STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	**08/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AUGUSTANA HCC OF APPLE VALLEY	**14650 GARRETT AVENUE APPLE VALLEY, MN 55124**

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 -** Few	**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 proper infection control measures were implemented to prevent cross-contamination; including lack of appropriate hand hygiene and glove use during cares, transfers, and during the use and handling of medical supplies and equipment, for 2 of 3 residents (R1, R2) who were observed during personal cares. Findings include: R1's quarterly Minimum Data Set ((MDS) dated [DATE], identified intact cognition based on a Brief Inventory of Mental Status (BIMS) score of 15. R1 relied on extensive assistance from staff for transfers, dressing, and toileting. R1 had [DIAGNOSES REDACTED]. R1's physician orders [REDACTED]. During continuous observation on 8/12/20, at 10:00 a.m. R1's hallway bathroom call light was blinking. Nursing assistant (NA)-A entered R1's room and put gloves on. A soiled incontinence brief was rolled up and located on R1's wheelchair seat cushion. NA-A removed the brief and placed it in the trash can. NA-A assisted R1 into a standing position. NA-A proceeded to wipe R1's bottom with a disposable washcloth. NA-A kept the same soiled gloves on for peri care and proceeded to pull up R1's clean brief and pants. R1 turned and sat in her wheelchair. NA-A tied R1's waist band. Without first removing his soiled gloves, NA-A grabbed the handles of R1's wheelchair and positioned the wheelchair so it was facing the sink. R1 had oxygen tubing, nasal cannula (NC) (part of oxygen tubing where one end splits into two prongs which are placed in the nostrils) draped over the handle. R1's NC fell off the wheelchair handle and onto the floor. NA-A stepped on the NC with his shoe, moved his foot then picked the NC up off the ground with the same soiled gloves on, and draped the NC back over the wheelchair handle. NA-A then removed the gloves and placed them in the trash can. R1 had not performed hand hygiene (HH). NA-A grabbed onto the contaminated wheelchair handles and NC and maneuvered R1's wheelchair out of the bathroom. NA-A exited R1's room and had not yet completed HH. NA-A next opened the door to a storage room in the hallway on 2nd floor, grabbed a handful of clean gloves out of a box and put the gloves in his shirt pocket. NA-A walked past the hallway hand sanitizer machine by the nurses station and was observed to go into R3's room, touched R3 on the right shoulder with his hand, rubbed R3's back and secured the call light tighter on R3's wheelchair handle with his soiled hands. NA-A exited R3's room. NA-A had not performed HH before entering R3's room nor exiting. When interviewed on 8/12/20, at 10:12 a.m. nursing assistant (NA)-A stated he was supposed to perform HH after resident cares. NA-A stated he did not do HH during or after R1's cares because there was no hand sanitizer in the room. NA-A stated he could have used the sink to wash his hands but forgot. NA-A stated the oxygen tubing was scheduled to be changed this weekend. NA-A was unable to comment when asked if it was acceptable to put the NC back on the wheelchair after it had fallen on the ground and been stepped on. When interviewed on 8/12/20, at 10:38 a.m. licensed practical nurse (LPN)-A stated oxygen tubing was changed once a week on Sunday nights. LPN-A stated it was unacceptable to not perform HH before, during, and after cares. LPN-A stated it was unacceptable to put dirty NC tubing back on a resident's wheelchair handles for use. LPN-A stated the expectation would be to tell the nurse and they would replace the tubing if it became contaminated. LPN-A then went to change the NC for R1. R2's significant change MDS dated [DATE], identified R2 had modified independence for with daily decision making. R2 required extensive assistance from staff for bed mobility, transfers, dressing, and toileting. R2 required supervision with walking in room. R2 had [DIAGNOSES REDACTED]. R2 required oxygen therapy. During continuous observation on 8/12/20, at 10:42 a.m. R2's room had wrinkled linen and towels laying in a pile directly on the floor between the bed and the bathroom. R2 had been weighed on the hallway scale and was brought back to the room in her wheelchair by nursing assistant (NA)-B. With bare hands, NA-B grabbed a plastic bag from the garbage can in R1's room, picked up the wrinkled linens from the floor, rolled up the linens while holding them against her scrub top, and placed the soiled linen in the bag. NA-B tied the bag and set it back on the floor. NA-B did not perform HH. NA-B held onto R2's arm and assisted R2 with a transfer from wheelchair to bed. NA-B put socks on R2's feet and left the room and stated she was going to get a warm blanket from the storage unit in the hallway. NA-B exited R2's room without first performing HH. NA-B then opened up the storage unit door in the hallway, opened the blanket warming device door, grabbed a warmed blanket and re-entered R2's room. NA-B had not performed HH upon re-entering. NA-B came back with a warm blanket and positioned the warm blanket over R2. NA-B then picked up some soiled-tissues from R2's bedside table and put them in the garbage can. NA-B moved the bedside table to be near R1. NA-B picked up R2's water mug by the lip and moved it within reach of R2. NA-B then removed the garbage bag that contained the used tissues, tied it, picked up the bag of dirty linen from the floor and exited the room to put the bags in the hallway soiled utility rooms without first washing her hands. NA-B then touched the door handle of the soiled utility room. NA-B proceeded to wash her hands after entering the soiled utility room. When interviewed on 8/12/10, at 10:53 a.m., NA-B stated she had to do the cares quick for R2 and didn't have time to bag the linen. NA-B stated HH was done before resident cares and when exiting resident room. NA-B was unable to comment on the practice for HH after picking dirty linen up from the floor. When interviewed on 8/12/20, at 10:54 a.m. licensed practical nurse (LPN)-B stated dirty linen should always go in a bag after being used and HH should be done after picking something up off the floor and before moving on to resident cares. On 8/12/20, at 11:00 a.m. the infection preventionist (IP) stated the expectation was soiled linen should be bagged and not left on the floor. HH needs to be performed when cares go from dirty to clean; and before and after gloving. A NC should be replaced immediately if it was on the floor or stepped on. IP stated the unit managers had completed ten audits weekly on HH and they were at approximately 85% compliance. On 8/12/20, at 12:00 p.m. the director of nursing (DON) nodded in agreement with the IP's expectations. The facility Hand Hygiene policy dated 10/2/18, identified hand washing/sanitizing was necessary before and after providing care to resident, after removing gloves, when hands are visibly soiled, after each resident contact, and after touching environmental surfaces or equipment near residents. The facility orientation form titled Linen and Garbage Collection, undated, identified soiled linen should never be put on the floor as this would contaminate the floor. Then germs could be carried to other areas of the building and equipment would be contaminated. Soiled linen was to be bagged on the bed.

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