Electronically delivered
December 28, 2020

Administrator
Franklin Restorative Care Center
900 3rd Street South
Franklin, MN 55333

RE: CCN: 245273
Cycle Start Date: November 19, 2020

Dear Administrator:

On December 9, 2020, we informed you of imposed enforcement remedies.

On December 8, 2020, the Minnesota Department 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 findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective January 23, 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 January 23, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 23, 2021.

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 December 9, 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 January 23, 2021.

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:

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program

Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, MN 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

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 May 19, 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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DIRECTED PLAN OF CORRECTION

A Directed Plan of Correction (DPOC) is imposed in accordance with 42 CFR § 488.424. Your facility must include the following in their POC for the deficient practice cited at F880:

ACTIVELY SCREENING RESIDENTS

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

POLICIES/PROCEDURES/SYSTEM CHANGES:

- The facility's Quality Assurance and Performance Improvement Committee must conduct a root cause analysis (RCA) to identify the problem(s) that resulted in this deficiency and develop intervention or corrective action plan to prevent recurrence.

The Infection Preventionist and Director of Nursing shall complete the following:

- Conduct active health screening and surveillance of residents upon admission and twice daily for fever (>100.0oF or subjective) and symptoms of COVID-19 (shortness of breath, new or change in cough, chills, sore throat, muscle aches).
- Develop and implement an infection sign and symptom tracking tool to monitor all residents for communicable, respiratory infection. All nursing leaders will be educated on how to use the tool.
- Group residents, or "cohorting," should be done when possible to separate residents with an infectious disease (positive residents) from residents who are not affected. Plans to cohort should be carefully established in advance and should be centered on implementation of infection control practices.
- Isolate and restrict incoming residents discharged from hospitals, or other facilities, to their room for 14 days.
- Assess newly admitted residents with respiratory symptoms that include cough, fever or shortness of breath for known exposure to a person with COVID-19 in the 14 days prior to illness onset, or recent admission to facilities with COVID-19 cases. Ask discharging facility whether diagnostic testing has been conducted for COVID-19.

TRAINING/EDUCATION:

- Guidance on the use of pulse oximetry is available from MDH: Pulse Oximetry and COVID-19: https://www.health.state.mn.us/diseases/coronavirus/hcp/pulseoximetry.pdf
- Remind residents to practice social distancing and perform frequent hand hygiene.
- Educate and assist the resident to utilize an appropriate mask to reduce droplet spread.

CDC RESOURCES:

Infection Control Guidance: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html

CDC: Isolation Precautions Guideline:
https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007): https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Personal Protective Equipment: https://www.cdc.gov/niosh/ppe/
Healthcare Infection Prevention and Control FAQs for COVID-19:
https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control-faq.html

MDH RESOURCES:

Personal Protective Equipment (PPE) for Infection Control:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/ppe/index.html
MDH Contingency Standards of Care for COVID-19: Personal Protective Equipment for Congregate Care Settings (PDF): https://www.health.state.mn.us/communities/ep/surge/crisis/ppegrid.pdf
Interim Guidance on Facemasks as a Source Control Measure (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/maskssource.pdf
Interim Guidance on Alternative Facemasks (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/masksalt.pdf
Aerosol-Generating Procedures and Patients with Suspected or Confirmed COVID-19 (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/aerosol.pdf
Droplet Precautions:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html
Airborne Precautions:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html

MONITORING/AUDITING:

- Chart all clinical measurements and symptoms daily for each resident.
- Use cumulative data to conduct active surveillance. Record daily the number of residents that have been transferred to acute care, even for non-respiratory disease, by using a sheet like that in Appendix E. In some LTC facilities, an increasing number of transferred residents has preceded confirmation of COVID-19 in the facility.
- All residents positive for fever or symptoms should be isolated, placed under transmission-based precautions, and tested for COVID-19. Clinicians are encouraged to test for other causes of respiratory illness in addition to COVID-19.
- Conduct a RCA (root cause analysis) which will be done with assistance from the Infection Preventionist, Quality Assurance and Performance Improvement (QAPI) committee and Governing Body. The RCA should be incorporated into the intervention plan. Information regarding RCAs is available in the Guidance for Performing Root Cause Analysis (RCA) with Performance Improvement Projects (PIPs).

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/GuidanceforRCA.pdf

TRACKING AND TRENDING INFECTION CONTROL PROGRAM

- Address how corrective action will be accomplished for those residents found to have been

affected by the deficient practice.

