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	345163	A. BUILDING _____ B. WING _____	C 10/09/2020

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GLENBRIDGE HEALTH AND REHABILTATION CENTER	211 MILTON BROWN HEIRS ROAD BOONE, NC 28607

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E 000	Initial Comments An unannounced COVID-19 Focused Survey was conducted on 09/15/20. The facility was found in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# QX4M11	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and complaint investigation were conducted on 09/15/20 with exit from the facility. Additional information was obtained through 10/2/2020. On 10/9/20 the credible allegation of compliance was validated. Therefore, The exit date was changed to 10/9/2020. 2 of the 2 complaint allegations were substantiated and cited. Event ID# QX4M11. Immediate Jeopardy (IJ) was identified at CFR 483.12 at tag F880 at a scope and severity of K. Immediate Jeopardy (IJ) began on 09/13/20 and was removed on 09/25/20.	F 000		
F 563 SS=E	Right to Receive/Deny Visitors CFR(s): 483.10(f)(4)(ii)-(v) §483.10(f)(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. (ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time; (iii) The facility must provide immediate access to	F 563		11/2/20

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

Electronically Signed | 10/26/2020

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F 563	Continued From page 1 a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time; (iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and (v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation. This REQUIREMENT is not met as evidenced by: Based on record review, observations, staff and family interviews, the facility failed to honor resident's rights to allow a resident's immediate family members to have end of life visitation in accordance with the Centers for Medicare and Medicaid Services (CMS) memo COVID-19 QSO-20-14-NH dated 03/13/20, the Centers for Disease Control and Prevention (CDC), and the facility's COVID-19 protocol for 7 of 8 residents reviewed for compassionate care visitation at end of life (Resident #12, #14, #16, #17, #18, #19, and #20). Findings included: A facility document dated February 2020 titled "Coronavirus 2020" indicated the facility should log and record the names of all individuals (staff and visitors) who enter the residents ' room. The	F 563	Address how corrective action will be accomplished for those residents found to have been affected: Residents #12, #14, #16, #17, #18, #19, and #20 affected are no longer in Facility. The facility allowed compassionate care visits soon as Administrator was aware of guidelines for COVID unit visitation. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Facility will identify through daily review of the 24-hour report any Resident that could potentially need Compassionate care visitation for resident related to end of life and not end of life The DON/designee will monitor 24-hour report daily for necessity of compassionate care visits for all Residents within the facility and will	

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F 563	Continued From page 2 visitor should be instructed on hand hygiene and the use of personal protective equipment (PPE) prior to visitation. According to a CMS Memo dated 03/13/20 titled Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes (REVISED) revealed all facilities should restrict all visitors and non-essential healthcare personnel except for compassionate care situations such as end-of-life situations. In those cases, visitors will be limited to a specific room only. It further indicated all visitors should be screened for a fever and respiratory symptoms and visitors permitted to enter the facility should be educated to perform hand hygiene and wear personal protective equipment. Review of the CDC website article dated 07/25/20 titled "Preparing for Coronavirus in Nursing Homes" indicated in part that visitation should be limited except in the case of compassionate care visits. An undated facility document written by the Director of Nursing indicated in part: Immediate family members and friends who need to visit for crucial or time sensitive reasons such as hospice-related visits, complete medical authorizations, etc. will be screened and if displaying or reporting signs and symptoms will be asked not to visit at this time. 1. Resident #12 was admitted to the facility on 05/16/20 with a readmission date of 12/05/19 with diagnoses that included chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF), but had been diagnosed with the COVID-19 virus on 09/03/20.	F 563	contact Responsible party/family to offer visitation with Resident and document in Resident's medical record. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The administrator sent a letter to both hospice companies to update them on the facility policy change on 10/21/20. The facility will continue to allow compassion care visits for non-COVID 19 diagnosis resident and revised visitation to allow compassion care visits for resident with diagnosis of COVID 19. Administrator educated receptionist on 10/19/20 on visitation policy related to compassionate care visits. The receptionist is responsible for taking visitation calls and scheduling visits and notifying appropriate staff of visit date and time. She will be also responsible for completing the screening process when the family member arrives to the facility for the visit and providing the family member appropriate PPE to be worn in the facility. The visitors will complete the facility screening tool that assesses for COVID 19 symptoms, fever, and if they have traveled internationally within the last 14 days upon entrance to facility. Administrative nurses have been educated on the following policy change by DON on 10/19/20. Unit supervisors are responsible for monitoring and ensuring responsible parties are updated daily during end of life care of a resident on their unit and that a compassion care visits has been offered to the family.	

