STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245229	A. BUILDING _____ B. WING _____	06/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FRIENDSHIP VILLAGE OF BLOOMINGTON	8100 HIGHWOOD DRIVE BLOOMINGTON, MN 55438

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure 1 of 1 rooms was appropriately disinfected to mitigate transmission of COVID-19, and failed to ensure staff donned (put on) appropriate personal protection equipment (PPE) for 1 of 1 residents (R1) in a quarantined room in accordance with Centers for Disease Control (CDC) and Centers for Medicare and Medicaid (CMS) guidance for COVID-19. Findings include: On 6/16/20, at 9:48 a.m., observation and interview of custodial worker (C)-A identified he was in the hallway outside room [ROOM NUMBER] and prepared to clean the vacated room for a new admission to arrive at 1:30 p.m. The room was a double occupancy room with two beds. The bed near the window had no bed linens, and the bed by the door had bed linens. There were two divider curtains that hung from the ceiling. C-A identified the room was vacated recently by a hospice resident who was on quarantine status. C-A sprayed a dry, clean rag with a spray cleaner and wiped the horizontal surfaces of the built in cabinets. C-A sprayed the rag and wiped surfaces of the head board, foot board, and grab bars with [MEDICATION NAME]. The surfaces were not left wet. C-A lowered himself onto the floor to clean the bed frame. When C-A wiped the bed frame, C-A sprayed the frame with the cleaner. When C-A wiped the frame, C-A crawled on his hands and knees, and drug the the rag across the floor with his hand. C-A continued with the same rag and sprayed the rag with cleaner, and continued to wipe the exterior and interior bedside table surfaces. C-A misted the room divider curtains with [MEDICATION NAME] and then End Block aerosol spray. The curtains were dry to touch. C-A identified the curtains were not visibly soiled and were not required to be changed unless they were visibly soiled. C-A misted the walls with [MEDICATION NAME]. C-A moved the undressed bed from the window side of the room to the door side of the room and the dressed bed next to the window. C-A identified the bed on the door side was not used by the previous resident. C-A misted the bedding with [MEDICATION NAME] and plugged the bed cord into the wall outlet by the window. With the same rag, C-A entered the bathroom, sprayed the rag and wiped the toilet, hand sanitizer and paper towel dispensers, and the sink. C-A opened the cabinet in the bathroom and wiped a wash basin, and emesis basin and the cabinet handles. C-A was unsure if the basins were used, and wiped them down to be sure they were cleaned before use. C-A finished the room and misted the End Block disinfectant spray throughout the room. The surfaces were observed to be dry. Interview on 6/16/20, at 11:35 a.m. with C-A identified he used [MEDICATION NAME], a peroxide-based general cleaner, and End Block to clean the room. Both cleaners killed all germs instantly, and no dry time was needed. [MEDICATION NAME] was effective against COVID-19 because it was peroxide based. End Block also killed germs immediately, and no wet contact time was needed. Use of both cleaners ensured surfaces were properly disinfected. Observation of the [MEDICATION NAME] and End Block manufacturer labels with C-A identified the labels had not included wet contact time or environmental protection agency (EPA) registration numbers on the labels. Additionally, the labels made no mention they killed COVID-19 viruses. C-A identified he had worked in housekeeping for [AGE] years and started work at the facility last September. He was not trained on how to terminally clean rooms because he was told at orientation, he knew what he was doing. He had not received any additional training about how to clean vacated rooms. He volunteered to clean the COVID-19 rooms because additional staff were needed to keep up with the demand for housekeeping duties. Interview on 6/16/20, at 3:50 p.m., with the administrator identified the [MEDICATION NAME] cleaner was a general purpose cleaner. Both [MEDICATION NAME] and End Block were not on the EPA approved list for disinfection against COVID-19. The Administrator identified she had trained all staff on housekeeping responsibilities during the initial staff training of COVID-19 requirements. The training included terminal cleaning, disinfectant products and wet contact times. She expected staff to remove privacy curtains and bed linens during a terminal room clean, and expected staff to replace cleaning rags when soiled or in contact with the floor. Surfaces were expected to be sprayed directly onto surfaces and left wet for the amount of time directed by the manufacturer. Interview on 6/17/20, at 1:30 p.m., with the environmental director identified C-A was trained to clean COVID-19 rooms on 5/30/20. Staff were expected to clean rooms according to facility policies and procedures. Privacy curtains were not changed during a terminal cleaning unless they were visibly soiled. Nursing was responsible to remove supplies and bed linens before housekeeping entered the room. Unused bedding was not changed unless it was visibly soiled. She was unaware C-A was not using EPA approved cleaners until she returned to work on 6/17/20. The environmental director verified [MEDICATION NAME] was only used for general cleaning, and was not a disinfectant used to complete terminal room cleaning. Review of the 2019, Infection Prevention and Control Manual Environmental Services/Housekeeping/Laundry identified when a resident moved out, the room was to be stripped, including the cubicle curtain. The bed frame, mattress bedside stand (inside and out), over bed table, chairs, lights, walls, bathroom, and closets were to be cleaned daily with an EPA approved hospital-grade disinfectant-detergent solution. Review of the 3/10/20, Environmental Cleaning and Disinfecting Special Focus on COVID-19 training PowerPoint identified staff were to ensure cleaning and disinfecting procedures were followed consistently and correctly and wet contact times for cleaners and disinfectants were adhered to. Staff were to ensure cleaning products not registered with the EPA had label claims for effectiveness against human coronavirus and were used according to label instructions. A terminal clean of a room included stripping the room, including privacy curtains. PPE USE Observation on 6/17/20, at 9:50 a.m., identified nursing assistant (NA)-A wore eye protection on the top of his head. NA-A walked throughout the common area and resident hallways while residents were present. Observation on 6/17/20, at 11:42 a.m., NA-A entered R1's room without donning (putting on a gown, gloves). NA-A's eye protection was on the top of his head. R1 was on quarantine. A PPE cart was at the doorway entrance. Signage posted identified staff were to use droplet precautions in the room. NA-A spoke to R1 and stood next to R1's wheelchair. NA-A did not wear PPE. NA-A exited R1's room without performing hand hygiene. Interview on 6/17/20, at 11:55 a.m., with NA-A identified R1 was on quarantine and had no symptoms of COVID-19. R1 fell frequently and required staff to check on him. NA-A went into the room to check on R1. NA-A identified if R1 would have needed anything, he would have went out to gown and glove before NA-A would assist R1 with cares. R1 was fine, and had not required any assistance, and no contact was make with R1. NA-A identified staff were to don gowns and gloves in addition to the eye protection and masks. He would have double masked because the room was a quarantine room. Staff were to wear N95 masks in all quarantine and COVID-positive resident rooms. The surgical mask was worn over the N95 for mask conservation. Interview on 6/17/20, at 12:30 p.m., with the director of nursing (DON) identified staff were expected to wear the appropriate PPE any time staff entered quarantined resident rooms. R1 was on droplet precautions due to COVID-19 quarantine practices. Droplet precautions included donning gowns, gloves, and wearing eye protections according to CDC and CMS guidance.

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

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.