DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 16, 2020

Administrator
Maplewood Care Center
1900 Sherren Avenue
Maplewood, MN 55109

RE: CCN: 245276
Cycle Start Date: October 2, 2020

Dear Administrator:

On October 14, 2020, we notified you a remedy was imposed. On December 14, 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 November 27, 2020.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective November 13, 2020 be discontinued as of November 27, 2020. (42 CFR 488.417 (b))

However, as we notified you in our letter of October 14, 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 November 13, 2020. This does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

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

Electronically delivered
October 14, 2020

Administrator
Maplewood Care Center
1900 Sherren Avenue
Maplewood, MN 55109

RE: CCN: 245276
Cycle Start Date: October 2, 2020

Dear Administrator:

On October 2, 2020, a survey was completed at your facility by the Minnesota Department(s) 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), 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:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective November 13, 2020.

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

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective November 13, 2020. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 13, 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 $11,160; 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 November 13, 2020, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Maplewood Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 13, 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:

Susanne Reuss, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: susanne.reuss@state.mn.us
Office: (651) 201-3793

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 April 2, 2021 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,

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
	245276	A. BUILDING _____ B. WING _____	C 10/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLEWOOD CARE CENTER	**1900 SHERREN AVENUE MAPLEWOOD, MN 55109**

(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 on October 1 & 2, 2020, at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.73(b)(6). The facility is IN compliance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On October 1 and 2, 2020, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found NOT to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5276177C, with a deficiency cited at F880. The following complaint was found to be UNSUBSTANTIATED: H5276178C and H5276179C In addition, A COVID-19 Focused Infection Control survey was conducted at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. Your facility was found NOT to be in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance.	F 000		

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

Electronically Signed | 10/23/2020

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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F 000	Continued From page 1 Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 880 SS=E	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 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	F 880		11/10/20

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F 880	Continued From page 2	F 880		

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.
(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

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F 880	Continued From page 3 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 utilized personal protective equipment (PPE) and cleaned shared equipment in a manner to prevent the potential spread of infection and in accordance with Centers for Disease Control (CDC) and State Health Department guidelines. This had the potential to affect 5 residents (R14, R13, R8, R9, R10) as well as several staff/visitors, observed for infection control. Findings Include: On 10/1/20, at 7:30 a.m., during interview, RN-A stated she thought there were five or six residents currently in the building affected by COVID, however was not sure as there was one resident who had not been doing well the previous day. On 10/1/20, at 7:44 a.m. during interview with the administrator and corporate regional director of operations, it was learned that as of the previous night there had been five or six COVID positive residents however had not checked yet because one of the resident's had not been doing well the previous night. R14: Observations, on 10/1/20, at 8:10 a.m., outside R14's room was a isolation cart with clean PPE stored in it and signs at the door instructing staff of when and how to use PPE along with a stop sign directing visitors to see the nurse before going into the room. A therapy staff (TS) was observed in R14's room. TS was observed wearing a yellow disposable gown, gloves, mask and eye protection and was standing next to	F 880	Survey of October 1 through October 2, 2020 F880 Infection Prevention and Control Individual residents and staff in survey citations R14 had no ill effects from the alleged deficient practice R13 had no ill effects from the alleged deficient practice R8 had no ill effects from the alleged deficient practice R9 had no ill effects from the alleged deficient practice R10 had no ill effects from the alleged deficient practice Staff TS was verbally educated on 10/2/2020 about the process for cleaning and disinfecting the vital signs machine and PPE use when leaving the room of a resident on droplet precautions. NA-A was verbally educated on 10/2/2020 about the process for cleaning and disinfecting the vital signs machine and PPE use when leaving the room of a resident on droplet precautions. NA-E was verbally educated on 10/2/2020 about the proper PPE and appropriate timing of hand hygiene for entering and leaving the room of a resident on droplet precautions. NA-G was verbally educated on 10/20/2020 about the appropriate us of PPE for residents on droplet precautions. RN-A was verbally educated about providing an appropriate Transmission-Based Precautions sign and	

