DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 1, 2020

Administrator
Shakopee Friendship Manor
1340 Third Avenue West
Shakopee, MN 55379

RE: CCN: 245445
Cycle Start Date: July 24, 2020

Dear Administrator:

On August 10, 2020, we notified you a remedy was imposed. On September 22, 2020 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of September 18, 2020.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective August 25, 2020 be discontinued as of September 18, 2020. (42 CFR 488.417 (b))

In our letter of August 10, 2020, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from September 18, 2020. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed or recommended remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 20, 2020

Administrator
Shakopee Friendship Manor
1340 Third Avenue West
Shakopee, MN 55379

RE: CCN: 245445
Cycle Start Date: July 24, 2020

Dear Administrator:

On August 10, 2020, we informed you of imposed enforcement remedies.

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 25, 2020.

- Civil money penalty. (42 CFR 488.430 through 488.444)

On August 5, 2020, the Minnesota Department(s) of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the survey/revisit findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 25, 2020, will remain in effect.

- Directed plan of correction, Federal regulations at 42 CFR § 488.424 Please see electronically attached documents for the DPOC.

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444).

You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 25, 2020. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 25, 2020.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

As we notified you in our letter of August 10, 2020, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 25, 2020.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 24, 2021 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION/ 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 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
	245445	A. BUILDING _____ B. WING _____	08/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAKOPEE FRIENDSHIP MANOR	1340 THIRD AVENUE WEST SHAKOPEE, MN 55379

(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 8/5/20, at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.73(b)(6). 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.	E 000		
E 013 SS=C	Development of EP Policies and Procedures CFR(s): 483.73(b) (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must	E 013		9/18/20

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

Electronically Signed | 08/28/2020

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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E 013	Continued From page 1 be reviewed and updated at least annually. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to prepare policies and procedures to activate a contingency staffing plan. The facility also failed to address staffing needs for hazards deemed significant based on the facility's all hazards risk assessment as part of their emergency preparedness plan of CFR 483.73(a)(1)(2). This deficient practice had the potential to affect all of the 44 residents. Findings include: On 8/5/20, at 9:58 a.m., the facility infection preventionist (IP) was asked what the facility's plan was should they develop a surge in numbers of staff absences due to COVID-19 exposures and illness. IP responded that she was thankful the facility has not had an issue with staffing and did not feel that going forward staffing would be an issue. IP admitted there was not a plan in place should a staffing shortage occur at their	E 013	The facility's EPP has been updated to include a detailed emergency staffing plan in case a surge in numbers of staff absences due to COVID-19 arises. Once all in-house staffing options have been exhausted, the facility will reach out to three local agency staffing companies (names and phone numbers included in the plan) and also the Minnesota State Emergency Operations Center (SEOC) Long-Term Care (LTC) staffing line (phone number and hours of operation included in the plan). Contact was made with the agency staffing companies and the SEOC, confirming that emergency staffing would be available upon request. Quality Assurance will review and approve the updated EPP.	

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E 013	Continued From page 2 facility. IP stated that she had spoken with a case manager from Scott County and was told at that time, she could contact the county and they would attempt to assist with their staffing shortage, should that develop. IP stated that this was not written and there was not a policy developed in regards to a surge in staff absences. IP also stated they do not use agency staffing and facility had not made any contacts with outside agencies for assistance if a staff shortage in their facility occurred. Review of the facilities COVID-19 processes and procedures found no documentation stating the facility had any type of contingency staffing plan.	E 013	Quality Assurance will review the EPP on an annual basis, updating the plan as deemed necessary.	
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control survey was conducted on 8/5/20, at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was determined NOT to be in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, a revisit of your facility will be conducted to validate 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		9/18/20

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F 880	Continued From page 3 §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:	F 880		

