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	345377	A. BUILDING _____ B. WING _____	C 07/22/2020

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EAST CAROLINA REHAB AND WELLNESS	2575 W 5TH STREET GREENVILLE, NC 27834

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E 000	Initial Comments An unannounced COVID-19 Focused Survey was conducted on 7/16/20 through 7/22/20. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# T63F11.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and complaint investigation were conducted on 7/16/20 through 7/22/20. The facility was found not in compliance with 42 CFR §483.80 infection control regulations resulting in Federal Citation F880. Five of the 10 complaint allegations were substantiated resulting in deficiencies. Event ID #T63F11.	F 000		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review the facility failed to provide nail care for 2 of 5 residents (Resident #3 and Resident #4) who were dependent on facility staff for activities of daily living. The findings included: 1. Resident #3 was admitted to the facility on 9/22/15 with diagnoses that included dementia and arthritis.	F 677	1. Residents #3 and #4 had their fingernail cleaned and trimmed on 7-16-2020. 2. The facility nursing staff (nurses and cna's) will be inserviced on the importance of keeping residents finernails clean and trimmed. This inservice will be completed by 8-14-2020. 3. An initial audit will be completed by 8-14-2020 to check the residents	8/14/20

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

Electronically Signed | 08/07/2020

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F 677	Continued From page 1 The resident's significant change Minimum Data Set (MDS) dated 7/6/20 revealed Resident #3 was moderately cognitively impaired with unclear speech and needed extensive to total assistance with activities of daily living. Resident had no behaviors or rejection of care and required total assistance with personal hygiene and bathing. The resident's care plan updated 7/8/20 indicated Resident #3 needed extensive total assistance with activities of daily living. The interventions included check nail length and trim and clean as necessary. During an observation on 7/16/20 at 10:15 AM Resident #3's nails were observed to be approximately ½ inch long with debris under the nails. An observation and interview were conducted on 7/16/20 at 10:19 AM with the Director of Nursing who stated she was unsure why Resident #3's nails were too long and dirty. She further stated she was not sure if Resident #3 had a shower since her return from the hospital on 6/30/20. An interview was conducted with Nursing Assistant (NA) #1 on 7/20/20 at 3:36 PM who stated that she washed her residents' hands. She further stated that the nurses trimmed nails and if she saw a resident that needed nail care she would notify a nurse. NA #1 explained that many of the residents were diabetic and the nurses performed nail care. She reported that she did not do any nail care on Resident #3 because she was diabetic. During an interview on 7/21/20 at 8:13 AM Nurse #2 stated nail care should be completed by the	F 677	fingernails to ensure that they are clean and trimmed. An additional audit will be completed on the residents in the facility to check their fingernails to ensure that they are clean and trimmed. This audit will take place weekly x 4 weeks and then monthly x 3 months. The audit will be completed by the Director of Nursing or their designee. 4. The results of these audits will be taken to the facility QA&A committee meetings to ensure that the residents fingernails are being kept clean and trimmed.	

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F 677	Continued From page 2	F 677		

assigned nurse aide every shift. She reported nails were considered long when they can be visualized when the resident's hand is turned over.

An interview was conducted with the Director of Nursing on 7/21/20 at 2:19 PM who stated the nurse aides or nurses should complete nail care as needed. She stated she was not sure why nail care was not done for Resident #3.

2. Resident #4 was admitted to the facility on 9/29/19 with diagnoses that included dementia and diabetes mellitus.

The resident's significant change Minimum Data Set (MDS) dated 6/25/20 revealed Resident #4 was severely cognitively impaired and needed extensive to total assistance with activities of daily living. Resident #4 had verbal behaviors directed towards others and required total assistance with personal hygiene and bathing.

The resident's care plan updated 7/9/20 indicated Resident #4 needed extensive total assistance with activities of daily living. The interventions included check nail length and trim and clean as necessary.

During an observation on 7/16/20 at 10:11 AM Resident #4's nails were observed to be approximately ½ inch long with debris under the nails.

