DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 1, 2020

Administrator
Caledonia Rehabilitation & Retirement Center
425 North Badger Street
Caledonia, MN 55921

RE: CCN: 245499
Survey Start Date: April 22, 2020

Dear Administrator:

On June 15, 2020 the Minnesota Department(s) 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 June 15, 2020. Per the CMS Memo QSO-20-20-All, enforcement remedies were suspended from March 23, 2020 to May 31, 2020 and will be evaluated at a later date.

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

Feel free to contact me if you have questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Electronically delivered
May 8, 2020

Administrator
Caledonia Rehabilitation & Retirement Center
425 North Badger Street
Caledonia, MN 55921

SUBJECT: SURVEY RESULTS
CCN: 245499
Cycle Start Date: April 22, 2020

Dear Administrator:

SUSPENSION OF SURVEY AND ENFORCEMENT ACTIVITIES

The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with Memorandum QSO-20-20-All, CMS is suspending certain Federal and State Survey Agency surveys, and delaying revisit surveys, for all certified provider and supplier types.

During this time, CMS is prioritizing and conducting only the following surveys: focused infection control surveys, investigations of complaints and facility-reported incidents that are triaged at the Immediate Jeopardy (IJ) level, and revisit surveys for unremoved IJ level deficiencies. With the exception of unremoved IJs, CMS will also be exercising enforcement discretion during the suspension period. For additional information on the prioritization of survey activities please visit https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0.

SURVEY RESULTS

On April 22, 2020, the Minnesota Department of Health completed a COVID-19 Focused Survey at Caledonia Rehabilitation & Retirement Center to determine if your facility was in compliance with Federal requirements related to implementing proper infection prevention and control practices to prevent the development and transmission of COVID-19. The survey revealed that your facility was not in substantial compliance. The findings from this survey are documented on the electronically delivered CMS 2567.

PLAN OF CORRECTION

You must submit an acceptable electronic plan of correction (ePOC) for the enclosed deficiencies that were cited during the April 22, 2020 survey. Caledonia Rehabilitation & Retirement Center may choose to delay submission of an ePOC until after the survey and enforcement suspensions have been lifted.

The provider will have ten days from the date the suspensions are lifted to submit an ePOC. 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. Please note that if an onsite revisit is required, the revisit will be delayed until after survey and enforcement suspensions are lifted. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation.

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; and
- The date that each deficiency will be corrected.

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

Jennifer Kolsrud Brown, Unit Supervisor
Fax: (507) 206-2711
Email: jennifer.kolsrud@state.mn.us

INFORMAL DISPUTE RESOLUTION

You have one opportunity to dispute the deficiencies cited on the April 22, 2020 survey through Informal Dispute Resolution (IDR) in accordance with 42 CFR § 488.331. To receive an IDR, send (1) your written request, (2) the specific deficiencies being disputed, (3) an explanation of why you are disputing those deficiencies, and (4) supporting documentation by fax or email to:

Jennifer Kolsrud Brown, Unit Supervisor
Fax: (507) 206-2711
Email: jennifer.kolsrud@state.mn.us

An IDR may not be used to challenge any aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

An IDR, including any face-to-face meetings, constitutes an informal administrative process that in no way is to be construed as a formal evidentiary hearing. If you wish to be accompanied by counsel for your IDR, then you must indicate that in your written request for informal dispute resolution.

Caledonia Rehabilitation & Retirement Center may choose to delay a request for an IDR until after the survey and enforcement suspensions have been lifted. The provider will have ten days from the date the suspensions are lifted to submit a request for an IDR in accordance with the instructions above.

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES

The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at https://qioprogram.org/. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at https://qioprogram.org/locate-your-qio.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245499	A. BUILDING _____ B. WING _____	C 04/22/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALEDONIA REHABILITATION & RETIREMENT CENTER	**425 NORTH BADGER STREET CALEDONIA, MN 55921**

(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 4/16/2020 at your facility with an exit conference 4/22/2020 by the Minnesota Department of health to determine compliance with Emergency Preparedness regulations [§] 483.73(b)(6). The facility was not in full compliance. 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, a revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form.	E 000		
E 024 SS=F	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6) [(b) Policies and procedures. The [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 (annually for LTC).] At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated	E 024		5/29/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/13/2020