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

POLICIES/PROCEDURES/SYSTEM CHANGES:

- The facility's Quality Assurance and Performance Improvement Committee must conduct a root cause analysis (RCA) to identify the problem(s) that resulted in this deficiency and develop intervention or corrective action plan to prevent recurrence.

The Infection Preventionist and Director of Nursing, shall complete the following:

- Review and revise policies for infection surveillance as needed.
- Develop and implement an infection control program sign and symptom tracking tool to monitor all residents and staff for communicable, respiratory infection, according to the CDC guidelines.
- Ensure that the charge nurse for each shift documents all resident and employee infections on the facility's shared infection tracking log. Compliance and review of the infection control log will be completed by the Infection Preventionist daily. The data will be analyzed for possible trends/outbreaks. The Infection Preventionist will investigate any potential outbreaks and follow up as appropriate.
- Conduct rounds throughout the facility to ensure staff is exercising appropriate use of personal protective equipment and to ensure infection control procedures are followed on each unit. Ad hoc education will be provided to persons who are not correctly utilizing equipment and/or infection prevention/control practices. Such monitoring will continue until the facility has been infection free for at least four weeks.
- Review infection prevention tracking and trending. Any unexpected increases in infection must be reported to the Medical Director, Public Health Department, and the state survey agency in order to obtain further assistance to control infection.

TRAINING/EDUCATION:

- As a part of corrective action plan, the facility must provide training for the Infection Preventionist, the Director of Nursing, nursing leadership/management, and facility administration. The training must cover standard infection control practices, active surveillance, tracking and trending for a comprehensive infection control program. The facility may use training resources made available by the Centers for Disease Control and Prevention or a program developed by well-established centers of geriatric health services education, such as schools of medicine or nursing, centers for aging, and area health education centers with established programs in geriatrics.
- Include documentation of the training completed with a timeline for completion.
- The training may be provided by the Director of Nursing, Infection Preventionist, or Medical Director with an attestation statement of completion.
- Tier three or four concerns (harm or IJ) training must be provided by a contracted outside infection prevention consultant.
- Online infection prevention training courses may be utilized. The CDC and MDH websites have several infection control training modules and materials.

CDC RESOURCES:

- Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic. https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html
- Infection Control Guidance for Healthcare Professionals about Coronavirus (COVID-19) https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html

CMS RESOURCES:

- CMS & CDC Offer a specialized, online Infection Prevention and Control Training For Nursing Home Staff in the Long-Term Care Setting

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/GuidanceforRCA.pdf

MDH RESOURCES:

- Infection Prevention and Control Guidelines https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/guidelines.html
- Infection Control Precautions https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/index.html
- National Healthcare Safety Network (NHSN) https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/nhsn.html
- COVID-19 Toolkit: Information for Long-term Care Facilities (PDF) https://www.health.state.mn.us/diseases/coronavirus/hcp/ltctoolkit.pdf
- Responding to and Monitoring COVID-19 Exposures in Health Care Settings (PDF) https://www.health.state.mn.us/diseases/coronavirus/hcp/response.pdf
- COVID-19 Infection Prevention and Control and Cohorting in Long-term Care (PDF) https://www.health.state.mn.us/diseases/coronavirus/hcp/ltcipchohort.pdf

MONITORING/AUDITING:

Monitoring of approaches to ensure infections are controlled will include:

- The Infection Preventionist and Director of Nursing, each day and more often as necessary, will review infection prevention tracking and trending logs and data analysis. Any unexpected increases in infection will result in communication with the Medical Director, Public Health Department and the state survey agency in order to obtain further assistance to control infection.
- The Director of Nursing, Infection Preventionist, or designee will review the results of audits and monitoring with the Quality Assurance Program Improvement (QAPI) program.

ACTIVE SCREENING

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

POLICIES/PROCEDURES/SYSTEM CHANGES:

- The facility's Quality Assurance and Performance Improvement Committee must conduct a root cause analysis (RCA) to identify the problem(s) that resulted in this deficiency and develop intervention or corrective action plan to prevent recurrence.

The Infection Preventionist and Director of Nursing, shall complete the following:

- Develop and implement procedures, policies, and forms regarding active screening for temperature and signs and symptoms of COVID-19, in accordance with CDC guidelines to be conducted at the point of entry for every person who enters the facility. The procedures and policy must restrict entrance to anyone who does not meet the criteria as outlined by the CDC. This procedure must include actively measuring and recording staff temperature and assessment of shortness of breath, new or changed cough, and sore throat. The results must be documented. The MDH COVID-19 Toolkithttps://www.health.state.mn.us/diseases/coronavirus/hcp/ltctoolkit.pdf has examples of forms to utilize for staff screening.

