DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 4, 2020

Administrator
The Emeralds At Grand Rapids Llc
2801 South Highway 169
Grand Rapids, MN 55744

RE: CCN: 245495
Cycle Start Date: June 4, 2020

Dear Administrator:

On July 17, 2020, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

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

Electronically delivered
June 10, 2020

Administrator
The Emeralds At Grand Rapids Llc
2801 South Highway 169
Grand Rapids, MN 55744

SUBJECT: SURVEY RESULTS
CCN: 245495
Cycle Start Date: June 4, 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 June 4, 2020, the Minnesota Department of Health completed a complaint investigation and a COVID-19 Focused Survey at The Emeralds At Grand Rapids Llc to determine if your facility was in compliance with Federal requirements related to the complaint and 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 June 4, 2020 survey. The Emeralds At Grand Rapids Llc 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:

Teresa Ament, Unit Supervisor
Email: teresa.ament@state.mn.us
Phone: (218) 302-6151
Fax: (218) 723-2359

INFORMAL DISPUTE RESOLUTION

You have one opportunity to dispute the deficiencies cited on the June 4, 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:

Teresa Ament, Unit Supervisor
Email: teresa.ament@state.mn.us
Phone: (218) 302-6151
Fax: (218) 723-2359

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.

The Emeralds At Grand Rapids Llc 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,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 06/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT GRAND RAPIDS LLC	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

(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 6/3/20, through 6/4/20, at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.475. The facility was in full compliance.	E 000		
F 000	INITIAL COMMENTS On 6/3/20, through 6/4/20, an abbreviated survey and a COVID-19 Focused infection Control survey were completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities and to determine compliance with §483.80 Infection Control. The survey identified the facility was not in compliance. In addition, a complaint investigation was also conducted. The following complaint was substantiated: H5495077C. 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. 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	Infection Prevention & Control	F 880		6/10/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/19/2020

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 880 SS=E	Continued From page 1 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 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	F 880		

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F 880	Continued From page 2 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 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 proper disinfection of a multi-use Hoyer lift (full body mechanical lift) was implemented to prevent the spread of infection for 2 of 2 residents (R2, R4) observed to utilize the Hoyer lift. This had the potential to affect 9 of 9 (R1, R2, R4, R5, R6, R7, R8, R9, and R10) residents residing on the 300 unit who required staff assistance with transfers with a Hoyer lift.	F 880	F Tag: F880 Infection Control Immediate Corrective Action: Immediate re-education for all nursing staff began on 6/3/20 as soon as the issue was identified. This included NA-A and NA-B. Corrective Action as it applies to others: The Policy and Procedure on cleaning equipment used between residents was reviewed and remains current.	

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F 880	Continued From page 3 Findings include: R1's quarterly Minimum Data Set (MDS) dated 4/30/20, indicated R2 required the use of a mechanical lift for all transfers. R2's quarterly MDS dated 4/16/20, indicated R2 required the use of mechanical lift for all transfers. R4's quarterly MDS dated 4/23/20, indicated R4 required the use of mechanical lift for all transfers. R5's quarterly MDS dated 4/16/20, indicated R4 required the use of mechanical lift for all transfers. R6's quarterly MDS dated 5/14/20, indicated R6 required the use of mechanical lift for all transfers. R7's quarterly MDS dated 5/14/20, indicated R4 required the use of mechanical lift for all transfers. R8's quarterly MDS dated 4/2/20, indicated R8 required the use of mechanical lift for all transfers. R9's quarterly MDS dated 5/4/20, indicated R9 required the use of mechanical lift for all transfers. R10's quarterly MDS dated 3/5/20, indicated R10 required the use of mechanical lift for all transfers.	F 880	All nursing staff will be re-educated on the policy by end of day 6/10/2020. Date of Compliance: 6/5/2020 Recurrence will be prevented by: Audits of equipment cleaning, specifically mechanical lifts used between residents will be completed 3x weekly on all Units x 4 weeks at various times then monthly x 2 months and the results shared with the ID Team and medical director for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: DON/IC Nurse	