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F 563	Continued From page 3 The COVID-19 rapid testing log revealed Resident #12 was rapid tested on 09/03/20 with a positive result. Resident #12' s medical record revealed he resided on the 200 hall since admission, was transferred to the 400 hall COVID-19 unit on 09/03/20, and expired on 09/16/20. An observation was made on 09/15/20 at 09:45 AM revealed the Responsible Party (RP) of Resident #12 exited the facility's front lobby doors and she was upset and crying as she got in her automobile parked outside the front door. An interview with the Administrator on 09/15/20 at 10:00 AM revealed Resident #12's responsible party (RP) had asked to visit with him for a compassionate care visit on 09/15/20 and had been told she was not allowed to visit inside the building. The Administrator revealed the facility had not allowed any compassionate care visits for any resident's since March 2020 due to COVID-19 pandemic. An interview with Resident #12's RP on 09/17/20 at 11:20 AM revealed on 09/15/20 she had arrived at the facility to visit Resident #12 and had went inside to request to go into see him. Resident #12's RP indicated she was denied the right to go in the facility and therefore, she sat outside the window of Resident #12's room crying because Resident #12 had been diagnosed with COVID-19 on 09/03/20 and she had not been allowed an in-person compassionate care visit until the state agency allowed her inside the building in the afternoon on 09/15/20. Resident #12's responsible party revealed she arrived on	F 563	Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The DON will monitor visitation during clinical meetings each morning when hospice care, and end of life care resident are discussed. DON will ensure each resident has been offered a compassion care visit. The DON will ensure a progress note is completed on the date the facility reached out the family member and offered a compassion care visitation, and if the visitation was accepted or declined by the family. Audit tool will be completed one time a week for four weeks to begin 10/19/2020. The Administrator or designee will present to QI committee will review the results of Audit Tool during monthly QA Meeting for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring for continued compliance for 3 months. Finding will be discussed at quarterly QA meeting.	

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09/03/20 for a visit and was informed Resident #12 had tested positive for COVID-19 and had been moved to the COVID unit in the facility. The RP revealed a staff member met her on the outside of the building outside Resident #12's new room on the COVID unit so she would know which room was his. The RP revealed she had been told daily that Resident #12 was stable and was recovering from the COVID-19 virus; however, on 09/15/20 when she entered the unit, she applied PPE on and was escorted to Resident #12 room, staff informed her she could not touch Resident #12 and as she stood next to his bed she described him to be gasping for air and struggling to breath. The RP visited for about an hour and stated Resident #12's condition left her traumatized and she had to exit the unit. The RP explained she remained at the window of Resident #12's room for the remainder of the day until dark before leaving. The RP indicated she was called on morning of 09/16/20 and was told Resident #12 would likely not make it through the day. The RP stated she arrived at the facility and stood outside Resident #12's window while she watched him struggling to breath. After a bit, the RP stated she had to ask the staff member in the room to check on him because she felt like he had quit breathing. The staff member in the room touched Resident #12 then exited the room and notified the nurse. The RP said the nurse arrived and confirmed Resident #12 had expired.

An interview with the Director of Nursing (DON) and the Administrator on 09/24/20 at 4:10 PM revealed they were both aware the facility had not allowed Resident #12's RP a compassionate care visit prior to 09/15/20 when the state agency made them aware visitation with residents at end of life was permitted with screening completed

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and personal protective equipment provided. The DON indicated Resident #12's RP had visited with Resident #12 via window almost daily since March 2020 when restricted visitation had begun.

2. Resident #14 was admitted to the facility on 05/28/20 with diagnoses that included dementia and neoplasm of the bone.

Resident #14's medical record revealed she had resided on the 400 hall unit since 06/04/20 and expired on 08/09/20.

An interview with Resident #14's Responsible Party (RP) on 09/22/20 at 5:30 PM revealed Resident #14 expired in the facility on 08/09/20 and was under hospice care for cancer. Resident #14's RP indicated he had not been able to visit Resident #14 since her admission secondary to his medical condition, but explained his sister (Resident #14's Secondary Contact) had not been allowed to visit with Resident #14 after her admission except via window visits.

