DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 12, 2020

Administrator
Guardian Angels Care Center
400 Evans Avenue
Elk River, MN 55330

RE: CCN: 245012
Cycle Start Date: June 29, 2020

Dear Administrator:

On July 21, 2020, we notified you a remedy was imposed. On September 9, 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 9, 2020.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective August 20, 2020 be discontinued as of September 9, 2020. (42 CFR 488.417 (b))

However, as we notified you in our letter of July 21, 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 July 30, 2020. This does not apply to or affect any previously imposed NATCEP loss.

Feel free to contact me if you have questions.

Sincerely,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING _____ B. WING _____	R 09/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS CARE CENTER	**400 EVANS AVENUE ELK RIVER, MN 55330**

(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 No Appendix Z, Emergency Preparedness, deficiencies were noted at the time of the abbreviated survey 6/29/20.	{E 000}		
{F 000}	INITIAL COMMENTS A revisit was conducted 9/9/20, to determine compliance with Federal deficiencies issued during a recertification survey exited on 6/29/20. The facility's deficiency was CORRECTED. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	{F 000}		

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

Electronically Signed | 10/12/2020

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.

Electronically delivered
July 21, 2020

Administrator
Guardian Angels Care Center
400 Evans Avenue
Elk River, MN 55330

RE: CCN: 245012
Cycle Start Date: June 29, 2020

Dear Administrator:

On June 29, 2020, a survey was completed at your facility by the Minnesota Department of Health 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 constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (level F), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 20, 2020.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 20, 2020. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 20, 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.

This Department is also recommending that CMS impose:

• 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.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $10,483; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by August 20, 2020, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Guardian Angels Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 20, 2020. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.
However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. 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.

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:

Susie Haben, Unit Supervisor
St. Cloud A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 West Division Street, Suite 212
St. Cloud, Minnesota 56301
Email: susie.haben@state.mn.us
Phone: 320-223-7356

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 December 29, 2020 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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 (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,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING _____ B. WING _____	06/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS CARE CENTER	400 EVANS AVENUE ELK RIVER, MN 55330

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E 000	Initial Comments A COVID-19 Focused Infection Control survey was conducted 6/29/20, at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations § 483.73(b)(6). The facility was in full 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 (month, date and year) at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was not in full 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		7/31/20

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

Electronically Signed | 07/31/2020

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F 880	Continued From page 1 §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: (A) The type and duration of the isolation,	F 880		

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F 880	Continued From page 2 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 staff were trained on and performed environmental cleaning and disinfection procedures, and reprocessing of reusable resident medical equipment (cleaning and disinfection of mechanical lifts, vitals machine, etc.), according to the disinfectant manufacturers' instructions for the prevention and potential transmission of COVID-19. This had the potential to affect all 111 residents currently residing in the facility at the time of the COVID-19 focused survey.	F 880	F880 Guardian Angels Care Center strives to adhere to all infection control standards in accordance with state and federal regulations and current standards of practice. Guardian Angels Care Center did conduct cleaning and disinfecting of resident medical equipment however staff were not able to provide the manufacturer’s instructions for use (dry/contact time).	