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F 880	Continued From page 4 On 6/3/20 at 9:37 a.m. nursing assistant (NA)-A was observed leaving R4's room with a Hoyer lift. NA-A proceeded to bring the Hoyer lift down the hallway and into R2's room, where she was joined by NA-B. NA-A and NA-B sanitized their hands, and donned clean gloves. R2 was observed to be sitting in his wheelchair (w/c) in front of the television with a Hoyer lift sling already in place underneath him. NA-A stated they were getting him up from his w/c and into his bed. NA-A and NA-B proceeded to attach the sling straps to the metal Hoyer lift arms. When asked if the Hoyer lift was sanitized after being used on R4, both NA-A and NA-B stated no. NA-B stated since R2 was not on contact precautions, they were not required to sanitized equipment in between uses. NA-A verified she had not cleaned the Hoyer lift after using it to transfer R4. NA-B stated it was her understanding the Hoyer lift could go from room to room on the unit, and did not require sanitizing unless the resident was on contact precaution. NA-A and NA-B proceeded with lifting R2 with the Hoyer lift. NA-A and NA-B then stopped the transfer, lowered R2 back into his w/c, and proceed to wipe down the Hoyer lift. NA-A did not change gloves or perform hand hygiene after sanitizing the Hoyer lift, and proceeded with the transfer. R2 was transferred into his bed, and the Hoyer lift sling was removed. NA-A removed her gloves, performed hand hygiene, and donned on clean gloves. NA-A took the Hoyer lift out into the hallway, and sanitized it. On 6/3/20 at 11:19 a.m. the director of nursing (DON) was interviewed and stated all reusable equipment such as vital machines and Hoyer lifts should be cleaned between residents on all units. The DON stated it was critical to be cleaning all	F 880		

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F 880	Continued From page 5 equipment to prevent the spread of infection. On 6/3/20 at 2:29 p.m. registered nurse (RN)-A stated their was only one Hoyer lift for residents on Unit 3. RN-A stated it cleaning equipment was important for infection control. RN-A further stated many residents on the unit are immunocompromised, and infection prevention was crucial for preventing the spread of infection. The facility policy Coronavirus (COVID-19) Infection Prevention and Control undated, directed cleaning and disinfecting of rooms, equipment, and high touch areas will be performed using products that have EPA-approving emerging viral pathogens claims that have demonstrated effectiveness against viruses.	F 880		

Electronically delivered
June 10, 2020

Administrator
The Emeralds At Grand Rapids Llc
2801 South Highway 169
Grand Rapids, MN 55744

Re: State Nursing Home Licensing Orders
Event ID: T4TW11

Dear Administrator:

The above facility was surveyed on June 3, 2020 through June 4, 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:

Teresa Ament, Unit Supervisor
Email: teresa.ament@state.mn.us
Phone: (218) 302-6151
Fax: (218) 723-2359

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.

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

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	00299	A. BUILDING: _____ B. WING _____	C 06/04/2020

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THE EMERALDS AT GRAND RAPIDS LLC	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

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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: A complaint investigation was conducted on 6/3/20, through 6/4/20, to investigate complaint H5495077C. The complaint was found to be substantiated with licensing orders issued. Please indicate in your electronic plan of correction that you have	2 000		

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2 000	Continued From page 1 reviewed these order, and identify the date when they will be corrected.	2 000		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper disinfection of a multi-use Hoyer lift (full body mechanical lift) was implemented to prevent the spread of infection for 2 of 2 residents (R2, R4) observed to utilize the Hoyer lift. This had the potential to affect 9 of 9 (R1, R2, R4, R5, R6, R7, R8, R9, and R10) residents residing on the 300 unit who required staff assistance with transfers with a Hoyer lift. Findings include: R1's quarterly Minimum Data Set (MDS) dated 4/30/20, indicated R2 required the use of a mechanical lift for all transfers. R2's quarterly MDS dated 4/16/20, indicated R2 required the use of mechanical lift for all transfers. R4's quarterly MDS dated 4/23/20, indicated R4 required the use of mechanical lift for all transfers.	21375	F Tag: F880 Infection Control Immediate Corrective Action: Immediate re-education for all nursing staff began on 6/3/20 as soon as the issue was identified. This included NA-A and NA-B. Corrective Action as it applies to others: The Policy and Procedure on cleaning equipment used between residents was reviewed and remains current. All nursing staff will be re-educated on the policy by end of day 6/10/2020. Date of Compliance: 6/5/2020 Recurrence will be prevented by: Audits of equipment cleaning, specifically mechanical lifts used between residents will be completed 3x weekly on all Units x 4 weeks at various times then monthly x 2 months and the results shared with the ID Team and medical director for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: DON/IC Nurse	6/10/20