An interview with Resident #14's Secondary Contact (family member) on 09/22/20 at 6:09 PM revealed she had requested to be able to see Resident #14 for a compassionate care visit before she expired but was denied admittance to the facility and was told she could only visit through the window.

An interview with the Director of Nursing (DON) and the Administrator on 09/24/20 at 4:10 PM revealed they were both aware the facility had not allowed Resident #14's RP a compassionate care visit prior to Resident #14's death because they were unaware visitation with residents at end of life was permitted with screening completed and

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personal protective equipment provided.

3. Resident #16 was admitted to the facility on 08/23/17 with diagnoses that included severe sepsis; however, had been diagnosed with COVID-19 on 08/11/20.

A lab report revealed a Polymerase Chain Reaction (PCR) test had been obtained on 08/07/20 and resulted as positive on 08/11/20.

Resident #16's medical record revealed had resided on the 200 hall and was transferred to the 400 hall COVID-19 unit on 08/11/20 and expired on 08/30/20.

An interview with Resident #16's Responsible Party (RP) on 09/23/20 at 10:15 AM revealed she had not been allowed a compassionate care visit prior to Resident #16 expiring on 08/30/20. Resident #16's RP indicated she had been told she was only allowed to visit through a closed window after Resident #16 had been diagnosed with COVID-19 until the date Resident #16 expired. Resident #16's RP explained for the last week Resident #16 was living Resident #16 had appeared frightened, anxious, and petrified with occasional tears observed each time she visited at the window because Resident #16 was unable to hear the RP speak and would reach out trying to motion the RP to come inside to be with her. Resident #16's RP recalled while standing outside the window she watched Resident #16 struggle to attain any air to breath and died while being alone in an empty room. Resident #16's RP further elaborated she had been contacted the day after Resident #16 expired to collect her wanted belongings.

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An interview with the Director of Nursing (DON) and the Administrator on 09/24/20 at 4:10 PM revealed they were both aware the facility had not allowed Resident #16's RP a compassionate care visit prior to Resident #16's death because they were unaware visitation with residents at end of life was permitted with screening completed and personal protective equipment provided. The DON confirmed she contacted Resident #16's RP after her death; however, the DON does not recall what was said during the conversation related to Resident #16's death.

4. Resident #17 was admitted to the facility on 09/02/20 for respite care with diagnoses that included Acute Respiratory Failure with Hypercapnia.

Resident #17's medical record revealed she resided on the 100 hall during her admission and expired four days after admission on 09/05/20.

The medical record does not contain a facility performed COVID-19 test during her admission and therefore her COVID-19 status is unknown.

An interview with Resident #17's responsible party (RP) on 09/23/20 at 11:57 AM revealed he had not been allowed a compassionate care visit since admission and was not notified there had been an outbreak of COVID-19 upon Resident #17's admission for respite care. He recalled a window visit on the day before Resident #17 expired where Resident #17 cried and stated, "I am not going to get better and go home now that I am here, I will die here." Resident #17's RP recalled the secondary contact requested to be able to have a compassionate care visit due to her having a broken ankle and being unable to

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get around to Resident #17's window but was denied and therefore was unable to see Resident #17 during her admission.

An interview with the Director of Nursing (DON) and the Administrator on 09/24/20 at 4:10 PM revealed they were both aware the facility had not allowed Resident #17's RP a compassionate care visit prior to Resident #17's death because they were unaware visitation with residents at end of life was permitted with screening completed and personal protective equipment provided.

5. Resident #18 was admitted to the facility on 01/15/20 with diagnoses that included chronic kidney disease and an unspecified sequela of cerebral infarction; however, was diagnosed with COVID-19 on 08/25/20.

Resident #18's medical record revealed she resided on the 400 hall during her entire admission and expired on 09/05/20.

A COVID-19 rapid resting log revealed Resident #18 was tested and resulted positive on 08/25/20.

An interview with Resident #18's responsible party (RP) on 09/23/20 at 12:32 PM revealed he had not been allowed a compassionate care visit prior to Resident #18's death. Resident #18's RP stated he had tried making a couple of window visits and it was causing Resident #18 to get so upset that he did not do anymore but had asked to come into the building for a visit but was denied.