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F 880	Continued From page 4 R14's bed checking vital signs (VS). At 8:12 a.m. TS was observed to remove gloves in R14's room, cleanse hands, and exited the room without removing the isolation gown. Still wearing the same gown, TS, pushed the VS machine from R14's room, walked into the hallway, past R14's door and left the VS machine stand in the hallway by the fire door. TS was not observed to clean the VS machine. R13: Outside R13's room was an isolation cart with clean PPE stored in it and there were signs at the door instructing staff of when and how to use PPE and a stop sign directing visitors to see the nurse before going into the room. At 8:13 a.m. nursing assistant (NA)-A exited R13's room pushing a VS machine monitor stand down the hallway, outside the Spa, and used hand sanitizer to clean hands, and was observed to push the VS machine down the hall, with out cleaning the machine. R8: At 8:15 NA-A, entered R8's room, with the unclean VS machine. NA-B and NA-A approached R8's bed to check VS's. When asked if the VS machine should be cleaned, NA-A stated, "yes", and acknowledged the resident whose VS has been taken right before R8 was on transmission/droplet precautions. NA-A stated, "I forgot to clean it." At this time both NA's came out of the room with the VS machine and were observed to clean the machine at 8:17 a.m. At 8:23 a.m. two staff were observed to walk down the hallway in the Transitional Care Unit (TCU) outside R13 and R14's rooms wearing a mask but not wearing face shield/goggles. Both staff briefly went into the nursing service office, came out and walked towards the front desk	F 880	PPE cart for all residents on droplet precautions. NA-D was verbally educated on 10/2/2020 about the requirement to wear eye protection; goggles or a face shield, when in the building. Populations at risk Residents, visitors and staff were at risk from the alleged infection prevention deficiencies identified during the survey. Systems reviews The facility□s Quality Assurance and Performance improvement Committee conducted a root cause analysis to identify causes of the alleged deficient practices. The following policies and procedures were reviewed and revised as needed: " Standard and transmission-based precautions " Staff use of PPE for residents on droplet precautions, including donning and doffing during COVID-19 with crisis standard of care, contingency standard of care and standard care. " cleaning and disinfection of shared vital signs equipment, " environmental disinfection " hand hygiene, " requirements for the use of eye protection or a face shield, " handling trash and linens for residents on droplet precautions, " providing signage and PPE for residents on droplet precautions and " source control masks Education Staff identified during the survey were provided with immediate education. Other	

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F 880	Continued From page 5 before leaving the building. On 10/1/20, at 9:22 a.m. NA-C stated the facility had designated 2 South as the COVID unit and residents had been moved into the COVID unit as of 9/25/20. NA-C explained that previously the facility had residents residing in the TCU unit and other floors in the facility with COVID precautions. NA-C also identified that staff had been provided education on PPE use, donning and doffing and all staff were supposed to wear goggles or a face shield and mask when in the building. On 10/1/20, at 9:48 a.m. two providers were observed on the 1st floor TCU unit standing outside the therapy room. Both were wearing face masks but no goggles or face shields. One of the providers was observed holding a face shield in her hand. One of the providers was observed to walk away from the therapy entry way and then both walked over and stood across from each other in the hallway outside room 118. On 10/1/20, at 9:53 a.m. the regional director of operations (RDO) explained it was the facility policy for "everyone to wear eyewear" which included staff and visitors. RDO approached the providers and brought them into the administrators office. On 10/1/20, at approximately 10:27 a.m. RN-B stated, "we are supposed to wipe the VS machine after each use with everyone". On 10/1/20, at 10:42 a.m. during an interview with the interim director of nursing (IDON) and RN-B, the IDON explained that due to a recent potential exposure of a resident and staff from over the weekend, the corporate staff development was at	F 880	staff who provide direct care, enter residents rooms, the Infection Preventionist (IP), Director of Maintenance, Director of Housekeeping and the Director of Nursing (DON) received education about " standard and transmission-based precautions, " appropriate staff use of PPE for residents on droplet precautions (donning and doffing), " cleaning and disinfection of shared medical equipment and the environment, " hand hygiene, " requirements for the use of eye protection or a face shield, " handling trash and linens for residents on droplet precautions, " providing signage and PPE for residents on droplet precautions and " source control masking by 11/10/2020. Competency testing was completed. Staff who did not pass initial competency testing received one on one education to demonstrate competence. Residents and their representatives received infection prevention and control education as it relates to them and to the degree possible consistent with the resident s capacity. Education was completed by 11/10/2020. Monitoring/Auditing " Observational audits of donning and doffing PPE for residents on droplet precautions will be conducted on all shifts four times per week for one week, then twice weekly for one week. " Observational audits of compliance with source control mask use for staff, visitors	