An interview was conducted with Nursing Assistant (NA) #1 on 7/20/20 at 3:36 PM who stated that she washed her residents' hands. She further stated that the nurses trimmed nails and if she saw a resident that needed nail care

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F 677	Continued From page 3 she would notify a nurse. NA #1 explained that many of the residents were diabetic and the nurses performed nail care. An interview was conducted with NA #6 on 7/21/20 at 7:56 AM who stated he performed nail care on Resident #4 approximately two weeks ago. During an interview on 7/21/20 at 8:13 AM Nurse #2 stated nail care should be completed by the assigned nurse aide every shift. She reported nails are considered long when they can be visualized when the resident's hand is turned over. An interview was conducted with the Assistant Director of Nursing on 7/21/20 at 10:22 AM who stated she was aware that Resident #4 had refused care in the past but was unsure if he had refused nail care. An interview was conducted with the Director of Nursing on 7/21/20 at 2:19 PM who stated the nurse aides or nurses should complete nail care as needed. She stated she was not sure why nail care was not done for Resident #4.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered	F 684		8/14/20

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F 684	Continued From page 4 care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to provide safe feeding assistance for 1 of 4 residents (Resident #3) reviewed for positioning. Findings included: Resident #3 was admitted to the facility on 9/22/15 with readmission on 6/30/20 with diagnoses which included: dysphagia, depression, and feeding difficulties. The most recent Minimum Data Set (MDS) dated 7/06/20 revealed she had moderate cognitive impairment and required total assistance with activities of daily living (ADL) including feeding. Record review of Resident #3's hospital discharge summary dated 6/30/20 included diet recommendation of "dysphagia on puree diet". Record review of Resident #3's care plan updated on 7/08/20, included problem onset of history of swallowing problem with Barrett's Esophagus with potential for aspiration. The care plan goal was that the resident will have no choking episodes when eating. The care plan approaches included to keep head of bed elevated 45° during meal and thirty minutes afterwards and give small bites and sips. During an observation on 7/16/20 at 10:19 AM, Hospitality Aide #1 was observed sitting at Resident # 3 bedside feeding her a high calorie ice cream cup. Resident #3 was in lying bed with the head of the bed at approximately a 20°	F 684	1. Hospitality Aide #1 was inserviced on the correct positioning of Resident #3 when that resident is being fed. 2. All of the facility hospitality aides were inserviced on the positioning of residents when they are being fed. This inservice will be completed by 8-14-2020. 3. An audit will be performed to ensure that the residents are being properly positioned when being fed by the hospitality aides. This audit will be completed weekly x 4 weeks and then monthly x 3 months. This audit will be performed by the Director of Nursing or their designee. 4. The results of these audit will be taken to the facility QA&A committee meetings to ensure that the hospitality aides are not feeding any residents that are not properly positioned.	

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F 684	Continued From page 5	F 684		

upright angle.

During an observation and interview with the Director of Nursing (DON) on 7/16/20 at 10:19 AM, she stated the Resident #3 head of bed was not at a 45° angle and the resident should have been in a more upright position prior to being fed. She also stated she did not know why she was not positioned correctly for feeding.

During an interview with the DON on 7/21/20 at 2:17 PM she stated she did not know if the Hospitality Aides had completed a state approved feeding assistant course.

During an interview with the Hospitality Aide on 7/16/20 at 1:45 PM, she stated she thought that Resident #3 was positioned correctly to be fed her snack. She also stated she feeds her a snack every day she works between breakfast and lunch and said, "I try to make sure she eats her magic cup." The Hospitality Aide stated she passed out ice, water and snacks to all residents. She also stated she assisted all residents with their snacks which included opening packages and feeding them.

During an interview with the Speech Therapist (ST) on 7/22/20 at 9:02 AM, he stated he had not seen Resident #3 since her return from the hospital. He stated he knew before her hospitalization she had diagnosed swallowing issues and dysphagia. The ST stated Resident #3 should have been placed in a more upright position before feeding and was not sure if the Hospitality Aide should have been feeding her.

During an interview with the Director of Therapy on 7/20/20 at 11:00 AM, he stated Resident #3

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F 684	Continued From page 6 had cognitive issues and swallowing issues and should not be fed by a feeding assistant. During an interview with the Administrator on 7/21/20 at 3:15 PM, he stated that Resident #3 should have been repositioned to the correct position to ensure resident safety during eating.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, observations, staff and physician interviews, the facility failed to stage pressure ulcers for 1 of 4 residents assessed to provide services to prevent or treat pressure ulcers (Resident #1). Findings included: Resident #1 was admitted to the facility on 2/04/00 and readmitted to the facility on 6/17/20 with diagnoses that included dementia and manic depression.	F 686	1. The facility treatment nurse was inserviced on the staging of pressure wounds. This inservice will be completed by 8-14-2020. 2. The facility only has one treatment nurse so the inservice that they receive will take care of the issues that arise from this area. 3. An initial audit will be performed to ensure that all pressure areas are staged	8/14/20