An interview with the Director of Nursing (DON) and the Administrator on 09/24/20 at 4:10 PM revealed they were both aware the facility had not

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allowed Resident #18's RP a compassionate care visit prior to Resident #18's death because they were unaware visitation with residents at end of life was permitted with screening completed and personal protective equipment provided.

6. Resident #19 was admitted to the facility on 05/21/18 with a readmission on 09/28/19 with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD); however, was diagnosed with COVID-19 on 08/26/20.

Resident #19's medical record revealed she resided on the 400 hall and expired on 09/08/20.

A COVID-19 rapid testing log revealed Resident #19 was tested and resulted with a positive test on 08/26/20.

An interview with Resident #19's responsible party (RP) on 9/23/20 at 12:55 PM revealed she was not allowed a compassionate care visit prior to Resident #19's death. Resident #19's RP stated she had even begged administration to see her mother prior to her death and told them she was willing to take every risk it may have put her in to have been able to go in and see her mother before she passed. Resident #19's RP explained she told the DON and Administrator that she had read the laws and knew she was allowed to visit at the end Resident #19's life. Resident #19 elaborated that is was impossible to even have a window visit after she was moved to the COVID -19 unit because Resident #19's window was on the side of the building where there was a huge embankment and a dangerous risk for any family member to attempt to get to where Resident #19's window was located. Resident #19 angrily stated "They wouldn't let me

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in and my mother had to die without the people who loved her."

An interview with the Director of Nursing (DON) and the Administrator on 09/24/20 at 4:10 PM revealed they were both aware the facility had not allowed Resident #19's RP a compassionate care visit prior to Resident #19's death because they were unaware visitation with residents at end of life was permitted with screening completed and personal protective equipment provided.

7. Resident #20 was admitted to the facility on 08/24/20 with diagnoses that included acute respiratory failure with hypoxia and pneumonia.

Resident #20's medical record revealed she resided on the 300 hall during her admission and expired on 09/11/20.

An interview with Resident #20's responsible party (RP) on 9/24/20 at 3:20 PM revealed she had not been allowed in the facility for a compassionate care visit at her mothers end of life. Resident #20's RP indicated she had asked once, but had been denied and knew neither her nor her family member could watch Resident #20 die through a window so they chose not to do window visits when she passed away.

An interview with the Director of Nursing (DON) and the Administrator on 09/24/20 at 4:10 PM revealed they were both aware the facility had not allowed Resident #20's RP a compassionate care visit prior to Resident #20's death because they were unaware visitation with residents at end of life was permitted with screening completed and personal protective equipment provided.

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F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15)	F 580		11/2/20

§483.10(g)(14) Notification of Changes.
(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-
(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;
(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and

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F 580	Continued From page 12 phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to notify the responsible party regarding a resident's known exposure to COVID-19 and positive COVID-19 test results for 1 of 1 resident reviewed for notification of changes (Resident #12). Findings included: The facility census log revealed Resident #13 and Resident #12 resided in the same room on 08/28/20 to 08/29/20. According to the COVID-19 rapid testing log, Resident #13 was tested for COVID-19 and initially resulted with a positive result on 08/29/20. According to the COVID-19 rapid testing log, Resident #12 was tested for COVID-19 and initially resulted with a positive result on 09/03/20 following a low grade fever. A laboratory report revealed Resident #12 was tested for COVID-19 with a Polymerase Chain Reaction test (PCR test) on 09/04/20 which	F 580	Address how corrective action will be accomplished for those residents found to have been affected: Resident #12 is no longer in Facility. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Facility will identify through daily review of the 24-hour report any Resident that has had a room change or has received a roommate. The DON/designee will monitor 24-hour report daily at the facility daily clinical morning meeting for room changes for all Residents within the facility to ensure that the POA/Family notification is documented in Resident's chart. All other residents that had been exposed to COVID or tested positive to COVID were reviewed to determine if they and/or their resident representative (as applicable) was notified. This was completed by Administrator. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not	

