

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 245213	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/01/2020
NAME OF PROVIDER OF SUPPLIER EBENEZER RIDGES GERIATRIC CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP 13820 COMMUNITY DRIVE BURNSVILLE, MN 55337	
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	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</p> <p>Based on observation, interview and document review, the facility failed to implement a comprehensive infection control program to include recommended COVID-19 staff health screening location procedures. This had the potential to affect all 109 residents that resided in the facility. Findings include: During the entrance conference on 3/31/20, at 12:15 p.m., the administrator explained staff screening for possible COVID-19 symptoms was completed on the nursing units. On 3/31/20, at approximately 2:30 p.m., an employee was observed to enter the building from an entrance that was not the main entrance. The employee walked through the transitional care unit, down a long hallway with adjoining offices, through the main lobby and up the elevator to his work location. Employee symptom screening and tracking was available on the unit. The second floor staff screening process was observed on 3/31/20, at 2:22 p.m. Employee (E)-1 was observed to take her own temperature and stated, I have no cough, fever or anything. A nurse signed off on the screening form for E1. E2 and E3 arrived on the unit at 2:27 p.m. A nurse took the temperatures of E2 and E3, however, E2 and E3 both completed the screening questionnaire on their own. The infection preventionist (IP) was interviewed on 3/31/20, at 3:01 p.m. The IP verified it was the current practice to screen all staff at the nursing station of each unit in the building. Additionally, the IP verified a nurse was to conduct the screening, which would include a check of staff temperature, ask screening questions and sign off when completed. The IP verified staff were not to take their own temperatures. The administrator, director of nursing (DON), and IP were interviewed on 3/31/20, at 3:30 p.m. The administrator agreed to allow an unscreened person to walk through the building could be a risk to spread [MEDICAL CONDITION]. The administrator stated screening at the main entrance for all staff would be initiated as soon as possible. The EBENEZER COVID EMERGENCY PREPAREDNESS PLAN, dated 3/27/20, indicated the administrator and director of nursing participated in daily calls with the Minnesota Department of Health to ensure all current practice standards were being followed.</p>		

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.