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F 686	Continued From page 7 Review of the most recent Minimum Data Set (MDS) dated 6/24/20 indicated Resident #1 had moderate cognitive impairment and was totally dependent on staff for activities of daily living (ADL). Resident #1 was coded to have 1 unstageable pressure ulcer. Observations of wound care during the Infection Control Focused survey and complaint investigation on 7/16/20 at 10:40 AM revealed Resident #1 had an open sacral wound with some slough, drainage and odor. Observations included the treatment nurse to clean the wound, pack with debriding agent and apply dressing. Review of hospital records dated 6/13/20 stated in part "patient presents from facility with stage 3 pressure ulcer to coccyx which is in the process of healing". Physical exam stated nurse "reports patient has a wound with yellow tissue extending from coccyx up to gluteal cleft skin fold". Review of nurses' progress note dated 6/23/20 at 4:25 PM revealed in part "sacrum wound unstageable and has 40% slough and 60% eschar in wound bed". Review of nurse's progress note dated 7/02/20 at 2:03 PM revealed in part "sacrum wound unstageable has 50% slough with surrounding edges intact". Review of nurses' progress note dated 7/16/20 at 3:34 PM revealed in part "sacrum wound unstageable has 25% slough around upper wound edges and 75% pink tissue with tunneling at 12:00".	F 686	correctly. This audit will be completed by 8-14-2020. An additional audit will be performed to ensure that pressure ulcers are being staged correctly. This audit will take place weekly x 4 weeks and then monthly x 3 months to ensure that all pressure ulcers are being staged correctly. This audit will be performed by the Director of Nursing or their designee. 4. The results of these audits will be taken to the facility QA&A committee meetings to ensure that pressure ulcers are being staged correctly.	

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During an interview on 7/21/20 at 9:30 AM with Nurse #1 who confirmed she was the facility treatment nurse. She stated she was taught if a pressure ulcer had slough or eschar not to give the wound a numerical stage.

During an interview on 7/21/20 at 12:33 PM with Physician #2, she stated she was Resident #1's primary physician at the facility. She also stated she had reviewed the resident's most recent hospital records dated 6/17/20 and was aware the resident had developed a stage 3 coccyx/sacral pressure ulcer at the hospital. Physician #2 stated she had not seen the sacral wound, but treatment might be different if she had been informed the wound was a stage 3 instead of unstageable.

During an interview on 7/21/20 at 12:51 PM with Nurse #1, she stated she had read some information on the Center for Medicaid and Medicare (CMS) website and it stated "once a pressure ulcer is debrided of enough slough or eschar such that it can be seen, the ulcer can be numerically staged; the pressure ulcer does not have to be fully debrided of eschar or slough to be staged. Nurse #1 then stated she Resident #1's sacral pressure ulcer was clear enough of slough and eschar to be staged and she should have staged it.

During an interview on 7/21/20 at 3:15 PM with the Administrator, he stated pressure ulcer wounds need to be appropriately staged and his treatment nurse provided the wound care at the facility. He further stated he had never had a problem with wound care before and his treatment nurse was very well qualified.

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F 880	Continued From page 9	F 880		
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 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;	F 880		8/14/20

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F 880	Continued From page 10 (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 IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, review of Centers for Disease Control (CDC) guidance, staff interviews, and physician interviews the facility failed to implement their policies and procedures for wearing Personal Protective Equipment (PPE) when 4 of 4 staff members Nursing Assistant (NA) #1, NA #2, NA #3, and NA #4), were observed not wearing appropriate (PPE) when entering or working on the COVID/quarantine	F 880	1. A. The staff were inserviced on the use of PPE on the covid unit and that if you enter the covid unit for any reason you must properly wear the required PPE equipment. B. The nursing assignment sheets were revised so that staff working within the covid unit would only work on the	