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F 880	Continued From page 3 Findings include: During interview on 6/29/20, at 9:51 a.m. housekeeper (HSKP)-A stated the facility cleaned and disinfected with two main chemicals; Ecolab's Neutral Disinfectant Cleaner for main environmental cleaning and Spartan's SparCling (restroom cleaner) for toilets. HSKP-A was unable to state manufacturers' instructions for use of these two chemicals or facility policy. HSKP-A stated when Neutral Disinfectant Cleaner was the required cleaner, surfaces (call lights, door knobs, etc.) were wiped with a wet rag and then a dry rag used to, "wipe it down right away to make sure it is not wet." HSKP-A further stated after applying the SparCling to toilet surfaces, "would dry off right away as it has acid in it," and, "if gets on resident skin it would burn and we would not want that to happen." HSKP-A obtained the safety data sheets (SDS) three ring binder located in the housekeeping room and stated inability to find the SDS sheets for these two products after review. HSPK-A stated the SDS sheets were where housekeeping staff went if information about the cleaner was needed. HSKP-A and surveyor read Neutral Disinfectant Cleaner label which indicated for Human Coronavirus "treated surfaces must remain wet for 1 minute. Wipe dry with a clean cloth, sponge, or mop or allow to air dry, " however, this label further indicated to kill Adenovirus Type 7 "let solution remain on surface for a minimum of 10 minutes. Rinse or allow to air dry." When interviewed on 6/29/20, at 11:42 a.m. nursing assistant (NA)-A stated facility had a shortage of, "purple top wipes," (Sani-Cloth disinfectant wipes) and thus staff had been using	F 880	All resident may have been or potential impacted by this practice. Corrective action to ensure that this practice does not occur will be to train staff on the manufacturers' instructions for dry/contact time of their disinfectant product for resident care equipment and environment cleaning of facility. Each staff person will demonstrate competency at the conclusion of the documented training. Policy and procedures will be changed to reflect current process for disinfecting resident medical equipment and cleaning of the facility. The Director of Housekeeping/Laundry, Director of Nursing, the Infection Preventionist, and/or other facility leadership will conduct audits of proper cleaning and disinfecting of resident use equipment/environmental cleaning on all shifts for one week, then may decrease frequency as determined by compliance. Correction date August 5, 2020	

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F 880	Continued From page 4	F 880		

Neutral Disinfectant Cleaner for cleaning and disinfecting resident care equipment (lifts, shower bed, etc.). NA-A stated uncertainty on manufacturers' instructions for Neutral Disinfectant Cleaner use. NA-A further stated a process for cleaning the shower bed was used; sprayed cleaner on shower bed, waited ten minutes, sprayed it off with water and let dry. NA-A stated since this was the process NA-A used for cleaning the shower bed, NA-A used it for other resident care equipment, with an added statement that once the ten minutes had passed the equipment was wiped down with a wet paper towel. NA-A stated training had not been provided on the use of Neutral Disinfectant Cleaner. NA-A and surveyor read the Neutral Disinfectant Cleaner spray bottle label which lacked instructions for use (dry/contact time).

During interview on 6/29/20, at 11:47 a.m. licensed practical nurse (LPN)-A stated the facility was, "out of wipes [Sani-Cloth] now," and thus staff had been using Neutral Disinfectant Cleaner as the main cleaner for resident care equipment. LPN-A stated the process used for the cleaner was to, "spray on a cloth and then wipe it on the machine ...it just dries then." LPN-A stated training had not been provided on the use of Neutral Disinfectant Cleaner. LPN-A and surveyor read the Neutral Disinfectant Cleaner spray bottle label which lacked instructions for use.

When interviewed on 6/29/20, at 12:36 p.m. housekeeping director (HD) stated the Neutral Disinfectant Cleaner was used on all surfaces other than the toilets, which required the SparCling to be used. HD stated not knowing dry/contact time of the SparCling but stated the kill time for the Neutral Disinfectant Cleaner was

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F 880	Continued From page 5	F 880		

one minute. HD presented surveyor with a bottle of SparCling which indicated "allow SparCling to remain wet on surface at least two minutes." HD stated chemical use training had been provided to housekeeping staff, "about eighteen months ago." HD further stated new housekeeping staff were trained on proper chemical use by information provided on the SDS sheets for each chemical. HD stated training did not instruct housekeeping staff on dry/contact times or specific instructions for each chemical used. HD stated inability to find manufacturers' instructions for use on the SDS sheets for SparCling and Neutral Disinfectant Cleaner. HD further stated no audits had been completed to ensure housekeeping staff used these products per manufacturers' instructions. HD stated the facility did not have housekeeping cleaning process or chemical use direction policies. HD stated housekeeping staff follow processes located in a three ring binder labeled Housekeeping Procedure.

