P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
August 20, 2020

Administrator
Benedictine Health Center Of Minneapolis
618 East 17th Street
Minneapolis, MN 55404

RE: CCN: 245266
Cycle Start Date: June 23, 2020

Dear Administrator:

On August 14, 2020, the Minnesota Department(s) of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 20, 2020

Administrator
Benedictine Health Center Of Minneapolis
618 East 17th Street
Minneapolis, MN 55404

RE: CCN: 245266
Cycle Start Date: June 23, 2020

Dear Administrator:

On June 23, 2020, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" tag) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Sarah Grebenc, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: sarah.grebenc@state.mn.us
Phone: (651) 201-3792
Fax: (651) 215-9697

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by September 23, 2020 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by December 23, 2020 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118   Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245266	A. BUILDING ______ B. WING ______	06/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE HEALTH CENTER OF MINNEAPOLIS	618 EAST 17TH STREET MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A COVID-19 Focused Infection Control survey was conducted 6/23/20, at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations § 483.73(b)(6). The facility was in compliance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is requires, it is required that the facilty acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control survey was conducted 6/23/20, at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was not in compliance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Upon receipt of an acceptable electronic POC, an revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		8/7/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 07/27/2020

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 880	Continued From page 1	F 880		

§483.80 Infection Control
The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:

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F 880	Continued From page 2 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement recommended COVID-19 infection control procedures for the use of personal protective equipment(PPE) including eye protection for 12 of 12 residents (R4, R5, R6, R7, R8, R9, R10, R11, R12, R16, R17 and R18) who required eye protection worn by staff with direct contact with residents. In addition, the facility failed to ensure equipment was sanitized between 3 of 3 residents (R13, R14 and R15) observed during	F 880	SS: F 1. Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? • All residents 2. How will you identify other residents having the potential to be affected by the same deficient practice? • All residents have the potentially to be affected with infection control practices	

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F 880	Continued From page 3	F 880		

vital monitoring by nursing staff. Further, the facility failed to implement hand hygiene for 2 of 2 residents (R16 and R17) observed while providing cares. This deficient practice had the potential to affect all 73 residents currently residing in the facility.

Findings include:

On 6/23/20, at 8:10 a.m. during entrance conference, Administrator confirmed the facility currently had 3 residents and 2 staff positive for COVID-19.

PPE
First floor:
During observations of serving breakfast trays on the first floor on 6/23/20 at 8:10 a.m. license practical nurse (LPN)-A was observed wearing a surgical mask which covered her nose and mouth area and had black eye glasses on. LPN-A obtained a room tray out of the silver serving cart, walked down the hallway, entered R5's room, set the breakfast tray on R5's bedside table while R5 sat on the edge of her bed. LPN-A told R5 her breakfast was here, talked briefly and left the room. LPN-A went back to the silver serving cart obtained another breakfast tray, walked down the hallway, entered R6's room, R6 was seated on the edge of the bed, LPN-A set the breakfast tray on the bed next to R6, talked briefly with R6 and left the room.
- at 8:17 a.m. LPN-A obtained a breakfast tray from the silver serving cart, walked down the hallway, entered R7's room, R7 was laying in bed covered up, LPN-A talked with R7 briefly, set the breakfast tray on R7's chair setting next to her bed, and left the room.
- at 8:20 a.m. health information coordinator

during a pandemic.
3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?
- All staff provided with eye protection-goggles/safety glasses/face shields.
- Additional eye protection available for all staff as needed.
- All staff reviewed protocols for PPE requirements, hand hygiene and equipment cleaning.

4. How will you monitor the corrective action(s) to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?
- The facility has reviewed protocols for PPE, hand hygiene, and equipment cleaning and staff have been able to review audits for expectation of requirement
- DON/designee is responsible for compliance. Audits of PPE usage including goggles, hand hygiene and equipment cleaning will be completed 5x/week for 4 weeks.
- The facility administrator and/or designee will monitor the audits are completed and results will be reviewed in QAPI for need of ongoing monitoring or until substantial compliance is maintained.