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F 880	Continued From page 11 unit. The facility also failed to assign dedicated health care personnel (HCP) to work only on the COVID-19 care unit (NA #1 and NA #2). These failures occurred during the COVID pandemic. Findings included: Infection Control signage posted on the COVID/quarantine unit door read in part "Special Droplet/Contact Precautions; everyone must wear PPE; wear a face mask, eye protection (face shield or goggles), gown, gloves; keep door closed". Review of Centers for Disease Control and Prevention (CDC) guidance "Responding to Coronavirus (COVID-19) in Nursing Homes updated April 30, 2020 read in part "Assign dedicated HCP to work only on the COVID-19 care unit." During an observation on 7/16/20 at 8:26 AM NA #1 was observed pushing the breakfast tray cart through the COVID unit door without donning personal protective equipment. NA #1 did not have on face shield, gloves or gown. She did wear a mask. She pushed the breakfast tray cart onto the unit and exited the unit. She returned to the unit one minute later after she donned a gown and gloves but was not wearing a face mask or goggles. She was observed at 8:45 AM entering room #227 and room #231 on the COVID-19 unit. During an interview with NA #1 on 7/16/20 at 8:55 AM she reported she should have donned a face mask on the COVID unit while feeding residents. She stated she had a split assignment between the COVID hall and the non-COVID hall and neglected to replace her face shield. Additionally,	F 880	covid unit. 2. A. All facility staff will be inserviced on the use of PPE on the covid unit. The inservices will be completed by 8-14-2020. This inservice will be delivered to the staff by the facility's infection control nurse. This inservice will include 2 videos and those videos are: **Keep Covid-19 Out! youtube.com/watch?v=7srwrF9MGdw&feature=youtu.be **Use Personal Protective Equipment (PPE) correctly for Covid-19 youtube.com/watch?v=YYTATw9yav4 The infection control nurse will also go over the main points of the video and ask if staff have any questions. She will reinforce that the staff are not to enter the covid unit unless they are wearing the required PPE and that staff are not to walk through the covid unit to get to other areas of the facility. The facility is also working with Alliant Health Solutions (a Quality Improvement Organization) and have developed a monitoring plan that will be implemented. We have set up a 3 month timeline with the QIO and had the webex meeting on 8-12-2020 to go over the schedule and what we were going to be monitoring. The QIO representative will be sending the administrator of the facility an email with the required documents and how to	

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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) COMPLETION DATE
F 880	Continued From page 12 NA #1 stated she should have donned PPE prior to pushing the breakfast trays onto the unit rather than pushing the tray cart into the unit and then exiting the unit to don PPE. During an observation and interview with NA #2 on 7/16/20 at 8:28 AM, she was observed walking through the COVID unit from east end to west end of the unit with wearing a mask but was not wearing any additional PPE. She exited the unit and then returned at 8:30 AM in mask, gown, gloves and face shield. During an interview with NA #2 on 7/16/20 at 8:32 AM she reported entered the COVID unit through the east end of the unit in order to secure PPE at the station at the west side door. She reported she was unaware of a better strategy to secure PPE. She stated she had residents assigned on the COVID hall and non-COVID halls. NA #2 stated she planned to speak with the administrator about the use of PPE when she had residents on both COVID and non-COVID units. During an observation and interview with NA #3 on 7/16/20 at 2:28 PM she was observed walking in the COVID unit without any PPE other than a face mask. She stated that she grabbed a bag of briefs from the COVID hall cart beside room 224 and was planning on placing them on the cart on the 200 hall outside the COVID unit. She reported that she was to don PPE if she was just briefly entering the unit. On 7/16/20 at 2:45 PM NA #4 observed to walk past Droplet/Contact precaution signs to enter COVID unit without a mask, gown, gloves, or any other PPE. He stated he was just walking through the unit to go to his assigned area on the 300 hall.	F 880	report the audits data. A follow up call with the QIO will happen every 2 weeks to review the data and that data will also be sent into the QIO representative that is assigned to the facility. The facility will be randomly auditing the wearing of masks to ensure that they are being worn properly. B. The facility's infection control nurse met with the director of nursing regarding the staff assignment sheets and the importance on having the staff that work on the covid unit only working on the covid unit. The assignment sheets were reviewed and will updated as necessary to ensure that those staff working on the covid unit did not work with residents outside of the covid unit. Currently the facility does not have any residents with positive covid tests but in the event a covid unit has to be set up within the facility the assignment sheets will be updated to ensure that staff working with the covid unit are not assigned to work with those outside of the covid unit. 3. A. The covid unit will be monitored to ensure that those staff on that unit are properly using PPE while on the unit and also for any staff that go into that unit. The monitoring of the use of PPE will be random and will continue while the facility has a dedicated covid unit. As of this time the facility does not have a covid unit due to all residents have been moved out of that area of the facility. The monitoring of staff using PPE on a covid unit will be performed by the Administrator, Director	