TRAINING/EDUCATION:

As part of a corrective action plan, the facility must provide training for Infection Preventionist and all other staff who enter the facility, as well as staff responsible for the screening. The training must cover the need for active screening. The CDC has training videos available for COVID-19 which may be utilized, Training for Healthcare Professionals; https://www.cdc.gov/coronavirus/2019-ncov/hcp/training.html and the MDH COVID-19 Toolkit may be utilized.

- Include documentation of the completed training with a timeline for completion.

- The training may be provided by the Director of Nursing, Infection Preventionist, or Medical Director with an attestation statement of completion.

CDC RESOURCES:
Infection Control Guidance: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html
CDC: Isolation Precautions Guideline:
https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007): https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Personal Protective Equipment: https://www.cdc.gov/niosh/ppe/
Healthcare Infection Prevention and Control FAQs for COVID-19:
https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control-faq.html

MDH RESOURCES:
Personal Protective Equipment (PPE) for Infection Control:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/ppe/index.html
MDH Contingency Standards of Care for COVID-19: Personal Protective Equipment for Congregate Care Settings (PDF): https://www.health.state.mn.us/communities/ep/surge/crisis/ppegrid.pdf
Interim Guidance on Facemasks as a Source Control Measure (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/maskssource.pdf

Interim Guidance on Alternative Facemasks (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/masksalt.pdf
Aerosol-Generating Procedures and Patients with Suspected or Confirmed COVID-19 (PDF):https://www.health.state.mn.us/diseases/coronavirus/hcp/aerosol.pdf
Droplet Precautions:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html
Airborne Precautions:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html

MONITORING/AUDITING:

- The Director of Nursing, the Infection Preventionist, and other facility leadership will conduct audits on all shifts, four times a week for one week, twice weekly for one week and biweekly thereafter, until 100% compliance is achieved to ensure active screening is being completed at the point of entry for all persons who enter the facility.

The Director of Nursing, Infection Preventionist or designee will review the results of audits and monitoring with the Quality Assurance Program Improvement (QAPI) program.

COHORTING RESIDENTS/TRANSMISSION BASED PRECAUTION "ISOLATION"

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

POLICIES/PROCEDURES/SYSTEM CHANGES:

- The facility's Quality Assurance and Performance Improvement Committee must conduct a root cause analysis (RCA) to identify the problem(s) that resulted in this deficiency and develop intervention or corrective action plan to prevent recurrence.

The Infection Preventionist and Director of Nursing shall complete the following:

- Grouping of residents, or "cohorting," should be done when possible to separate residents with an infectious disease (positive residents) from residents who are not affected. Plans to cohort should be carefully established in advance and should be centered on implementation of infection control practices.
- Dedicate a unit or part of a unit as the care location for residents with disease, including those with or without current symptoms of illness. Anticipate ways to close off units to prevent spread of illness from ill residents to non-ill residents (e.g., for symptomatic COVID-19, recovered COVID-19 residents, non-COVID-19 suspected residents).
- Confine symptomatic residents and exposed roommates to their rooms. If they must leave their room, ensure the resident is wearing a mask.
- Provide dedicated equipment for areas, as able.

When a resident is placed on transmission-based precautions, the staff should implement the

following:

- Clearly identify the type of precautions and the appropriate PPE to be used.
- Place signage in a conspicuous place outside the resident's room (e.g., the door or on the wall next to the door) identifying the CDC category of transmission-based precautions (e.g., contact, droplet, or airborne), instructions for use of PPE, and/or instructions to see the nurse before entering. Ensure that signage also complies with residents' rights to confidentiality and privacy.
- Make PPE readily available near the entrance to the resident's room.
- Don appropriate PPE upon entry into the environment (e.g., room or cubicle) of resident on transmission-based precautions (e.g., contact precautions).
- Use disposable or dedicated noncritical resident-care equipment (e.g., blood pressure cuff, bedside commode). If noncritical equipment is shared between residents, it will be cleaned and disinfected following manufacturer's instructions with an EPA-registered disinfectant after use.
- Clean and disinfect objects and environmental surfaces that are touched frequently (e.g., bed rails, over-bed table, bedside commode, lavatory surfaces in resident bathrooms).