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F 880	Continued From page 6 the facility assisting with staff education. The IDON stated currently there were five residents with COVID in the COVID unit. The IDON stated the resident and staff who had been exposed on 3rd floor had negative rapid test and the resident had been put on precautions. RN-B then added the resident currently was negative and asymptomatic. At 10:56 a.m. when asked about cleaning equipment between residents, the IDON stated staff, "should be cleaning it and there are wipes for them between resident use." The IDON explained that currently staff stored their PPE, including goggles or face shields downstairs and thought that was why staff were walking in the building without wearing eye protection. The IDON further stated all staff and visitors to the facility were supposed to follow the policies which included use of eye protection. On 10/2/20, at 8:18 a.m. TS stated on 10/1/20, she had cleaned the VS machine inside R14's room, who was on precautions, and pushed it into the hallway for other people to use. TS stated, "I cleaned the finger pulse oximeter, blood pressure cuff and the monitor when in the room." TS was unsure of how much of the VS machine needed to be cleaned if a resident was in a transmission/droplet precautions room. TS acknowledged keeping the gown on when leaving R14's room and walking down the hallway with the VS machine. TS explained not being finished with R14 and was going back to the room after she returned the VS machine to the hallway, incase it was needed. At 8:30 a.m., TS provided additional information and stated the IDON stated the machine was supposed to be cleaned at the door way of a residents room while staff was still	F 880	and residents will be conducted four times per week for one week, then twice weekly until 100% compliance is reached. " Observational audits of PPE use during aerosolized generating procedures will be conducted in real time as nurses administer treatments until each nurse has been observed to be compliant. " Observational audits of proper cleaning and disinfection of shared medical equipment and the environment will be conducted on all shifts, every day for one week. " Observational audits of staff performance of hand hygiene, handling trash and linens for residents on droplet precautions, appropriate signage and PPE for residents on droplet precautions will be conducted on all shifts, three times per week for one week. " Issues identified during observational audits will be addressed at the time they are identified. Results of audits will be reported to the QAPI Committee and the Committee□s recommendations will be followed for further action. Residents in the facility are monitored every shift for signs or symptoms of COVID-19, as defined by the CDC and results are documented in each medical record. Residents are tested, using a PCR test (MedSchenker STM). If a resident develops COVID-19 symptoms, as defined by the CDC, rapid antigen testing is used to provide information about the resident□s COVID-19 status to facilitate decision-making about isolation and management of potential exposure to staff, residents and the environment. The	

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	245276	A. BUILDING _____ B. WING _____	C 10/02/2020

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F 880	Continued From page 7 wearing PPE, and then push it out of a residents room, and remove PPE gown before entering the hallway. On 10/2/20, at 9:20 a.m. NA-E was observed to enter R14's room which was a transmission/droplet room without a gown. As NA-E entered the room she applied a pair of gloves, and went to the bathroom door where NA-A was assisting R14. NA-A asked NA-E to assist in R9's room. NA-E left R14's room, removed gloves as leaving R14's room, went down the hallway and cleansed hands using the hand sanitizer outside the SPA room. NA-E then turned around, walked towards the nursing station and went to the opposite hallway. On 10/2/20, at 10:06 a.m. during a tour of the 3rd floor, isolation carts with PPE and signs directing staff to use PPE were observed outside the rooms and on the doors of all occupied rooms on the floor except R12's room. -At 10:07 a.m. to 10:12 a.m. NA-G was observed to exit R12's room carrying two clear plastic bags of linen and garbage, and went into the soiled utility room down the hallway. NA-G then went into the linen closet and retrieved clean linen and NA-F and NA-G were observed to enter R12's room without applying gowns or gloves and shut the door. -RN-A was interviewed at 10:13 a.m. who stated currently all residents on the floor were supposed to be on droplet precautions because there was a pending COVID test for one of the residents. RN-A also stated the previous evening another resident from the floor had tested positive and had been moved to the COVID unit and so staff were supposed to use droplet precautions. RN-A verified there was no isolation cart or signs	F 880	organization□s policies and procedures for monitoring residents, managing COVID-19 positive residents and reporting COVID-19 test results are followed. The Executive Director is responsible for compliance Compliance will be achieved by November 10, 2020	