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21375	Continued From page 2	21375		

R5's quarterly MDS dated 4/16/20, indicated R4 required the use of mechanical lift for all transfers.

R6's quarterly MDS dated 5/14/20, indicated R6 required the use of mechanical lift for all transfers.

R7's quarterly MDS dated 5/14/20, indicated R4 required the use of mechanical lift for all transfers.

R8's quarterly MDS dated 4/2/20, indicated R8 required the use of mechanical lift for all transfers.

R9's quarterly MDS dated 5/4/20, indicated R9 required the use of mechanical lift for all transfers.

R10's quarterly MDS dated 3/5/20, indicated R10 required the use of mechanical lift for all transfers.

On 6/3/20 at 9:37 a.m. nursing assistant (NA)-A was observed leaving R4's room with a Hoyer lift. NA-A proceeded to bring the Hoyer lift down the hallway and into R2's room, where she was joined by NA-B. NA-A and NA-B sanitized their hands, and donned clean gloves. R2 was observed to be sitting in his wheelchair (w/c) in front of the television with a Hoyer lift sling already in place underneath him. NA-A stated they were getting him up from his w/c and into his bed. NA-A and NA-B proceeded to attach the sling straps to the metal Hoyer lift arms. When asked if the Hoyer lift was sanitized after being used on R4, both NA-A and NA-B stated no. NA-B stated since R2 was not on contact precautions, they were not required to sanitized

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00299	A. BUILDING: _____ B. WING _____	C 06/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT GRAND RAPIDS LLC	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

(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
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equipment in between uses. NA-A verified she had not cleaned the Hoyer lift after using it to transfer R4. NA-B stated it was her understanding the Hoyer lift could go from room to room on the unit, and did not require sanitizing unless the resident was on contact precaution. NA-A and NA-B proceeded with lifting R2 with the Hoyer lift. NA-A and NA-B then stopped the transfer, lowered R2 back into his w/c, and proceed to wipe down the Hoyer lift. NA-A did not change gloves or perform hand hygiene after sanitizing the Hoyer lift, and proceeded with the transfer. R2 was transferred into his bed, and the Hoyer lift sling was removed. NA-A removed her gloves, performed hand hygiene, and donned on clean gloves. NA-A took the Hoyer lift out into the hallway, and sanitized it.

On 6/3/20 at 11:19 a.m. the director of nursing (DON) was interviewed and stated all reusable equipment such as vital machines and Hoyer lifts should be cleaned between residents on all units. The DON stated it was critical to be cleaning all equipment to prevent the spread of infection.

On 6/3/20 at 2:29 p.m. registered nurse (RN)-A stated their was only one Hoyer lift for residents on Unit 3. RN-A stated it cleaning equipment was important for infection control. RN-A further stated many residents on the unit are immunocompromised, and infection prevention was crucial for preventing the spread of infection.

The facility policy Coronavirus (COVID-19) Infection Prevention and Control undated, directed cleaning and disinfecting of rooms, equipment, and high touch areas will be performed using products that have EPA-approving emerging viral pathogens claims that have demonstrated effectiveness against

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21375	Continued From page 4 viruses. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could review and revise policies and procedures related infection control practices including cleansing of equipment. The DON or designee could educate all staff on these policy and procedures. The DON or designee could implement a monitoring system in order to assure an on-going effective infection control program is maintained. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		