TRAINING/EDUCATION:

- Provide education to residents (to the degree possible/consistent with the resident's capacity) and their representatives or visitors on the use of transmission-based precautions.
- Refer to CDC Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings. https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
- Refer to MDH COVID-19 Infection Prevention and Control and Cohorting in Long-term Care. https://www.health.state.mn.us/diseases/coronavirus/hcp/ltcipchohort.pdf
- MDH: Interim Guidance for Hospital Discharge to Home or Admission to Congregate Living Settings and Discontinuing Transmission-Based Precautions. https://www.health.state.mn.us/diseases/coronavirus/hcp/hospdischarge.pdf

CDC RESOURCES:
Infection Control Guidance: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html
CDC: Isolation Precautions Guideline:
https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007): https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Personal Protective Equipment: https://www.cdc.gov/niosh/ppe/
Healthcare Infection Prevention and Control FAQs for COVID-19:
https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control-faq.html

MDH RESOURCES:
Personal Protective Equipment (PPE) for Infection Control:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/ppe/index.html
MDH Contingency Standards of Care for COVID-19: Personal Protective Equipment for Congregate Care Settings (PDF): https://www.health.state.mn.us/communities/ep/surge/crisis/ppegrid.pdf

Interim Guidance on Facemasks as a Source Control Measure (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/maskssource.pdf
Interim Guidance on Alternative Facemasks (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/masksalt.pdf
Aerosol-Generating Procedures and Patients with Suspected or Confirmed COVID-19 (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/aerosol.pdf
Droplet Precautions:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html
Airborne Precautions:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html

MONITORING/AUDITING:

- The Director of Nursing, the Infection Preventionist and other facility leadership will verify the placement of each new admission and location and audit for transmission based precautions are being appropriately implemented.
- Conduct a Root Cause Analysis (RCA) which will be done with assistance from the Infection Preventionist, Quality Assurance and Performance Improvement (QAPI) committee and Governing Body. The RCA should be incorporated into the intervention plan. Information regarding RCAs can be found in the document: Guidance for Performing Root Cause Analysis (RCA)with Performance Improvement Projects (PIPs)
https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/GuidanceforRCA.pdf

In accordance with 42 CFR § 488.402(f), the DPOC remedy is effective 15 calendar days from the date of the enforcement letter. The DPOC may be completed before or after that date. A revisit will not be approved prior to receipt of documentation confirming the DPOC was completed. To successfully complete the DPOC, the facility must provide all of the following documentation identified in the chart below.

Documentation must be uploaded as attachments through ePOC to ensure you have completed this remedy.

Imposition of this DPOC does not replace the requirement that the facility must submit a complete POC for all cited deficiencies (including F880) within 10 days after receipt of the Form CMS 2567.

Item	Checklist: Documents Required for Successful Completion of the Directed Plan
1	Documentation of the RCA and intervention or corrective action plan based on the results with signatures of the QAPI Committee members.
2	Documentation that the interventions or corrective action plan that resulted from the RCA was fully implemented
3	Content of the training provided to staff, including a syllabus, outline, or agenda, as well as any

	other materials used or provided to staff for the training
4	Names and positions of all staff that attended and took the trainings
5	Staff training sign-in sheets
6	Summary of staff training post-test results, to include facility actions in response to any failed post-tests
7	Documentation of efforts to monitor and track progress of the interventions or corrective action plan

In order to speed up our review, identify all submitted documents with the number in the "Item" column.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245273	A. BUILDING _____ B. WING _____	12/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN RESTORATIVE CARE CENTER	**900 3RD STREET SOUTH FRANKLIN, MN 55333**

(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 from 12/7/20 through 12/8/20, 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 required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control survey was conducted on 12/7/20 through 12/8/20, 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		1/23/21

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

Electronically Signed | 01/07/2021

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	245273	A. BUILDING _____ B. WING _____	12/08/2020

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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 interview and document review, the facility failed to follow Centers for Disease Control (CDC) and Centers for Medicare and Medicaid Services (CMS) guidance by implementing or discontiuing isolation and transmission based-precautions (TBP) for the recommended timeframe of 14 days or when a resident was suspected of COVID for 6 of 25 residents (R17, R18, R19, R20, R21, and R22). Staff also failed to ensure 1 of 1 resident (R23) was appropriately screened for COVID-19 upon entrance after returning from the hospital. The facility also failed	F 880	Franklin Rehabilitation Healthcare Center Focused Infection Control Survey: 12/08/2020 Plan of Correction Deficiencies cited: F880, SS=F Date Certain: January 23, 2021 Preparation, submission and implementation of this plan of correction do not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our plan of	