COMPLETION DATE: August 7, 2020.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 4 (HIC) walked up to the silver serving cart and was observed wearing a surgical mask which covered her nose and mouth area and had black eye glasses on. HIC obtained a breakfast tray from the silver cart, walked down the hallway, entered R8's room, set the breakfast tray on the bed side table next to resident while he sat on the edge of his bed, left the room. LPN-A and HIC continued to serve breakfast trays to the residents on the first floor and was not observed to be wearing proper eye protection while assisting resident with their breakfast trays. Third floor: During observations of serving breakfast trays on 6/23/20 at 8:29 a.m. the social worker (SW) was observed wearing a surgical mask and had no eye protection on. The SW obtained a breakfast out of the silver serving cart, set the tray down on the table next to R18, poured him some beverages and visited with him. She proceeded to walk across the dining room area, stood right next to R10, bent down and spoke to R10 briefly then walked away. SW walked down the hallway, entered R9's room while he laid in the bed, and stood next to registered nurse (RN)-B who stood approximately 4 feet away from R9. RN-B wore a surgical mask, prescription glasses on and held her face shield in her right hand. The SW talked briefly to R9 and RN-B and SW exited R9's room. RN-B walked down the length of the hallway back to her medication cart with her face shield in her hand, while the SW obtained a breakfast tray out of the silver serving cart, walked down the hallway, entered R11's room, sat her breakfast tray on her bedside table while R11 sat on her bed. SW stood directly in front of R11 while she visited with her a little bit, and proceeded to exit the room. SW walked down the entire hallway	F 880		

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F 880	Continued From page 5 back to the dining room area, walked up to R10, approximately one to two feet away, and visited with R10. SW and the RN-B was not observed to be wearing eye protection while assisting residents with their breakfast meals. On 6/23/20, at 9:13 a.m. maintenance technician (MT)-A was observed in R4's room on the fourth floor,while mopping. MT-A was wearing a white mask, with no eye protection. R4 was in a wheelchair near a table in the room while MT-A completed the mopping. R4 then moved his wheelchair to a different area of the room, while MT-A mopped where R4 had been sitting. At 9:16 a.m. MT-A stopped mopping, swept the carpet in the doorway of R4's room, proceeded to walk back into the room, fold up R4's walker, place it out of the way, then closed R4's door. MT-A was observed multiple times while in R4's room less than 6 feet away from R4. On 6/23/20, at 9:17 a.m. MT-A indicated the usual housekeeper was off, so he was doing all the cleaning on the floor that day. MT-A confirmed he was not wearing eye protection, and had not worn eye protection while cleaning R4's room. MT-A indicated he had eye protection available but did not wear eye protection unless he was in a room with a resident who had COVID-19, then he would wear all personal protective equipment (PPE). MT-A indicated that specific wing did not have any COVID-19 positive residents, so he did not wear any eye protection. MT-A indicated he had never been told he should wear eye protection in residents' rooms, and confirmed he did not wear eye protection for regular cleaning.	F 880		

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F 880	Continued From page 6 - at 9:50 a.m. R12 was lying in bed, covered with the head of his bed up, MT entered R12's room wearing a surgical mask and had no eye protection on. MT began to mop R12's entire floor while R12 continued to watch him from his bed. MT finished mopping R12's floor, came out of his room, replaced the mop head with a clean one, entered R12's room again and began to mop the floor. MT mopped under R12's bed and around him while coming in close contact with R12 and was observed not to be wearing any eye protection while cleaning R12's room. MT-A was observed multiple times while in R12's room less than 6 feet away from R12. On 6/23/20 at 1:48 p.m. HIC indicated she assisted staff to pass meal trays on the first floor for breakfast and lunch and confirmed she does not wear any eye protection while passing the meal trays to the resident rooms. HIC indicated she only wore her surgical mask and her regular eye glasses when passing room trays. HIC indicated she had not been told she needed to wear eye protection when passing the meal trays to residents. HIC indicated she was not providing cares to the residents and thought she did not need to wear eye protection. On 6/23/20, at 2:44 p.m. environmental services director (ESD)-A indicated his expectation did not include housekeeping staff to wear eye protection when cleaning all residents' rooms, but they all had goggles on their cart available. ESD-A indicated he would expect the staff to wear eye protection only if a resident was showing symptoms of COVID-19 and he expected them to wear full PPE in COVID-19 positive residents' rooms.	F 880		

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F 880	Continued From page 7	F 880		

On 6/23/20, at 3:28 p.m. during joint interview with director of nursing (DON) and Administrator, DON confirmed she expected all nursing staff to wear eye protection at all times for direct patient care. DON confirmed this included while medication administration was completed by nurses. DON indicated if staff were not in the nursing department, she would not consider passing meal trays as direct care, so eye protection would not need to be worn at that time by them. Both confirmed if staff were in resident rooms, eye protection should be worn. DON indicated hand hygiene should be performed before and after all cares. DON indicated the MDH Contingency Standards Of Care For COVID-19 was being used for personal protective equipment use in the facility. DON also confirmed her expectation was for nursing staff to disinfect high touch areas of equipment between each resident with the green top wipes, including the vital machines.