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	345377	A. BUILDING _____ B. WING _____	C 07/22/2020

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F 880	Continued From page 13 On 7/16/20 at 3:00 PM during an interview with Assistant Director of Nursing (ADON), she stated staff should wear PPE when on the COVID unit and should not walk through the unit to get to the 300 hall. She stated staff should not have split assignments between the COVID unit and non COVID units on the same day. She further stated they had 4 new residents who have tested positive for COVID between 7/09/20 and 7/16/20. She further stated she felt the staff had probably transmitted COVID to the newly diagnosed residents since the residents had not been out of the facility. During an interview on 7/21/20 at 2:17 PM with the Director of Nursing (DON), she stated staff should not be walking through the COVID unit to go to the 300 hall. She also stated the COVID unit should have dedicated staff that only work on that unit. The DON stated she does the daily staff assignment and did not know how the staff got assigned residents on the COVID unit and non COVID unit on the same day. During an interview on 7/17/20 at 2:00 pm with the Medical Director, he stated there should be dedicated staff who only work on the COVID unit and all staff on the COVID unit should wear PPE from 'head to toe'. During an interview with the Administrator on 7/17/20 at 1:28pm, he stated 2 additional COVID positive residents last week in the facility. One was symptomatic and tested positive on 7/9/20. The other one was sent to the hospital on 7/10 and tested positive. Two additional residents were tested this week and were both positive. The Administrator also stated PPE should be worn on	F 880	of Nursing or their designee. Although the facility does not currently have any residents with a positive test for covid-19 we will continue to monitor the use of PPE as outlined above in conjunction with the QIO the facility has partnered with. These audits will be performed weekly for the next 3 months with data being collected at the facility level and reported back to the QIO every 2 weeks during follow up calls. B. The staff assignment sheets will be monitored to ensure that staff who are working in a covid unit are only assigned to those within the covid unit and that they are not assigned to work with others outside of the covid unit. A root cause analysis will also be performed. The root cause analysis will be completed by 8-14-2020. The root cause analysis has been started and here is the information: A. When the staff were asked why they were not properly wearing their PPE the following statements were said: "I was just trying to get to another area of the facility", "I wasn't going to be going into any resident rooms". These staff members were educated on the imporatance of wearing proper PPE anytime they entered the covid 19 - that it was for their safety and the safety of all of the residents, especially those outside of the covid unit. That we are trying to stop the spread of covid within the facility and it takes everyone's cooperation to stop the	

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F 880	Continued From page 14 the COVID unit and there should be dedicated staff who only work on the COVID unit.	F 880	spread. The staff understood this and stated that from now on anytime that they entered the covid unit for any reason that they would wear the proper PPE. To help monitor the use of PPE in the facility the facility has partnered with Alliant Health Solutions (a QIO) to come up with an audit tool that the facility will be using on a weekly basis to ensure that the staff are using PPE. These audit will be random and we will be auditing 8 staff members a week throughout the facility. All data will be turned into the administrator for recording and that data will then be reported to the QIO representative assigned to the facility. B. The staff member who used the assignment sheets was asked why staff were assigned to residents both inside and outside of the covid unit on that day. When asked this staff member stated that she did not realized that the staff was assigned in this way. This staff member was informed that staff should not be assigned to residents both inside and outside of the covid unit. This staff member stated that they understood and the staffing assignment sheets were reviewed. Going forward - if they facility has to have a covid unit due to the presents of residents with positive covid 19 tests then the staff assigned to take care of those residents will not take care of residents outside of that unit. The staffing assignment sheets will be reviewed to	

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F 880	Continued From page 15	F 880	ensure that staff are not taking care of residents both inside and outside of the covid unit. These staffing assignment sheets will be looked at before each shift. 4. The results of the monitoring of the use of PPE will be taken to the facility QA&A committee meetings to ensure that the staff are using PPE properly when entering or working on the covid unit. The results of the staff assignment sheets to ensure that staff assigned to work in the covid unit are not assigned to take care of residents outside of that unit will be taken to the facility QA&A committee meetings to ensure that staff working within the covid unit are not assigned to work with residents outside of the covid unit.	