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F 880	Continued From page 8	F 880		

outside R12's room. When RN-A opened R12's door and observed NA-F and NA-G in the room without gowns, RN-A instructed the NA's to use proper PPE while assisting R12. At 10:14 a.m. NA-G identified knowing that the whole unit was on droplet precautions however, explained there was no sign on R12's room door, to apply PPE.

R10: On 10/2/20, at 10:39 a.m. during a random observation in the Memory Care Unit, NA-D was observed standing behind R10 whose wheelchair was slightly tilted over as NA-D stood over R10 with his goggles sitting on top of his head.

The facility policy for Optimizing the Supply of Eye Protection, Face Shields During COVID-19 - Pandemic Revised July 20, 2020, directed staff, "To provide source control during the COVID-19 Pandemic, universal masking with face shield and or goggles of employees will be followed in Skilled Nursing Facilities, Assisted Living and Independent Living utilizing the strategies listed below.

Staff are required to wear a facemask and a face shield and/or goggles when coming in contact or the potential to come in contact with ALL residents and staff. This would include COVID-19 Positive, COVID-19 Negative, and/or COVID-19 Status unknown residents.

Examples of when to wear a face mask and face shield and/or goggles are:
When doing resident direct care
When in common resident areas
When in hallways
When at receptionist desk
When working in the dietary department
Whenever cleaning or disinfecting any areas

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F 880	Continued From page 9 When in an office and unable to social distance of at least 6 feet Any other locations in the building when unable to social distance of at least 6 feet..." The facility Infection Prevention and Control Manual Interim policy for suspected or confirmed Coronavirus (Covid-19) indicated "Dedicated or disposable patient care equipment should be used if equipment must be used for more than one resident, it will be cleaned and disinfected before use on another resident according to manufacturers recommendations using EPA registered disinfectants against Covid-19..."	F 880		

Electronically delivered
October 14, 2020

Administrator
Maplewood Care Center
1900 Sherren Avenue
Maplewood, MN 55109

Re: State Nursing Home Licensing Orders
Event ID: PB4K11

Dear Administrator:

The above facility was surveyed on October 1, 2020 through October 2, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are

the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Susanne Reuss, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: susanne.reuss@state.mn.us
Office: (651) 201-3793

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any 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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On October 1 & 2, 2020, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5276177C with a licensing order issued at S1385. The following complaint was found to be UNSUBSTANTIATED: H5276178C and H5276179C The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		
21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure staff utilized personal protective equipment (PPE) and cleaned shared equipment in a manner to prevent the potential spread of infection and in accordance with Centers for Disease Control (CDC) and State Health Department guidelines. This had the potential to affect 5 residents (R14, R13, R8, R9, R10) as well as several staff/visitors, observed for infection control. Findings Include: On 10/1/20, at 7:30 a.m., during interview, RN-A stated she thought there were five or six residents	21385	Corrected.	11/10/20

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21385	Continued From page 2 currently in the building affected by COVID, however was not sure as there was one resident who had not been doing well the previous day. On 10/1/20, at 7:44 a.m. during interview with the administrator and corporate regional director of operations, it was learned that as of the previous night there had been five or six COVID positive residents however had not checked yet because one of the resident's had not been doing well the previous night. R14: Observations, on 10/1/20, at 8:10 a.m., outside R14's room was a isolation cart with clean PPE stored in it and signs at the door instructing staff of when and how to use PPE along with a stop sign directing visitors to see the nurse before going into the room. A therapy staff (TS) was observed in R14's room. TS was observed wearing a yellow disposable gown, gloves, mask and eye protection and was standing next to R14's bed checking vital signs (VS). At 8:12 a.m. TS was observed to remove gloves in R14's room, cleanse hands, and exited the room without removing the isolation gown. Still wearing the same gown, TS, pushed the VS machine from R14's room, walked into the hallway, past R14's door and left the VS machine stand in the hallway by the fire door. TS was not observed to clean the VS machine. R13: Outside R13's room was an isolation cart with clean PPE stored in it and there were signs at the door instructing staff of when and how to use PPE and a stop sign directing visitors to see the nurse before going into the room. At 8:13 a.m. nursing assistant (NA)-A exited R13's room pushing a VS machine monitor stand down the hallway, outside the Spa, and used hand sanitizer to clean hands, and was observed to push the VS	21385		