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F 880	Continued From page 3 to have appropriate infection control (IC) surveillance to monitor, track and trend, and analyze data for signs and symptoms of suspected or potential COVID-19 and other infections. This had the potential to affect all 25 residents. Findings include: RESIDENT SCREENING/ ISOLATION Review of the below residents' progress notes, the COVID-19 Tracking list, 24-hour report sheets, and resident bowel records identified the following: R17's progress notes identified on 11/19/20, R17 had diarrhea and mild nausea. The COVID tracking list identified R17 tested positive for COVID on 11/20/20 and was placed into TBP. The TBP were removed on 12/3/20. There was no indication R17 had been placed into TBP on 11/19/20, when symptoms appeared. R18's progress notes identified on 11/21/20, R18 refused medications and had a temperature of 99.6 degrees, and his oxygen saturation was 86% on room air. Report was passed to the night shift to continue monitoring the resident. There was no mention R18 was isolated and placed on TBP on 11/21/20. On 11/22/20, R18 tested positive for COVID. TBP were then implemented and family was notified. R19's progress notes identified on 11/23/20, R19 tested positive for COVID-19 and was placed in TBP. On 11/30/20, R19's PCR COVID test was negative and R19 was removed from TBP, 7 days earlier than the required 14 day CDC guideline for	F 880	correction is prepared and executed as a mean to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. DIRECTED PLAN OF CORRECTION A Directed Plan of Correction (DPOC) is imposed in accordance with 42 CFR § 488.424. Your facility must include the following in their POC for the deficient practice cited at F880: F880 • R17, R18, R19, R20, R21, R22, and R23: MD/Regional Director of Clinical Services attended a virtual meeting to review the 2567, F880- S/S = F received on 12/28/2020. MD was notified on 12/28/2020 during Medical Director/Regional Director of Clinical Services weekly reoccurring meeting, of the breach in the infection control practice of implementing or discontinuing isolation and transmission based-precautions (TBP) for the recommended timeframe of 14 days or when a resident was suspected of COVID for 6 of 25 residents (R17, R18, R19, R20, R21, and R22) and Staff also failed to ensure 1 of 1 resident (R23) was appropriately screened for COVID-19 upon entrance after returning from the hospital. The facility also failed to have appropriate infection control (IC) surveillance to monitor, track and trend, and analyze data for signs and symptoms of suspected or potential COVID-19 and other infections. This deficient practice had the potential to affect all 25 residents.	

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F 880	Continued From page 4 removal of isolation. R20's progress notes identified On 11/23/20, R20 had a new cough and tested for COVID-19, and was placed on TBP. On 12/1/20, R20's progress note identified R20 had been receiving tylenol for body aches and headache. On 12/2/20, R20 had no symptoms of cough, shortness of breath or body aches. On 12/3/20, R20's TBP were discontinued after 10 days. On 12/4/20, R20 was given tylenol for a headache, and also had a cough and crackles in her lower lungs and productive cough with light green thin sputum. NP-A was contacted, and ordered Docycycline and Tessalon pearls for cough. R20's MAR identified on between 12/1/20, and 12/2/20, R20 received tylenol 650 milligrams (mg) twice daily as needed for pain rated 8/10. On 12/1/20, 12/3/20, and 12/4/20 R20 received ibuprofen 200 mg for headache and hip pain. R20's progress notes made no mention NP-A was notified of continued symptoms of COVID-19 prior to discontinuing TBP after day 10, or the facility followed the CDC guidelines of TBP for 14 days, to be extended if the resident was still symptomatic. R21's progress note identified on 12/1/20, R21 was admitted to the facility and was COVID positive. On 12/3/20, R21 complained of body aches "all over". On 12/4/20, R20 had harsh coughing episodes, shortness of breath, oxygen saturations (SpO2) in the low 70 percent (%) range and was sent to kidney dialysis. The dialysis center called and wanted R21 sent to the emergency room (ER) for low SpO2. The NP-A was notified and was going to call the dialysis center to speak with them directly. It is unknown if R21 was assessed at the hospital. Later on On	F 880	R18 was hospice and expired from co-morbidities and complications of COVID. R21 was discharged from Franklin RHCC. R17, R19, R20, R22, and R23 currently reside at Franklin RHCC and have recovered from COVID. • On 01/06/21 Medical Director/NP-A/Regional Director of Clinical Services attended a virtual meeting to discuss review: o DPOC o Root Cause Analysis o COVID Focused Survey EDUCATION PACKET/Training Agenda o F880 Active Screening Education Training o Reviewed Policies; Change in Resident's Condition or Status, Isolation – Initiating TBP, Isolation – Notices of TBP, Isolation – Categories of TBP, COVID-19 Facility Guidelines, COVID-19 Step by Step Preparation o MDH Infection Control Tracking Log – Resident Log and Staff Log, Track and Trending, Infection Prevention Training for facility administration (IP, DON) IP training completed: see attached IP certificates of course completed. DON assigned IP training to be completed by 01/22/2021 o Updated Resident/Visitor screening log to include GI symptoms o CDC Poster "Droplet Precautions", staff educated to initiate isolation and notify nurse of new infectious processes for assessment. • Licensed/unlicensed nursing staff were in-serviced on 01/04/21 and 01/05/21 at ALL STAFF MEETING. Nursing staff educated to alert ON CALL	