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F 580	Continued From page 13 resulted positive for COVID-19. A minimum Data Set (MDS) dated 09/03/20 revealed Resident #12 was had moderate cognitive impairment Resident #12's MDS preference interview revealed keeping family involved in his care was very important. Interview with a family member on 09/17/20 at 11:20 AM revealed she was Resident #12's Responsible Party (RP). The family member stated she arrived at the facility on 08/29/20 for a window visit and was greeted by a staff member at the window. The family member revealed the staff yelled through the window that she could not open the window because Resident #12 had been exposed to COVID-19. The family member stated no staff member had informed her prior to her visit that Resident # 12 had been exposed to COVID-19. The family member revealed she arrived on 09/03/20 for another window visit and was informed Resident #12 had tested positive for COVID-19 and had been moved to the COVID unit in the facility. According to the family member no one had called to notify her the Resident was being tested for COVID-19 or had tested positive for COVID-19. An interview with Nurse #11 on 09/24/20 at 2:38 PM revealed she was the nurse on the 200 hall on night shift. Nurse #11 further revealed the hall nurse was not assigned the task of notifying families of changes in resident conditions and was told one of the nurses on the administrative team had been assigned to do that so she did not notify Resident #12's family he had a potential exposure to COVID-19. An interview with Nurse #9 on 09/24/20 at 3:50	F 580	recur: medical record. DON will complete education by 10/30/20 to all administrative nurses, that if a room change occurs both parties and parties POA if applicable must be notified prior to the room change, a room change assessment and/or progress note completed. If unit supervisor is on shift this is their responsibility to ensure this action has taken place. If a weekend, or after business hours, it is the On-Call nurse responsibility to ensure resident/POA for both parties involved is notified prior to a resident being moved. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: DON or designee will audit all room changes during the facility's daily clinical meeting held Monday through Friday, ensuring that the facility has reached out to the POA if applicable. The DON or designee will complete an audit form for room changes weekly for four weeks. The Administrator or designee will present to QI committee will review the results of Audit Tool during monthly QA Meeting for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring for continued compliance for 3 months. Finding will be discussed at quarterly QA meeting.	

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F 580	Continued From page 14 PM she was unsure who was assigned to notify the families of changes in condition. An interview with the Director of Nursing (DON) on 09/24/20 at 4:19 PM revealed Nurse #9, or the unit managers should have been responsible to notify Resident #12's RP of potential exposures to COVID-19 and his COVID-19 positive test. An interview with the Nurse Practitioner on 09/24/20 at 6:07 PM revealed she would expect a member of the nursing staff to notify the families of any changes to the residents especially with a potential exposure to COVID-19. An interview with Resident #12's Physician on 09/28/20 at 10:10 AM revealed he would expect a member of the nursing staff to notify the families of any changes to the resident's condition, especially with a potential exposure to COVID-19.	F 580		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff, nurse practitioner and physician interview, the facility failed to provide supervision to prevent a newly admitted resident, who was assessed as being a moderate risk for wandering and not assessed for	F 689	Address how corrective action will be accomplished for those residents found to have been affected: Upon immediate discovery of Resident #7's wishes to smoke while at facility a	11/2/20

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F 689	Continued From page 15 smoking risk during the admission assessments, from exiting the facility to where a patio which included signage that indicated no smoking and smoking outside of the facility for 1 of 1 residents reviewed for safety (Resident #7). Findings included: A review of the facility document titled "Smoking Policy- Resident" revised July 2019 indicated all residents will be evaluated on admission to determine if he or she is a smoker. If resident is determined to be a smoker an evaluation should include the following: a current level of safety while smoking, method of tobacco consumption, desire to quit smoking, and ability to smoke safely with or without supervision. The staff would consult with the physician to determine of restrictions needed to be placed on the residents smoking privileges. Any smoking resulted privileges would be documented on the plan of care. Residents who are determined to have independent smoking privileges are not permitted to keep cigarettes, pipes, tobacco, or other smoking articles in their possession. Items are to be locked on the nurses' cart until resident can use them. A list provided by the Administrator on 09/15/20 did not include Resident #7 as a known safe smoker. The facility's designated smoking schedule included the following times: 6:30 AM as requested, 9:30 AM, 1:00 PM, 3:30 PM, 6:00 PM, and at bedtime as requested. Resident #7 was admitted to the facility on 09/04/20 with diagnoses that included syncope	F 689	Smoking Assessment was completed on 9/15/2020. Resident # 7 smoking equipment that included cigarettes and lighter was immediately removed from room and placed on medication cart. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: An audit was conducted by Unit Managers of all current Residents in the facility who have been identified as active smokers was completed on 9/15/20 and have a completed smoking assessment in Resident's medical record and that all smoking materials were locked on medication per facility smoking policy. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: medical record. DON reviewed the nursing admission process and revised the admission assessments check list to include all resident must have a smoking assessment completed on 10/22/20. If the resident is not a tobacco user, this will be documented in the assessment. SDC nurse will complete 100% in service for all nurses with new changes to the admission assessments including the smoking assessment target date for completion will be 10/26/20. Unit supervisors will be responsible for complete the admission check list and ensuring that a smoking assessment was completed for each new admit. Unit supervisors have been educated by the DON on 10/22/20 to complete an admission check list and return the audit	