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21385	Continued From page 3 machine down the hall, with out cleaning the machine. R8: At 8:15 NA-A, entered R8's room, with the unclean VS machine. NA-B and NA-A approached R8's bed to check VS's. When asked if the VS machine should be cleaned, NA-A stated, "yes", and acknowledged the resident whose VS has been taken right before R8 was on transmission/droplet precautions. NA-A stated, "I forgot to clean it." At this time both NA's came out of the room with the VS machine and were observed to clean the machine at 8:17 a.m. At 8:23 a.m. two staff were observed to walk down the hallway in the Transitional Care Unit (TCU) outside R13 and R14's rooms wearing a mask but not wearing face shield/goggles. Both staff briefly went into the nursing service office, came out and walked towards the front desk before leaving the building. On 10/1/20, at 9:22 a.m. NA-C stated the facility had designated 2 South as the COVID unit and residents had been moved into the COVID unit as of 9/25/20. NA-C explained that previously the facility had residents residing in the TCU unit and other floors in the facility with COVID precautions. NA-C also identified that staff had been provided education on PPE use, donning and doffing and all staff were supposed to wear goggles or a face shield and mask when in the building. On 10/1/20, at 9:48 a.m. two providers were observed on the 1st floor TCU unit standing outside the therapy room. Both were wearing face masks but no goggles or face shields. One of the providers was observed holding a face shield in her hand. One of the providers was observed to walk away from the therapy entry way and then	21385		

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21385	Continued From page 4 both walked over and stood across from each other in the hallway outside room 118. On 10/1/20, at 9:53 a.m. the regional director of operations (RDO) explained it was the facility policy for "everyone to wear eyewear" which included staff and visitors. RDO approached the providers and brought them into the administrators office. On 10/1/20, at approximately 10:27 a.m. RN-B stated, "we are supposed to wipe the VS machine after each use with everyone". On 10/1/20, at 10:42 a.m. during an interview with the interim director of nursing (IDON) and RN-B, the IDON explained that due to a recent potential exposure of a resident and staff from over the weekend, the corporate staff development was at the facility assisting with staff education. The IDON stated currently there were five residents with COVID in the COVID unit. The IDON stated the resident and staff who had been exposed on 3rd floor had negative rapid test and the resident had been put on precautions. RN-B then added the resident currently was negative and asymptomatic. At 10:56 a.m. when asked about cleaning equipment between residents, the IDON stated staff, "should be cleaning it and there are wipes for them between resident use." The IDON explained that currently staff stored their PPE, including goggles or face shields downstairs and thought that was why staff were walking in the building without wearing eye protection. The IDON further stated all staff and visitors to the facility were supposed to follow the policies which included use of eye protection.	21385		

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(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) COMPLETE DATE
21385	Continued From page 7 Staff are required to wear a facemask and a face shield and/or goggles when coming in contact or the potential to come in contact with ALL residents and staff. This would include COVID-19 Positive, COVID-19 Negative, and/or COVID-19 Status unknown residents. Examples of when to wear a face mask and face shield and/or goggles are: When doing resident direct care When in common resident areas When in hallways When at receptionist desk When working in the dietary department Whenever cleaning or disinfecting any areas When in an office and unable to social distance of at least 6 feet Any other locations in the building when unable to social distance of at least 6 feet..." The facility Infection Prevention and Control Manual Interim policy for suspected or confirmed Coronavirus (Covid-19) indicated "Dedicated or disposable patient care equipment should be used if equipment must be used for more than one resident, it will be cleaned and disinfected before use on another resident according to manufacturers recommendations using EPA registered disinfectants against Covid-19..." Suggested Method of Correction: The DON (Director of Nursing) or designee could monitor to assure proper PPE is worn to prevent the potential spread of infections. The DON or designee could monitor to assure resident shared equipment/machines are properly disinfected between resident use. The DON or designee could educate staff and perform audits to ensure	21385		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00520	A. BUILDING: _____ B. WING _____	C 10/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLEWOOD CARE CENTER	**1900 SHERREN AVENUE MAPLEWOOD, MN 55109**