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F 880	Continued From page 5 12/4/20, R21 was taken off TBP per administrator. R21's bowel record identified R21 had diarrhea on 12/6/20, 12/7/20 and 12/8/20. R21's progress notes and COVID Screening Tool made no mention of R21's symptoms. The 24 hour report made no mention of R21's symptoms or status. There was no indication why R21 was taken off TBP 3 days after admission with known COVID. R22's progress notes identified on 11/16/20 at 7:20 a.m., R22 complained of his voice being scratchy, a temperature of 99 degrees F, and decreased SpO2 of 86%. There was no mention R22 was immediately placed on TBP. At 9:22 a.m., staff noted R22 to have a COVID positive test result. R22 was then placed on TBP. On 11/25/20 R22 reported he had a loose stools. On 11/26/20, R22 reported to the nurse he had four loose stools over the past 24 hours. R22 was given Immodium for the loose stools. The COVID line list identified R22 was removed from TBP on 11/26/20, only 10 days after implementation prior to the 14 day isolation required from CDC to be continued if the resident was symptomatic. On 11/27/20, R22 reported he had a headache. During an observation and interview on 12/8/20 at 4:45 p.m., R23 was observed being transported on a gurney assisted by emergency medical services (EMS) to the entrance nearest the nurse station. R23 was not wearing a mask. No staff were at the desk. Nursing assistant (NA)-A, and NA-B were summoned to the door. They opened the door and assisted R23 into the facility into the locked unit. Neither NA-A, nor NA-B attempted to place a mask on R23, no perform a symptom screen prior to transporting R23 to her room on the locked unit. There were unidentified staff and	F 880	RN/DON by phone during off hours to report any staff or resident illness suspect for potential COVID. Staff educated on process for completing resident screening for re-entrance upon return to facility at designated screening entrance. Please review attached education documentation for education/training and post-test. • Infection Preventionist/DON is responsible for compliance. Nursing staff educated to report any suspected staff or resident illness on 24hr Nurse Report form or by phone after hours to ON CALL RN/DON. 24 Hour Nurse Report to be reviewed daily by IP/DON. DON/Administrator to monitor IP work weekly to ensure timely and accurate completion of assigned duties. • Audits completed by IP/DON/Designee; Ongoing audits of MDH IC Tracking Resident Log and Staff Log, Daily IP Surveillance audits, Cumulative New Admit TBP audits, Audit schedule will begin x 4 weekly for one month and then x2 weekly for two additional months, then x1 weekly for 3 months, and then x1 monthly for six months to equal 12 months of IP auditing. • All audits results will be reviewed by the Administrator and the Administrator will take audits to monthly QAPI meetings x12 months to ensure consistent implementation of the facility's policy with tracking and trending of policy compliance. Medical Director to attend quarterly QAPI meetings. • Please See DPOC for further information and reference RCA as applicable.	

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F 880	Continued From page 6 residents present in the locked unit hallway at the time R23 was transported to her room. Interview with NA-A and NA-B identified R23 was at the hospital for a few days. She had dementia, and was not complaint with wearing a mask. EMS brought R23 to the incorrect entrance, and should have been redirected to the designated entrance where she would have been screened and provided a mask. They agreed even though she was at the incorrect entrance they could have obtained a mask, offered it to R23, and found a thermometer, and performed a COVID Symptoms screen at the entrance prior to assisting R23 into the facility. An interview on 12/3/20 at 4:55 p.m., with the administrator identified staff were expected to screen all residents for COVID-19 when returning from a hospital stay, and should have attempted to place a mask on R23 prior to entering the facility. An interview on 12/8/20 at 5:00 p.m., with the DON identified staff should have attempted to place a mask on R23, and performed a COVID-19 symptoms screen prior to assisting R23 into the facility. R23 was at the wrong entrance, and "staff were just confused on what to do". SURVEILLANCE During interview on 12/7/20 at 10:57 a.m., with the director of nursing (DON) identified she was unfamiliar with the infection control (IC) program at the facility. The facility had no in-house infection preventionist (IP) as of 11/4/20. The DON was not trained in IC, but was assigned to	F 880	• Date Certain: Jan 23, 2021	