During interview on 6/29/20, at 1:09 p.m. director of nursing/interim infection control preventionist (DON), stated chemical training was provided in, "huddles (small meetings)." DON stated the information provided in the "huddles" had not been documented. This training consisted of direction to, "wipe stuff down ....using orange sani-wipes that have 1:10 bleach and if out then they use the spray." DON further stated the dry/kill time training provided was a, "standard policy of two minutes," with additional statements of, "that is what I would do being a nurse, " and, "expectation for at least two minutes," where staff sprayed, "down areas where the resident touched." DON initially denied having performed audits that ensured proper cleaning and disinfection of resident care equipment but did

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F 880	Continued From page 6	F 880		

provide audits, dated 5/1/20 and 5/4/20, which showed six nursing assistants verbalized how to correctly disinfect equipment Hoyer/ez stand from room to room. DON stated not having a process template which was used for auditor to follow during the audits to ensure visualization and/or verbalization had been followed per facility policy/processes and chemical manufacturers' instructions.

A provided facility Coronavirus/COVID-19 Preparedness/Employee Illness policy, dated 5/7/20, identified "common areas/frequently touched surfaces will be frequently sanitized using cleaning products identified as effective for destroying COVID-19." The policy failed to provide manufacturers' instructions and/or guidance on which cleaning products were identified effective for destroying COVID-19. The policy furthermore failed to identify staff training guidelines for cleaning and chemical use processes in relation to COVID-19.

A provided facility Disinfecting Reusable Equipment and Environmental Surfaces policy, dated 5/16/2017, identified "reusable equipment and environmental surfaces will be properly disinfected after use." The policy further identified the equipment procedure of "spray with premixed sterilizing solution of 1:10 bleach solution or sterilizing product approved by the RN" and environmental services procedure of "environmental surfaces must be disinfected after use, clean any obvious soiled material with paper towels and soapy water, then spray with premixed sterilizing solution or 1:10 bleach solution or sterilizing product approved by the RN, allow to air dry." The policy failed to provide instruction on current cleaning processes related to COVID-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING _____ B. WING _____	06/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS CARE CENTER	400 EVANS AVENUE ELK RIVER, MN 55330

(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	F 880		

and which products were approved as effective for destroying COVID-19.

A provided facility Infection Control - Care Center policy, dated 6/13/18, identified surveillance procedures to "provide procedures with ongoing review for accepted standards to reduce transmission of infections and environmental cleaning and disinfection of equipment/supplies by department procedures." The policy further identified "staff training provided at orientation, annually, and ad hoc."

An Ecolab website (http://www.ecolab.com/articles/2020/01/a-novel-coronavirus) article COVID-19, dated 3/24/20, indicated Neutral Disinfectant Cleaner met the criteria for claims against COVID-19 when used in accordance with the directions for use against listed supporting viruses on hard, non-porous surfaces. Directions for use indicated Neutral Disinfectant Cleaner was supported by the Adenovirus Type 7 with a dilution rate of 2oz/gal, and a contact time of 10 minutes.

A provided Ecolab Neutral Disinfectant Cleaner reference sheet, dated 2007, stated directions indicated for disinfection/cleaning/deodorizing to "let the solution remain on surface for a minimum of 10 minutes. Rinse or allow to air dry." The reference sheet further indicated a 10-minute contact time effective against Human coronavirus, SARS (Severe Acute Respiratory Syndrome) Associated Coronavirus, and Adenovirus Type 7.

Provided SDS for Ecolab's Neutral Disinfectant Cleaner, dated 9/17/13, and Spartan's SparCling, dated 8/30/16, failed to provide instructions

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F 880	Continued From page 8 (direction on use/contact time) for environmental surfaces or resident care equipment. A provided facility 3-ring binder labeled Housekeeping Procedure indicated the following information; instructions for supplies required on the housekeeping cart, restroom, toilet, urinal, and window cleaning steps, along with a reference sheet for Neutral Disinfectant Cleaner. The instructions/steps in the binder failed to instruct housekeeping staff on specific chemical products to use or dry/contact times. The instructions/steps in the binder were not in facility policy formatting.	F 880		