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F 880	Continued From page 4 (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 ensure COVID-19 infection control measures were followed when proper hand hygiene was not performed during direct cares. Further, the facility failed to clearly identify rooms that required the use of personal protective equipment (PPE) for entry due to COVID-19 isolation. This had the potential to affect all 46 residents in the facility. Findings include:	F 880	Nursing assistant NA-B failed to use proper infection control, specifically hand-washing while performing cares on resident R1. NA-B was immediately re-educated on the facility's hand-washing policies. All nursing staff in contact with the residents were reminded about the importance of following the facility's infection control policies specifically	

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F 880	Continued From page 5 On 8/5/20, at 11:30 a.m. nursing assistant (NA)-B was observed in room and assisted a resident to use the toilet. NA-B donned gloves, placed a 2 wheeled walker in front of the resident, and positioned a wheelchair at the bathroom doorway. NA-B cued R1 to stand and use the walker, performed peri care, raised clothing, turned and asked R1 to sit in the wheelchair. NA-B doffed gloves, wet a paper towel, applied soap to hands, washed for 2 seconds, rinsed for 5 seconds, shook water off hands vigorously, and used a clean paper towel to dry hands. NA B then handed R1 a wet paper towel to clean her hands and turned the water faucet off with a bare hand. At 11:35 a.m. NA-B was interviewed and confirmed he had infection control and hand hygiene training. NA-B stated hands should be washed with soap and water for 15 seconds. When asked, NA-B stated during observation by the surveyor, he washed his hands for approximately 10 seconds. On 8/5/20, at 12:14 p.m., RN-A was interviewed and stated the hand hygiene policy should indicate proper hand washing was 20 seconds. RN-A further stated staff training consisted of a video that directed staff to wash hands for 20 seconds. RN-A stated her expectation would be for staff to wash with soap and water for 20 seconds. A previous interview with RN-A at 9:50 a.m. indicated no hand hygiene audits were completed to verify staff washed their hands for the appropriate amount of time. The provided facility policy, Hand Hygiene for all Healthcare Workers, dated 2/15/19, indicated the routine hand washing procedure includes	F 880	hand-washing. NA-B and all staff will be required to attend a mandatory in-service on the facility's Infection Prevention and Control Program (IPCP). A detailed description of the facility's upcoming training is included under the description "DIRECTED PLAN OF CORRECTION (DPOC). The Infection Control Nurse (ICN) will routinely audit and monitor all staff on infection control, correcting and educating as needed. The Director of Nursing (DON) and ICN will randomly conduct audits of all staff to ensure proper infection control policies are being followed. Quality Assurance will review the facility's IPCP on a quarterly basis updating policies as deemed necessary. Not placing a PPE sign on room 400 was an oversight. The facility has secured appropriate PPE signs to be placed on the rooms as necessary. The ICN who sets up the carts and equipment to be used in designated rooms, and certainly the rooms in the Isolation Wing, will place the signs up ensuring all staff are aware of the precautions necessary to enter the room. The ICN who monitors all isolation rooms will verify that all signs are present. The DON will randomly audit the facility to	