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 024	Continued From page 1 health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to develop an emergency staffing plan which had the potential to effect all 41 resident in the facility. An emergency preparedness (EP) policy related to staffing during an emergency was requested, was not provided. According to a telephone interview on 4/22/20, at 10:03 a.m., the facility administrator said they discussed possible plans for staffing adjustments; however, administrator confirmed the facility did not have a EP policy related to emergency staffing.	E 024	Caledonia Rehab and Retirement has developed an Emergency Preparedness Plan that lists protocols, policies, and procedures for various emergency events that, based on a comprehensive assessment, could affect the facility, its residents, and/or its staff. This plan is reviewed and revised on an annual basis. As part of the Emergency Preparedness Plan, Caledonia Rehab and Retirement has written a detailed policy/plan for Emergency Staff during an emergency event. (See Plan below) The written Emergency Staffing Plan will be reviewed with all staff by May 29, 2020. The Administrator will be responsible for monitoring and/or revising this Emergency Staffing Plan to ensure its success.	

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E 024	Continued From page 2	E 024	POLICY: To ensure minimal staffing during emergencies, including the COVID-19 pandemic. PROCEDURE: 1. Conservation of Current Direct Care Staff. The organization will identify areas where staff are conserved while ensuring resident needs are prioritized and cared for. a. Staff will consider the following based upon the staffing situation: i. Bundling care and services requiring less frequent visits. ii. Request orders from the resident's primary care provider to eliminate or reduce all non-essential medications and treatments. iii. Reduce bathing practices where residents will receive one bath per week. If staffing reaches a point where providing a weekly bath is an undue strain on resources, will consider no baths and, in place, thorough AM and PM cares. iv. A designated COVID-19 team will be assigned to care for residents who are quarantined with symptoms, or positive/suspected COVID-19. b. Staff will be asked not to take voluntary time off during the pandemic. [Consider suspending the cap on vacation so staff can continue to accrue vacation even if they cannot spend it down at this time]. c. Overtime hours will be approved more	

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E 024	Continued From page 3	E 024	readily while mindful of staff health and burnout. d. Consider shift changes such as implementing 12-hour shifts. 2. Non-Direct Care Staff. The organization will evaluate non-direct care staff and determine areas where non-direct care staff can assist in the direct-care area. If training to perform these duties is required, the organization will provide training to the extent the non-direct care staff member is safe to complete tasks assigned. [Consider using trainings available such as the Basic Care Aide, Nursing Assistant Training, or Feeding Assistant Trainings to get more hands on deck] a. Therapy staff, including PT, OT, ST, will perform tasks within their scope of practice. Examples include, assistance with dining, assistance with ADL care, assistance with bathing, etc. b. Nurses in administrative roles will participate in direct care. [Consider other staff you may train for assistance or re-deploy, such as activity staff, marketing, back office, administration, receptionists, or others] 3. Alternative Staffing Resources. During the COVID-19 pandemic the organization may need to use alternative staffing resources. a. New-hires will receive an abbreviated new hire and training process consistent with current state and federal guidance.	

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E 024	Continued From page 4	E 024	The community will assure new hires are trained and competent to perform skills for which they were hired. b. The community administration will: i. Contact our casual staff to fill open shifts, implement our mandatory overtime policy, or use our bonus program for staff volunteering for a bonus qualified shift ii. Contact supplemental staffing agencies and will have contract(s) with at least one SNSA to assist with filling staff shortages. Contact numbers are: 1. Nurzee (763) 339-0214 2. Titan Medical (866) 332-9600 ext. 1126 3. AnnLeo (712) 336-6999 4. Grape Tree (712) 336-0800 ext. 1134 5. Manpower, LLC (651) 309-1085 [Consider monitoring daily mailings regarding displaced workers available for hire from your provider association and Caring Careers Start Here] iii. Reach out to related facilities, partners, or local university health career related programs for staffing support. iv. Reach out to organizations with which we have entered into a Memorandum of Understanding as part of our Emergency Preparedness planning. v. Engage the professional trade association. vi. Contact your area hospitals, clinics, or homecare agencies for staff that may be available; vii. Reach out to community paramedics; viii. Reach out to Houston County's	