(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) COMPLETE DATE
21385	Continued From page 8 the policies are being followed. Time Period for Correction: Twenty-one (21) days.	21385		

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:

PERSONAL PROTECTIVE EQUIPMENT (PPE)

- 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 policies and procedures for donning/doffing PPE during COVID-19 with current guidelines to include crisis standard of care, contingency standard of care and standard care.
- Develop and implement a policy and procedure for source control masks.
- Review policies regarding standard and transmission based precautions and revise as needed.

TRAINING/EDUCATION:

As a part of corrective action plan, the facility must provide training for the Infection Preventionist, the Director of Nursing, all staff providing direct care to residents, and all staff entering resident's rooms, whether it be for residents' dietary needs or cleaning and maintenance services. The training must cover standard infection control practices, including but not limited to, transmission-based precautions, appropriate PPE use, and donning and doffing of PPE.

- The training may be provided by the Director of Nursing, Infection Preventionist, or Medical Director with an attestation statement of completion.
- The training must include competency testing of staff and this must be documented.
- Residents and their representatives should receive education on the facility's Infection Prevention Control Program as it related to them and to the degree possible/consistent with resident's capacity.
- Online infection prevention training courses may be utilized. The CDC and MDH websites have several infection control training modules and materials.

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 of donning/doffing PPE with Transmission Based Precautions i.e. Droplet precautions.
- The Director of Nursing, Infection Preventionist, and other facility leadership will conduct routine audits on all shifts four times a week for one week, then twice weekly for one week once compliance is met. Audits should continue until 100% compliance is met on source control masking for staff, visitors and residents.
- The Director of Nursing, Infection Preventionist, and other facility leadership will conduct real time audits on all aerosolized generating procedures to ensure PPE is in us.
- The Director of Nursing, Infection Preventionist, or designee will review the results of audits and monitoring with the Quality Assurance Program Improvement (QAPI) program.

EQUIPMENT/ENVIRONMENT

- 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 director of housekeeping, director of maintenance, and director of nursing must review policies and procedures regarding disinfecting multiuse/shared equipment/items and/or environmental disinfection to ensure they meet the CDC guidance for disinfection in health care facilities and follow disinfectant product manufacturer directions for use including contact time.

TRAINING/EDUCATION :

- The Director of Housekeeping/Maintenance, and/or Director of Nursing, or Infection Preventionist must train all staff responsible for resident care equipment and environment on the facility policies/practices for proper disinfection, including following manufacturer direction for use. Each staff person must demonstrate competency at the conclusion of the training.

Training and competency testing must be documented. The Minnesota Department of Health (MDH), Center for Disease Control (CDC), and Environmental Protection Agency have education materials that may be used for training.

- CDC: Infection Control Guidelines and Guidance Library. https://www.cdc.gov/infectioncontrol/guidelines/index.html/eic_in_HCF_03.pdf
- MDH COVID-19 Toolkit. https://www.health.state.mn.us/diseases/coronavirus/hcp/ltctoolkit.pdf
- EPA: List N: Disinfectants for Use Against SARS-CoV-2 (COVID-19) https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2-covid-19

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/or other facility leadership will conduct audits for proper cleaning and disinfection of resident use equipment/environmental cleaning, on all shifts every day for one week, then may decrease frequency as determined by compliance.

In accordance with 42 CFR § 488.402(f), this remedy is effective 15 calendar days from the date of the enforcement letter. The DPOC may be completed on or after that date. The effective date is not a deadline for completion of the DPOC. However, a revisit will not be approved prior to receipt of documentation confirming the DPOC was completed. To demonstrate that the facility successfully completed the DPOC, the facility must provide all of the following documentation. Documentation should be uploaded as attachments through ePOC.

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.

Attach all items into ePOC.