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be the interim facility IP until the new IP was in place. The regional nurse consultant (RN)-A was assisting her with IC. The DON would review the 24-hour nurse report sheets, the Existing Resident COVID-19 Screening Tool, and would interviewed staff every day to monitor for potential symptoms of COVID. The DON identified RN-A currently had all the IC data offsite, but was expected to be at the facility in about an hour. The DON was unsure where any IC policies and procedures were, and deferred answering any IC question until RN-A arrived.

During interview on 12/7/20 at 12:10 p.m., RN-A identified the facility COVID outbreak began in the West [locked unit] wing and quickly spread throughout the facility. During the initial outbreak, the DON and previous IP had COVID and were not allowed to work. A nurse practitioner (NP) and RN-A were onsite to assist with the outbreak in their absence. RN-A was at the facility during the outbreak from 11/16/20 until 11/24/20. After 11/24/20, she had not been active with the facility's IC surveillance and had not been onsite until 12/7/20. A line list was not implemented to monitor for presence of COVID-19 symptoms prior to and during the outbreak. The facility was waiting for the new IP to assume the role and be oriented to the IP position. In the meantime, the DON reviewed the Resident COVID-19 screening Tool in resident's EMR, the 24-hour nurse report sheets, and interviewed staff to identify symptoms of COVID-19 in the facility. There was no IC data available for November 2020 and December 2020. RN-A had previously taken the limited IC information with her and was in the process of reviewing the November and December 2020 IC data offsite.

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Review 11/15/20 through 12/7/20, 24-hour report sheets identified the sheets consisted of the date and wing and had three columns labeled Resident, 6 a.m. to 6 p.m., and 6 p.m. to 6 a.m. The sheets identified if residents were positive for COVID-19, and included information resident needs, and when residents had a change in condition. Report sheets from 11/19/20, 11/21/20, 11/24/20, 11/25/20, and 11/29/20, were not included in the documentation provided by the DON.

Further interview on 12/7/20 at 1:30 p.m., with the DON identified she was reviewing resident information and was making a list of residents who were prescribed antibiotics, and would provide the list of those residents when it was completed. She was unable to locate the 24-hour reports sheets noted above she had identified as having reviewed. If staff didn't put them in her mailbox or on her desk, they were not available. The DON later confirmed she had no documentation available to identify infection surveillance occurred on a continuous, daily, ongoing basis as the facility relied only on 24 hour reports and had no formal system for surveillance.

Review of the facility's infection control (IC) surveillance and tracking documentation identified the facility used the 24 hour nursing report sheets and the COVID-19 screening tool located in the resident's electronic medical record (EMR). A green IC binder was provided reported to contain IC data. November 2020, and December 2020, IC data was not included in the IC binder. A separate list of residents who had COVID-19 was provided, however there was limited documentation only to show when a

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resident became positive and when they were off TBP. There was no documentation to show any tracking, trending or analyzing of any data had occurred.

A facility COVID-19 Tracking list was provided and listed residents in the facility for residents who had known COVID-19. The list was comprised of four columns titled "Resident Name", "Date Positive", "If 24 Hour Symptoms Free", and "End Isolation Date". The list did not include resident specific symptoms or the date of symptom onset.

During an interview on 12/8/20 at 3:00 p.m., with the medical director identified NP-A was assigned to the facility to assist during the COVID-19 outbreak. She was the person onsite daily, and was most able to answer any questions specific to resident care. He expected the facility to follow recommendations and policies for implementing and removing TBP, and to notify providers of any symptoms of illness or changes in condition. He identified there were "so many sick people", paperwork would not be expected to be completed and the focus should should be on providing support, education, tools, and people.

During an interview on 12/8/20 at 3:40 p.m., with the administrator identified he agreed the IC program was deficient. The old IP had not been updating a line list for "quite some time". The DON was out of the facility with COVID during the outbreak. The former IP was no longer employed at the facility as of November 2020. RN-A acted as the interim IP while the DON was gone. RN-A was from the corporate office and was IC certified. RN-A was onsite during the outbreak, but currently provided oversight of the DON and

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the IP program remotely. The DON was the current onsite interim IP, and had not received IC training. The administrator expected the IP program to continue to function according to the policy, however, during the outbreak, staffing was "slim", and the resident's care took priority. The facility had an onsite NP during the outbreak to monitor the ill residents and over see their care. A new IP was hired, however she had just started and was too new and had not yet assumed the IP role. Additionally NP-A was onsite to provide care for COVID-19 affected residents during the outbreak and provided guidance for implementing and removing TBP. After the outbreak, NP-A was available to provide recommendations.