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E 024	Continued From page 5	E 024	Medical Reserve Corps to assist. 651-201-5700 or minnesotaresponds@state.mn.us ix. Contact Regional Health Care Preparedness Coordinators or Public Health Preparedness Coordinators; x. Utilize the SHCC Minnesota Healthcare Resource Call Center (MHRCC) at 1-833-454-0149 (toll free) or 651-201-3970 (local). xi. Explore emergency management options through our county; and xii. The community will reach out to the Minnesota Department of Health when staffing issues start. Staff removed from the schedule – COVID-19 Concerns: Staff will be removed from the schedule following state and federal guidelines for staff quarantine and symptom self-monitoring. Self-quarantine periods will be re-considered if the community becomes unable to provide minimal staffing during the pandemic. Employee return to work will be prioritized based upon several factors including who is nearest to their RTW date. Additionally, employees returning to work will follow current PPE guidelines. c. If not already done, allow HCP with suspected or confirmed COVID-19 to perform job duties where they do not interact with others (e.g., patients or other HCP), such as in telemedicine services. d. Allow HCP with confirmed COVID-19 to provide direct care only for patients with confirmed COVID-19, preferably in a cohort setting.	

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E 024	Continued From page 6	E 024	e. Allow HCP with confirmed COVID-19 to provide direct care for patients with suspected COVID-19. f. As a last resort, allow HCP with confirmed COVID-19 to provide direct care for patients without suspected or confirmed COVID-19. Date of Compliance: 5/29/2020	
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control survey was conducted 4/16/2020 at your facility with an exit conference 4/22/2020 by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was not in full compliance. 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. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form.	F 000		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §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	F 880		5/21/20

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F 880	Continued From page 7	F 880		

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, 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.

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F 880	Continued From page 8 (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 actively screen staff and visitors upon entrance to the facility. In addition, the facility failed to properly disinfect equipment between resident uses. Findings include: On 4/16/2020 at 9:30 a.m., surveyors entered the facilities entry way and observed a tray table with masks, gloves, gowns, bottle of hand sanitizer and a wall mounted hand sanitizer, sign in sheet with symptom check questions, thermometer in small container with alcohol wipes, signs posted included an instruction sheet that read, "stop, you must check temperature and wear a mask before entering the facility per Centers for Disease	F 880	The facility has established 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. Caledonia Rehab and Retirement on March 12, 2020, in response to the COVID-19 Pandemic, locked down our facility. Only allowing staff who were screened for the virus to enter the building. We discontinued all group activities and our communal dining program. Also, on that date we conducted a staff education regarding the COVID19 Virus, infection control procedures and the protocol for the facility	

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F 880	Continued From page 9 Control and Prevention (CDC) guidelines dated 4/5/2020", and an instruction sheet on how to use the thermometer. During observation and interview on 4/16/2020 at 9:33 a.m., family member (FM)-A and FM-B entered the buildings entry way neither one used hand hygiene. FM-B took the thermometer and obtained FM-A temperature and placed the thermometer back in the container without wiping it down. FM-B assisted FM-A with mask and gown. FM-A placed coat and cane on the tray table of the PPE supplies. FM-A wrote name and temperature on sheet but did not answer the screening questions. FM-A proceeded to enter the facility through the next set of doors. FM-B said that the facility just started to allow FM-A to come visit since significant other was in the dying process. FM-B left the building. The administrator and director of nursing (DON) came to the entry area where they were updated of the process and screening process for staff and visitors. DON confirmed that staff and visitors have been self-screening. A dietary aide (DA)-A entered the facility and was observed to not perform hand hygiene. DON asked DA-A to check back in on the screening sheet and the DON then screened DA-A after surveyor updated DON staff were not to screen themselves. Surveyors had asked DA-A to perform hand hygiene before proceeding through the next set of doors. DON asked surveyors to complete the screening sheet. During an observation on 4/16/2020 at 9:58 a.m., maintenance (MAINT)-A entered the west entrance door. MAINT-A proceeded to pick up the thermometer, opened the alcohol wipe packet and wiped off the end of the thermometer.	F 880	lock down. On April 16, 2020, the Minnesota Department of Health surveyor came to the building to conduct a COVID19 Infection Control survey. They did notice that the facility was in lock down and that we had a system for screening employees who entered the building. Unfortunately, they informed the administrator that our system was less than effective giving our current process. They observed a family member of a resident who was actively dying not follow proper infection control protocol. The facility immediately changed our protocol to include an assigned/trained staff person at the point of entry who would conduct the screening at the point of entry looking for signs/symptom of the virus on the person entering the building. Then consistently having the person do hand hygiene using the hand sanitizer then taking the persons temperature and filling out the information on our screening log. The tightening of this protocol has been effective and consistent with the MDH recommendations. During the survey, the surveyors observed a staff member using a mechanical lift on one resident in their room, then removing the lift and taking it directly into another resident's room without sanitizing the lift in between resident use. This is against our infection control policy and procedure. The DON did immediate training of the staff person involved. She then provided	