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F 689	Continued From page 16 and collapse, need for assistance with personal care, a history of falling and a personal history of nicotine dependence. Resident #7 discharged from the facility on 9/19/20. Resident #7's admission assessment completed by the Nurse #6 and dated 09/04/20 indicated he was alert and oriented and was a current smoker of 1-2 packs of cigarettes every 3 days for the last 20 years. A self-care deficit care plan dated 09/04/20 indicated Resident #7 required supervision with ambulation due to a recurrent history of falls. Resident #7's wandering risk assessment completed by Nurse #6 and dated 09/04/20 indicated Resident #7 was at moderate risk for wandering. The admission Minimum Data Set (MDS) dated 9/17/20 noted Resident #7 had intact cognition and required no assistance with activities of daily living. The admission MDS indicated Resident #7 was able to walk in his room and corridor independently and could stabilize balance during transfers and walking without human assistance. There was no limitation of range of motion noted in his upper or lower extremities. No wandering was noted. Resident #7 had one fall the month prior to his admission. An interview with Nurse #6 on 09/15/20 at 3:05 PM revealed she was the 100 hall nurse on that date. Nurse #6 indicated she was unaware Resident #7 was a known smoker, had his own smoking material, or had exited the unit to smoke during her shift. Nurse #6 stated all residents were to be assessed for smoking on admission	F 689	the DON after the have ensured all assessments have been completed on each new admission. All new admitting residents and or responsible party will continue to be educated during the admission process of our smoking policy and will sign form acknowledging they have received the smoking policy within the admission packet. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The DON or designee will audit the admission check lists and Pointclickcare documentation to ensure smoking assessment is completed on all new admissions one time a week for 4 weeks beginning 10/22/2020 for all new admissions. Administrator or designee will audit the admission packet document for the validation of acknowledgement of receiving the admission packet which includes facility smoking policy one time a week for 4 weeks beginning on 10/22/2020 for all new admissions. The Administrator or designee will present to QI committee will review the results of Audit Tool during monthly QA Meeting for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring for continued compliance for 3 months. Finding will be discussed at quarterly QA meeting.	

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but was unable to locate a smoking risk assessment or a plan of care for Resident #7's smoking. Nurse #6 verbalized all smoking items and tobacco products were to be locked in the nurses' cart at times and only to be distributed to the approved residents during scheduled smoking times

Resident #7's comprehensive care plan dated 09/04/20 revealed Resident #7 had a problem with hypertension (high blood pressure) related to smoking, but there were no care plan goals or interventions that had to do with him smoking. Resident #7's electronic medical record (EMR) revealed a smoking risk assessment was not completed.

A continuous observation on 09/15/20 beginning at 1:40 PM and ending at 1:45 PM revealed Resident #7 was walking by himself when on the 100 hallway which was the hallway he resided, with cigarettes and a lighter in his right hand. Resident #7 exited through the closed wooden double doors to the 100 hall unit. Resident #7 ambulated through the 200 hall resident care unit and through the adjacent corridor and opened a door across from rooms #400 and #402 and exited the facility. Resident #7 exited through a door with signage that indicated No Smoking area. The resident was observed to walk outside to where a courtyard while still carrying cigarettes and a lighter in his right hand. Resident #7 sat down in a chair outside and lit the cigarette then put the lighter in his pocket. The surveyor asked Resident #7 what his name was, but Resident #7 was unable to be clearly identified when he responded. The surveyor approached Nurse #8 who exited the facility where Resident #7 was observed sitting and smoking. Nurse #8 asked

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Resident #7 his name and then identified Resident #7 to the surveyor.

An interview with Nurse #8 on 09/15/20 at 1:45 PM revealed Nurse #8 was the nurse assigned to the 300 hall on that date. Nurse #8 indicated she did not know Resident #7 but verified Resident #7's name for the surveyor after speaking to Resident #7. Nurse #8 stated she was not sure if Resident #7 had been assessed as a safe smoker and indicated the surveyor would have to speak to the nurse assigned to Resident #7.

