but no eye protection in the first floor long-term care (LTC) dining area while standing within six feet of resident (R)-9's room. R9 was unmasked and sitting inside the door threshold, facing into the dining area. - At 11:32 a.m., RN-A wore a mask down under her chin and no eye protection while eating a banana at first floor LTC nursing desk. Doorways into resident rooms were within six feet of the nursing desk. - At 12:05 p.m., the assistant director of nursing (ADON)-A wore a mask but no eye protection at the first floor LTC nursing desk. Two unidentified residents were within six feet of the ADON-A in wheelchairs, one with a mask and one without a mask. - At 12:06 p.m., nursing assistant (NA)-B wore a mask but no eye protection and entered R10's room in the first floor LTC unit. - At 12:00 pm., dietary aide (DA)-A entered R11's room on the second floor with a tray of food. DA-A exited R11's room, picked up another food tray, and took the tray into R12's room. DA-A did not perform hand hygiene between residents. DA-A wore a mask but no face shield. Upon interview, DA-A stated he usually wore a face shield when he entered residents' rooms and he forgot it. DA-A left the area and returned wearing a face shield. -At 12:15 p.m., RN-B and LPN-A entered R2's room on the second floor. RN-B wore a mask but her face shield was hanging from her arm. While LPN-A wore a mask and eye protection, and performed hand hygiene upon exiting the room; RN-B did not perform hand hygiene. Both RN-B and LPN-A were within six feet of R2. - At 12:30 p.m., the ADON-A wore a mask but no eye protection while she walked through the LTC dining area on the first floor with six unidentified residents present. ADON-A walked beween tables and came within six feet of four residents. - At 12:47 p.m., WC-D walked through the long-term care unit with mask on and faceshield in hand; she stopped to ask an unidentified resident eating in the hallway if anything was wrong. The resident was not wearing personal protective equipment. WC-D leaned within two feet of the resident's face to hear the resident. The resident coughed and WC-D patted the resident on the back, stated she was just checking, and proceeded down the hallway. WC-D was not observed to perform hand hygiene. - At 1:20 p.m., NA-A wore a mask below his chin and eye protection when he exited R6's room on second floor. R6 was in the room. - At 3:00 p.m. WC-D was sitting next to an unidentified resident two to three feet away, assisting with a bingo activity wearing surgical mask, corrective glasses, and no face shield. On 9/10/20, the following observations were made at the identified times: - At 8:50 a.m., in the first floor LTC dining area, DA-B wore a mask but no eye protection while he dished food from large pots to individual residents' trays. Residents were in the hallway and in the dining area. - At 8:50 a.m., in the first floor LTC dining area, WC-D wore a mask but no eye protection while she placed drinks on residents' trays, which she the handed to other staff to deliver to residents. Residents were in the hallway and in the dining area. - At 8:55 a.m., trained medication aide (TMA)-A wore a mask but her eye goggles were on the top of her head while she prepped medication at the medication cart in the first floor LTC dining area. Several residents were in the dining area eating without masks. TMA-A was less than six feet from R7 and R8, who were eating and were not wearing masks. - At 8:58 a.m., TMA-A wore a mask but her eye goggles were still on the top of her head when she entered R8's room with medications in her hand. TMA-A exited the R8's room without medications and did not perform hand hygiene when exiting the room. - At 9:35 a.m., occupational therapist (OT)-A, wore a mask and goggles and entered R9's room on first floor in the transitional care unit. OT-A then donned gown and gloves without first performing hand hygiene; R9 was in contact precautions. - At 9:50 a.m., OT-A doffed her gown and gloves but did not perform hand hygiene. OT-A immediately typed on a laptop which was on a rolling stand in the hallway, just outside of R9's room. - At 10:02 a.m., TMA-A wore a mask but her eye goggles were still on the top of her head when she entered R9's room with medications. TMA-A exited the room without medications and did not perform hand hygiene. - At 11:07 a.m., the director of social services (DSS) wore a mask but no eye protection. DSS stated she just came from a resident room. - At 1:30 p.m., WC-D wore a mask but no eye protection while assisting two different residents during Bingo in the first floor LTC dining room. At times, she was within six feet of both residents. During an interview on 9/9/20, at 9:10 a.m., Infection Preventionist (IP)-E stated staff do not wear a mask when they enter the building. IP-E further stated staff enter, are screened, then receive a new mask for the day and proceed to the area where their face shield is located. During an interview on 9/9/20, at 10:49 a.m., the facility administrator stated staff are not expected to be wearing any PPE when they enter the building. The administrator further stated staff are expected to maintain social distance and don a surgical mask after screening. The administrator stated all staff are expected to wear a mask and faceshield if less than six feet from a resident. The administrator further stated dietary staff would be required to wear a mask and faceshield if they are entering the unit. During an interview on 9/9/20, at 3:03 p.m., WC-D was in the resident dining room, wearing a mask and eyeglasses. WC-D further stated she should wear a face shield when doing direct care with the residents, and when coming within six feet of a resident in their room, such as when doing 1:1 visits or filling out a menu for the week. During an interview on 9/10/20, at 10:23 a.m., ADON-B was observed wearing a mask but no eye protection. ADON-B stated her expectation for staff was to wear PPE appropriately - surgical mask at all times and eye protection if within six feet of residents. ADON-B stated staff did not need eye protection in resident rooms if staff stayed six feet away from resident. During an interview on 9/10/20, at 10:30 a.m., ADON-A was observed wearing a mask but no eye protection. ADON-A stated her expectation was for staff to wear PPE the right way every day, all shifts and all days of the week. ADON-A stated her expectations included hand hygiene and following precautions. ADON-A stated all staff were supposed to come into the facility wearing a mask. Every staff was supposed to wear a mask when entering a resident room and wear eye protection if within six feet of a resident in the resident room. The facility's Guidance on Personal Protective Equipment (PPE) policy, revised August 19, 2020, directed for associates, surgical masks and eye protection were placed at the beginning of the shift and removed at the end of the shift. The facility's Guidance on Personal Protective Equipment (PPE) policy, revised August 19, 2020, did not reflect current standards related to use of face shields in LTC facilities as guided by the Centers for Disease Control (CDC) and Minnesota Department of Health (MDH)'s LTC Toolkit. This facility's policy guided nursing, wellness, and therapy associates to implement use of a face shield only during resident care encounters.