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F 880	Continued From page 6 washing hands "for at least 15 seconds", as well as use a clean paper towel to turn off the faucet. The provided facility policy, Prevention and Control of Coronavirus (COVID-19) Disease, updated 7/27/20, indicated "Prior to entering and exiting the unit and resident room, HCP must perform hand hygiene by washing hands at least 20 seconds with soap and water or applying alcohol-based hand sanitizer." The policy further directed "Ongoing staff education on proper hand hygiene," and "Observe staff-hand hygiene, putting on and taking off PPE and during care." On 8/5/20, at 10:24 a.m. A room on the 400 wing was observed to have a personal protective equipment (PPE) cart outside the room door. No signage was visible on the door or near the room to indicate the level of of precautions or appropriate PPE to don for safe entry into the room. At 10:25 a.m. NA-A was interviewed and stated the resident in the room was on precautions due to the roommate who had tested positive for COVID-19. NA-A stated the needed PPE was in the cart outside the door, and usually the presence of the cart was an indicator to wear PPE when staff entered a room. If NA-A saw a cart, she would just assume the resident was on precautions. NA-A further stated normally there would be a sign to indicate the level of precautions, but with COVID it is not used. At 10:46 a.m. licensed practical nurse (LPN)-A was interviewed and stated residents with carts outside rooms were on isolation precautions. LPN-A stated she has not seen signs posted to indicate the type of precautions for the room.	F 880	ensure that all appropriate signage has been placed. DIRECTED PLAN OF CORRECTION (DPOC) The facility's IPCP is initiated by identifying possible communicable disease or infections with a quarterly review of all infection reports, skin reports and incident reports by a designated team. The DON and ICN are on the designated team, and are the team members staff are to report possible incidents of communicable disease or infections. Contact and/or droplet precautions should be instituted when a resident develops signs or symptoms of a transmissible infection, and staff should reference the facility's "Infection Control Guidelines Policy" for guidance. Determining when and how isolation is implemented will depend on the organism/infection involved, the mode of transmission, level of risk of spread to others, the potential severity of the infection and the availability of effective treatment, and also the mental state of the resident and their response to isolation. To protect our staff, anyone with skin problems such as open lesions or weeping skin rash must refrain from all direct resident care and from handling resident care equipment until cleared by the DON or ICN. The hand hygiene procedures to be followed by staff involved in direct resident contact would be to use soap and water, rubbing hands together vigorously for at least 20	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAKOPEE FRIENDSHIP MANOR	1340 THIRD AVENUE WEST SHAKOPEE, MN 55379

(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
F 880	Continued From page 7 When asked how staff would know if the resident was on precautions, LPN-A stated, "I think with the cart, people know". At 10:55 a.m., the dedicated Covid unit was observed with PPE carts present in hall outside resident rooms. Signage posted outside the unit indicated "Stop" and "Do not enter". No signs indicated the level of precautions and what PPE was required to wear for safety beyond that point. At 12:14 p.m., RN-A was interviewed and stated they have a sign "See Nurse Before Entering Room", but hadn't put it up on rooms currently on isolation precautions. RN-A stated they do not post isolation precautions on the resident door due to privacy concerns. The provided facility policy, Prevention and Control of Coronavirus (COVID-19) Disease, updated 7/27/20, indicated to "ensure isolation carts with isolation signs are centrally located near residents in isolation to put on and off PPE."	F 880	seconds, rinse hands with water, and dry hands with a disposable towel. The staff member may use an alcohol-containing hand rub if hands are not visibly dirty. Hand hygiene is necessary before and after resident contact, before food preparation or serving, and after removing gloves. To minimize the chances of the spread of COVID-19 within the facility all staff will be re-educated on proper infection control policies. An emphasis will be placed on appropriate PPE use, donning and doffing of PPE, transmission-based precautions, wearing face shields and masks, hand washing, and overall environmental safety concerns dealing with infection control. A root cause analysis (RCA) shows the potential that staff are not following the education they received on infection control prevention, specifically hand washing. All staff will be re-educated on PPE use, donning and doffing of PPE, transmission-based precautions, wearing face shields and masks, and environmental safety regarding infection control. The DON and ICN will review the policies and procedures for appropriate placement of isolation carts and signage to direct staff what is the appropriate PPE donning/doffing to wear before entering an isolation room. The training will be done by the DON and ICN and will include:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245445	A. BUILDING _____ B. WING _____	08/05/2020

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F 880	Continued From page 8	F 880	- Instructional video on donning and doffing of PPE. - Instructional video on hand washing. - Instructional video on Standard and Isolation Precautions. Each video will come with a quiz, to be corrected and retained. All residents and their representatives have received education on the facility's Infection Prevention Control Program. This was/is done by Social Services. The DON and ICN will conduct audits on all shifts, every day for one week, then decrease the frequency based upon compliance. 100% compliance is required. The results of the audits and monitoring will be reviewed at the Quality Assurance meetings on a quarterly basis.	