STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	04/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

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 observation, interview and document review the facility failed to implement the Centers for Medicare and Medicaid Services (CMS) 3/13/20 QSO-20-14-NH for restricting communal dining, 3/20/20 QSO-20-20-All for screening of visitors and staff at the entrance of the facility and requirement for cleaning of shared equipment, 4/2/20 COVID-19 Long Term Care Facility Guidance for daily monitoring of resident temperatures, symptoms and utilization of source control masks. This had the potential to affect all 56 residents, staff and visitors of the facility. Findings include: On 4/9/20, at 9:00 a.m. at the time of entrance, facility staff opened the doors and instructed surveyors that screening was done at the 2nd floor nurse's station which was down the hallway past resident rooms and dining area. Although QSO-20-20-All recommended screening of all staff and visitors at the entry of a facility and source control masks be worn, the staff opening doors to the facility were not wearing a source control mask, nor was symptom screening or temperature taken at the entrance. Surveyors walked past a few resident rooms, past the dining area which had dirty dishes on the table with place settings directly next to each other and across the table, indicating communal dining. Surveyors were asked by a nurse to sign a log and indicate any respiratory concerns. The nurse used an ear probe thermometer and was wearing a source control mask. During this exchange, the head of maintenance greeted surveyors and lacked a source control mask. On 4/9/20, at 9:22 a.m. an entrance conference/meeting was conducted with the director of nursing (DON) and the administrator (ADMIN). Neither was wearing a source control mask. The DON stated the facility was continuing with communal dining and was not social distancing in the dining room, however, residents were restricted to the floor they lived on. DON explained implementation of the CDC recommendation to feed residents in their rooms would place a big strain on the facilitiy's staff and would be to the detriment of residents. Further, DON stated the guidance from the QSO memos were more of a recommendation, not a regulation. During a subsequent interview, at 9:29 a.m. the DON stated staff and visitors were directed to the 2nd floor nursing station to complete the screening tool and have their temperature taken by nursing staff. Staff that worked on 3rd floor were screened at the 3rd floor nurses' station and 1st floor staff were screened at the 1st floor nurses' station. The facility did not complete the screening process at the entrance of the facility. During an observation on 4/9/20, at 11:27 a.m. certified nurse assistant (CNA)-A entered room [ROOM NUMBER] with the standing lift and closed the door. CNA-A exited the room, with the lift and placed in the hall, she re-entered the room and brought out a dirty linen bag, placed it in the soiled utility room and proceeded to perform hand hygiene. During a subsequent interview, CNA-A stated the lifts were shared between residents and required cleaning after each use. Further, CNA-A stated she had not cleaned the lift after it had been used in room [ROOM NUMBER]. CNA-A was not wearing a source control mask. During constant observation on 4/9/20, at 11:58 a.m. CNA-B entered room [ROOM NUMBER] with the standing lift and closed the door. CNA-B exited room [ROOM NUMBER] with the lift and proceeded to room [ROOM NUMBER] without cleaning the lift. CNA-B entered room [ROOM NUMBER] and closed the door. At 12:09 p.m. CNA-B exited room [ROOM NUMBER] with the standing lift and placed it in the hall. CNA-B retrieved the resident from the room and transported her to the dining room. During a subsequent interview, CNA-B stated residents share lift slings and was not aware of the cleaning process for them. However, cleaning of the lifts happened at night. CNA-B was not wearing a source control mask. During an interview on 4/9/20, at 11:35 a.m. infection preventionist (IP) was not wearing a face mask and stated stand lift users shared harnesses and harnesses were laundered between each use. IP stated lifts were not cleaned after each use and housekeeping was alerted to clean lifts when visibly soiled. IP stated the facility utilized a computer based monitoring system for tracking of infections and for symptoms of COVID called ABX Tracker. However, documentation lacked evidence that resident temperatures were taken daily as was recommended by CDC QSO-20-20-All. During an interview on 4/9/20, at 12:14 p.m. housekeeping (HSK)-A was not wearing a face mask and stated lifts were cleaned once a week on each floor and when requested by staff. However, HSK-A stated her practice was to wipe down high touch areas of the lift when she passed by. QSO-20-20-All directed cleaning of shared equipment after resident use and was not being followed. During an interview on 4/9/20, at 11:46 a.m. register nurse (RN)-A was not wearing a face mask and stated vital were taken twice everyday for residents receiving skilled services. During an interview on 4/9/20, at 12:38 p.m. RN-B was wearing a face mask and stated residents vitals were not taken everyday. However, if staff suspected symptoms, they were to report to the nurse manager. RN-B stated there were no current residents with any respiratory issues. Further, RN-B stated staff were not expected to wear face masks, nor would the facility provide them. However, wearing a mask provided RN-B comfort. During an interview on 4/9/20, at 12:43 p.m. RN-C was not wearing a mask and stated the leadership team monitored residents' condition by discussing newly documented symptoms at daily morning meeting. During an interview on 4/9/20, at 12:45 p.m. CNA-C stated staff verbally reported any new symptoms of coughing or sneezing by residents to the charge nurse. However, there was no current respiratory issues on the floor. Further, CNA-C was not wearing a source control mask. CNA-C stated staff was screened at the beginning of a shift and it was an option for staff to wear a face mask and there was a supply of homemade masks at the nurses' station. During an interview on 4/9/20, at 12:50 p.m. CNA-D stated it was not the expectation to wear a face mask while on duty. However, she kept one in her uniform pocket to don when performing personal cares. Further, CNA-D stated today was the first day she had a homemade mask but was not aware of how to launder it. During an interview on 4/9/20, at 12:55 p.m. licensed practical nurse (LPN)-A stated residents were monitored for symptoms of cough, shortness of breath, and temperature. However, temperatures were not taken daily on every resident, nor were possible symptoms being recorded. However, if a resident had a temperature, they would be isolated and precautions would be implemented. LPN-A was not wearing a source control mask and stated homemade masks were available if staff wanted to wear them. Further, LPN-A stated all staff were screened at the beginning of their shift at the nurses station located on the floor they were assigned to. During an interview on 4/9/20, at 1:10 p.m. DON stated all staff were screened for temperature, cough, or respiratory concerns at the beginning of their shift at the nurses' station on the floor they were assigned to. DON stated the facility practice was to send staff home when they presented with a temperature and follow up the next day. Further, DON stated it was up to the individual if they wanted to wear a face mask. However the facility would not provide one. DON stated she was aware of CDC recommendations but felt they were recommendations not regulations. The facility's COVID-19 Policy & Procedure, dated 3/27/20, directed All staff plays an essential role in the prevention of transmission of infectious disease and will be responsible for meticulous infection control practices as well as daily screening for illness. The policy lacked specific information as to who, what, and when the screening process included. The policy lacked direction related to screening of employees for COVID-19 symptoms and risk prior to entering the facility. The policy lacked direction related to communal dining. The policy lacked direction for equipment cleaning. The policy indicated Per updated CDC guidance, it may be prudent for all individuals to wear cloth/masks/face coverings when in community settings. All employees have the right to wear a mask or other face covering, as they prefer.

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.