During an interview on 12/8/20 at 4:35 p.m. with NP-A identified she was onsite at the facility during the outbreak between 11/12/20, and 11/18/20. Her role was to assist in resident care by monitoring residents affected with COVID-19 for changes in condition and provide treatment. She also was responsible to update residents' providers of their conditions. She was not involved with the IC program at the facility. After 11/18/20, she was no longer onsite, but continued to be available to respond to resident care needs. NP-A worked with RN-A regarding resident symptoms and provided guidance for when to implement and remove TBP only when the facility contacted her. She expected staff to assess residents prior to contacting her in order to make appropriate resident care decisions regarding TBP, changes in condition, and other needs residents had and to follow CDC guidelines. NP-A recalled being notified of R21's continued symptoms, and recommended she remain on precautions for a few more days. NP-A expected staff to follow her recommendations. R17's

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symptoms had improved prior to removing TBP. NP-A was unaware of specific CDC guidelines for removing residents from TBP. If continued symptoms were present, she expected to be notified and would recommended residents remain on TBP past the 14 day recommended timeframe and additional treatment or tests be completed to rule out any additional illnesses.

Review of the August 2019, Isolation-Initiating Transmission-Based Precautions policy identified TBP were to be initiated when a resident developed signs or symptoms (s/s) of a transmissible infection, arrive for admission with symptoms of an infection; or had a laboratory confirmed infection and was risk of transmitting the infection to other residents.

Review of the 11/9/20, electronic email identified management wrote, "Attention Nurses: Requirements for shift documentation for ALL residents identified staff were to report any abnormal vital signs immediately to the charge nurse, the DON, Nurse Practitioner or Medical Director. Abnormal Vitals to be reported immediately to the DON/Chart/Medical director were a temperature greater than 99.5 degrees F, an oxygen saturation less than 92%, or a change in the O2 sat of more than 4% (example...was 96% and now 92%)". There was no mention the email followed current CDC guidelines for potential signs and symptoms of COVID-19 or if staff had a list or knowledge of all s/s associated with COVID-19.

Review of the 8/28/20, COVID-19 Facility Guidelines identified if staff suspected a resident had COVID-19, they were to immediately place them in TBP, place a mask on them, close their

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245273	A. BUILDING _____ B. WING _____	12/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN RESTORATIVE CARE CENTER	**900 3RD STREET SOUTH FRANKLIN, MN 55333**

(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 12	F 880		

door, contact the Minnesota Department of Health, the RC, and local hospital. In addition, staff were to contact the resident's representative, MD, or any other provider and notify them of the resident's status. Staff were reminded to update the Infection Control Line Listing at that time. For COVID positive residents or persons under investigation, staff were to check for signs and symptoms of such residents 3 x per day. There was no mention of who was responsible for the overall IC program to ensure ongoing daily cumulative surveillance was being performed.

Review of the 8/20/20, COVID-19 Discontinuing Transmission-Based Precautions policy identified the decision to discontinue TBP for residents with confirmed COVID-19 infection was to be made on a symptom-based strategy. Residents were to be in a private room with a private bathroom and be monitored three times daily for 14 days to determine whether symptoms develop that could be consistent with COVID-19. Residents should stay isolated in the room for the 14-day period. The resident was able to to be moved out of a private room if they remained asymptomatic after the 14-day period. Discontinuation of TBP with Symptom-based strategies included the following: (1) for residents with mild to moderate illness no severely Immunocompromised, at least 10 days have passed since the first symptoms appeared and at least 24 hours have passed since the last fever without use of fever-reducing medications, and symptoms had improved. (2)TBP for asymptomatic residents were to be discontinued when at least 10 days had passed since the date of the first positive viral diagnostic test. (3) Residents with severe to critical illness who were severely Immunocompromised: TBP was able to be discontinued at least 20 days after symptoms

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F 880	Continued From page 13 first appeared and at least 24 hours had passed since the last fever without use of fever-reducing medication and symptoms had improved. The highest level of illness severity experienced by a resident at any point was to be used when determining the duration of of TBP. Once a resident was moved from the COVID unit, they were able to cohort with a resident who was monitored for 14-days with no experienced COVID symptoms.	F 880		