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	245499	A. BUILDING _____ B. WING _____	C 04/22/2020

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CALEDONIA REHABILITATION & RETIREMENT CENTER	**425 NORTH BADGER STREET CALEDONIA, MN 55921**

(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 10 MAINT-A placed the thermometer on the forehead, looked at the reading and proceeded to repeat the process two more times then placed the thermometer in the yellow bin on top of the alcohol wipe packets. MAINT-A completed the screening questions independently, mask on, used the hand sanitizer and proceeded through the doors into the hallway. During an interview on 4/16/2020 at 10:00 a.m., housekeeping (HSKP)-A stated staff perform self-screening at the west entrance. During interview on 4/16/2020 at 10:05 a.m., MAINT-A verified the thermometer was not cleaned after use. MAINT-A stated alcohol wipes are there to clean before taking temperature. MAINT-A stated was unaware thermometer needed to be wiped down after use. During an interview on 4/16/2020 at 10:22 a.m., physical therapist (PT)-A stated staff have been doing self-screening upon entrance. During an interview on 4/16/2020 at 10:30 a.m., registered nurse (RN)-A stated all staff perform self-screening at the west entrance. During an interview on 4/16/2020 at 10:59 a.m., nurse aide (NA)-A stated all staff self-screen every time entering the facility. NA-A stated staff take own temperature, answer the questions, and apply new mask each time they enter the facility. NA-A stated visitors self-screen and are required to wear mask, gown, and gloves. EQUIPMENT CLEANING During an observation on 4/16/2020 at 12:15	F 880	education to all Certified Nursing Assistants working on 4/16/20 on our policy and procedures for sanitizing all equipment between use on a resident before being used on the next resident. She followed up with a C.N.A. meeting on Thursday, May 21, 2020, again covering the expectation of using effective infection control protocol on equipment between resident use. We also hired a CNA mentor/skills trainer to observe cares and conduct on the spot education for our staff on all shifts. The Director of Nursing and the Infection Control Preventionist will monitor for on going compliance of our Infection Control Policy and Procedures and for our controlled entry into the building during lock down. Date of Compliance: 5/21/20	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245499	A. BUILDING _____ B. WING _____	C 04/22/2020

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F 880	Continued From page 11	F 880		

p.m., NA-B exited resident room with ez-stand carrying small garbage bag. NA-B left ez-stand outside doorway. NA-B disposed of garbage and used hand sanitizer. NA-B then moved ez-stand into another resident room without being disinfected. NA-B exited the room at 12:30 p.m. and placed ez-stand in hallway and was not observed to be disinfected.

During an interview on 4/16/2020 at 12:33 p.m., NA-B stated had been educated on infection control, hand hygiene, personal protective equipment (PPE), etc. NA-B verified ez-stand was to be cleaned between residents. NA-B confirmed disinfection was not completed. NA-B stated there is usually sani-wipes in the bag on the ez-stand and vital sign machine. NA-B confirmed there was not any sani-wipes on either machine or in the area.

During an interview on 4/16/2020 at 12:37 p.m., NA-C stated staff should be disinfecting equipment in between residents and that equipment should be wiped down right after using. NA-C stated wipes should be available on the equipment.

During an interview on 4/16/2020 at 12:40 p.m., DON stated supplies are available for staff to obtain as necessary. DON confirmed sani-wipes should be on the equipment and used in between residents.

Facility policy on Equipment Cleaning and Disinfection to Prevent Spread of Coronavirus Disease 2020 indicated all e-z stand, hoyer lifts, blood pressure cuffs, pulse oximeter's, stethoscopes, bath/shower chairs, thermometers, etc. will be cleaned after every resident use by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245499	A. BUILDING _____ B. WING _____	C 04/22/2020

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F 880	Continued From page 12 spraying with EPA-registered disinfectants and leaving on surface or scrubbing per disinfectants recommendations.	F 880		