Disinfecting common use equipment and Handwashing

Fourth floor:
During continuous observations on 6/23/20, at 9:20 a.m. R13 was lying in bed, when registered nurse (RN)-A entered her room wearing a surgical face mask and face shield. RN-A was carrying a blue plastic tray which contained R13's medication and brought the portable vital sign machine into R13's room. RN-A proceeded to give R13 her medications, apply gloves to both hands, and took R13's vital signs using the oximeter, blood pressure cuff and thermometer from the portable vital machine. After RN-A

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F 880	Continued From page 8	F 880		

completed R13's vital signs, he brought the blue plastic medication tray and the portable vital machine out of R13's room, walked down the hallway to the nurses station, and placed the portable vital machine next to the medication cart. RN-A was not observed to clean the portable vital machine after leaving R13's room.

-at 9:41 a.m. R14 was lying in bed covered with the head of her bed in a seated position, RN-A entered her room wearing a surgical face mask and face shield covering his entire face. RN-A carried a blue plastic tray which contained R14's medication and brought in the portable vital machine into R14's room. RN-A administered R14's medications, applied gloves and took R14's vitals using the oximeter, blood pressure cuff and thermometer from the portable vital machine. RN-A brought the portable vital machine out of R14's room, and placed the portable vital machine next to the medication cart. RN-A was not observed to clean the portable vital machine after leaving R14's room.

- at 9:57 a.m. R15 was lying in bed, covered with head of bed slightly elevated, RN-A entered her room with the portable vital sign machine. RN-A took R15's vitals using the oximeter, blood pressure cuff and thermometer from the portable vital machine. RN-A proceeded to move the portable vital machine out of R15's room, and placed the portable vital machine next to the medication cart. RN-A did not clean the portable vital machine after he left R15's room.

RN-A did not clean/disinfect the portable vital machine between resident uses.

On 6/23/20 at 10:08 a.m. RN-A confirmed he had

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	245266	A. BUILDING ______ B. WING ______	06/23/2020

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BENEDICTINE HEALTH CENTER OF MINNEAPOLIS	**618 EAST 17TH STREET MINNEAPOLIS, MN 55404**

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F 880	Continued From page 9	F 880		

not sanitized the portable vital sign machine after each resident use and indicated he usually sanitized the machine in the morning before he started to use it. RN-A indicated he has not been cleaning the vital machine or other equipment after being in a residents room unless the resident had symptoms of COVID 19. RN-A indicated if the resident was positive for COVID 19 then the resident would have their own equipment to use and the equipment would be left in the room. RN-A indicated he should be cleaning the equipment after each resident use so he doesn't spread anything to other residents.

Hand Hygiene

On 6/23/20 at 2:02 p.m. NA-A entered R16's room with his face shield on top of his head, and approached R16 while she sat on the edge of her bed. NA-A pulled his face shield down while standing next to R16 on the left side, placed a gait belt around her waist and proceeded to assist R16 to standing position and transfer from her bed to her wheelchair using a gait belt. NA-A removed the gait belt from R16's waist, hung it in the bathroom, gave R16 her Ipad, removed his gloves, threw them away and immediately left the room. NA-A was not observed to wash his hands after removing his gloves and caring for the resident.

- at 2:08 p.m. NA-A grabbed gloves off the top of a cart as he walked down the hallway gloving his hands and entered R17's room. R17 was laying further down in bed on his back while the bed was in low position and his feet were hanging off the right side of the bed and NA-B was standing at the end of the bed wearing a surgical mask, eye protection. R17 complained of his ankle

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F 880	Continued From page 10	F 880		

hurting, NA-A removed his gloves, threw them in the garbage and immediately left R17's room. NA-A walked down to the nurses station, then walked down another hallway, entered R15's room to answer her call light and told R15 he would be right back in a few minutes and to shut her call light off. NA-A proceeded to walk back up to the nurses desk, reported R17's ankle to LPN-B and immediately walked back into R17's room. NA-A was not observed to wash his hands after removing his gloves and caring for the resident.

PPE

- at 2:15 p.m. NA-A, NA-B and LPN-B were present in R17's room. NA-A stood at the end of R17's bed and lifted up his face shield and placed it on top of his head, raised the bed to a working level while LPN-B held R17's feet and checked R17's ankles. NA-A was approximately 3 to 4 feet away from R17. NA-A proceeded to walk to the side of R17, while LPN-B to the other side, together they used a draw sheet to boost R17 up in bed. NA-A continued to wear his face shield on top of his head, while he assisted to reposition R17 in bed.

On 6/23/20, at 2:16 p.m. during a joint interview with infection control registered nurse (ICRN)-A and ICRN-B, both confirmed they were using the Minnesota Departement of Health (MDH) Contingency Standards Of Care For Covid 19, dated 5/29/20, for PPE guidance for COVID 19 infection control practices, which was kept in binders on each wing. ICRN-A and ICRN-B confirmed all nurses and nursing assistants should be wearing their eye protection at all times. They confirmed all facility staff should be

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F 880	Continued From page 11	F 880		

wearing eye protection when interacting with the residents. ICRN-A indicated the facility expected all housekeeping staff to be wearing eye protection at all times, even when residents were not in the rooms being cleaned. ICRN-A and ICRN-B confirmed they expected equipment to be disinfected between residents when shared, including the vitals machines (medical devises used to check blood pressure, pulse, temperature and oxygen level).

On 6/23/20 at 2:33 p.m. NA-A indicated staff were to wear their surgical face masks and face shields at all times when working with the residents and indicated they do not take them off until they leave for the day. NA-A indicated he puts his face shield up sometimes because he has breathing problems at times and indicated he knows he was not to take his shield off when working with the residents. NA-A indicated he should be washing his hands before and after working with residents and confirmed he was not washing his hands earlier.

On 6/23/20, at 3:10 p.m. during a follow up interview ICRN-A confirmed he expected all nurses and nursing assistants to wear eye shields at all times.

Review of the Clorox Health Care Cleaning And Disinfecting Equipment After Resident Care, undated, which ICRN-B identified as the facility guide used for equipment cleaning in the facility. The guide identified Healthcare Hydrogen Peroxide wipes were to be used for resident rooms after resident care. The guide identified Healthcare Bleach Germicidal wipes were to be used for resident rooms for C. diff (Clostridiodes difficile bacterial infection) + Isolation+ Outbreaks.

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F 880	Continued From page 12	F 880		

Continued From page 12

The protocol instructed to remove soil, apply disinfectant, wait (contact time), then discard wipe. The guide identified key surfaces which included a picture of a vitals machine.

The facility policy titled 2019 Novel Coronavirus, undated, identified the purpose was to minimize chance of exposure to residents and associates. The policy included instructions to wash your hands often with soap and water for at least 20 seconds and to use alcohol based hand sanitizer if soap and water was not available. The policy also instructed to clean and disinfect frequently touched objects and surfaces.

The facility policy titled Personal Protective Equipment, dated 6/17, identified personal protective equipment (PPE) as specialized clothing or equipment worn by the associates for protection against blood or other potentially infectious materials from reaching their clothing, eyes, mouth or other mucous membranes. The policy instructed associates to wash hands immediately after removing gloves or other PPE , or as soon as feasible. The policy instructed associates to remove PPE after it became contaminated and before leaving the work area and PPE should never be worn outside of resident room or work area. The policy further included instructions to wear appropriate face and eye protection when splashes, sprays, splatters, or droplets of blood or other infectious materials posed a hazard to the eye, nose or mouth.

The CDC (Centers For Disease Control and Prevention) Coronavirus Disease 2019 (COVID-19)
Healthcare Infection Prevention and Control FAQs for COVID-19, updated 6/5/20, identified

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F 880	Continued From page 13	F 880		

HCP (health care provider) working in facilities located in areas with moderate to substantial community transmission are more likely to encounter asymptomatic patients with COVID-19. If COVID-19 is not suspected in a patient presenting for care
(based on symptom and exposure history), HCP should follow Standard Precautions (and Transmission-Based
Precautions if required based on the suspected diagnosis). They should also: Wear eye protection in addition to their facemask to ensure the eyes, nose, and mouth are all protected from splashes and sprays of infectious material from others. The memo also instructed HCP working in areas with minimal to no community transmission, the universal eye protection and respirator recommendations (described above) for areas with moderate to substantial community transmission are optional. However, HCP should continue to use eye protection or an N95 or higher-level respirator whenever recommended for patient care as a part of Standard or Transmission-Based Precautions.

The Minnesota Departement of Health (MDH) Contingency Standards Of Care For COVID 19, dated 5/29/20, included instructions for personal protective equipment for long term care, assisted living and other non acute care facilities. The form identified HCP (health care personal) with face-to-face contact with COVID negative residents to wear surgical mask, eye protection and hand hygiene, and to implement "extended use" universal surgical mask and eye protection.. The form further instructed non-HCP with periodic face-to-face contact with residents to wear surgical mask, eye protection and hand hygiene and if employees go into resident care area to

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F 880	Continued From page 14 don surgical mask and eye protection for that period of time. The facility policy titled Hand Hygiene dated 6/17, identified infection prevention begins with the basic hand hygiene. The policy identified times to perform hand hygiene included: before and after direct resident contact.	F 880		