An interview with the Administrator on 09/15/20 at 3:30 PM revealed she was unaware that Resident #7 was a known smoker and acknowledged Resident #7 was not on the list of approved smokers provided to the surveyor and was smoking at unapproved smoking times. The Administrator stated all residents were to be assessed for their ability to smoke safely and all smoking items were to be stored and locked on the nurses' cart and only distributed to approved residents during designated smoking times. The Administrator further indicated a smoking risk assessment should be competed on all residents on admission to the facility. If the resident is determined to be a smoker, further evaluation should be completed to include residents' ability to smoke safely and a smoking care plan should be developed. The Administrator revealed the admitting nurse, or a nursing supervisor should complete all resident assessment during the admission process. The Administrator stated the admitting nurse, or a nursing supervisor should complete the smoking assessment during the resident's admission.

An interview with the Director of Nursing (DON)

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F 689	Continued From page 19 on 09/21/20 at 10:27 AM revealed she was unaware Resident #7 was a smoker or that he had smoking items on his person The DON further revealed a smoking risk assessment should be completed for every resident on admission and if the resident was found to be a smoker, all smoking items should be locked in the nurses' cart and it should be documented in the resident's plan of care. The DON was unsure why a smoking assessment was not competed for Resident #7 who had a known history of smoking. The DON stated the admitting nurse or a nursing supervisor should complete the smoking assessment during the resident's admission.	F 689		
F 880 SS=K	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	F 880		11/4/20

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conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(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

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F 880	Continued From page 21 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, record review, staff, nurse practitioner and physician, and family interview, the facility failed to identify residents with COVID-19 by not placing them on Enhanced Droplet Contact Precautions. The facility failed to educate staff on the importance preventing cross contamination by removing all Personal Protective Equipment (PPE) to include gowns and gloves and performing hand hygiene between caring for residents who are COVID-19 positive and COVID-19 negative. The facility failed to screen employees to ensure staff were asymptomatic when on duty. The facility failed to ensure staff were using cleaning chemicals approved and listed on the EPA website to kill COVID-19. The facility failed to educate staff on proper use of cleaning chemicals. Facility failed to screen and test residents before room transfers within the facility to prevent potential exposure of COVID-19 to other residents. Facility failed to implement a policy for storage of PPE (N-95 masks and face shields). These failures in infection control practices occurred during a COVID-19 pandemic and had the potential to affect all residents and staff in the facility through the transmission of COVID-19. The facility resulted in 60 positive residents and 15 positive employees as of 09/26/20. The immediate jeopardy began on 9/13/20 when the facility failed to identify a symptomatic employee (Nurse #5) to care for residents on the	F 880	1.Address how corrective action will be accomplished for those residents found to have been affected: All residents that required enhanced contact droplet precautions had signage placed on doors per CDC guidance. This was competed on 9/16/20. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents with a known COVID positive diagnosis, new admission with an unknown COVID status, or symptomatic resident with pending results will be identified and correct signage will be placed on doors. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: medical record. Unit managers posted the Enhanced Droplet Contact Precaution signs on all resident doors that are under this precaution, also quarantine door to COVID-19 unit has Enhanced Droplet Contact Precaution signs posted. This was completed by each unit supervisor and 100% audit was completed on 9/16/2020 to ensure all signage was	

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F 880	Continued From page 22 100 Hall New Patient Observation wing. Immediate Jeopardy was removed on 09/25/20 when the facility provided and implemented a credible allegation of immediate jeopardy removal. The facility remained out of compliance at a lower scope and severity level of E (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems put into place are effective. The findings included: 1. A memo written by the DON dated 03/17/20 indicated "all staff must be screened for symptoms and the employee's temperature taken prior to reporting to their shift". It further indicated "all staff must check their own temperature at the time clock and document it next to their name. If a temperature is noted, the on-call nurse was to be called. If afebrile, staff were to proceed to step #2. Step #2 indicated all staff were to report or deny symptoms that included shortness of breath or cough next to their name. If these symptoms are present, the on-call nurse must be notified." Visitors were to be screened which included their temperature taken and logged; however, no questions related to symptoms were asked during the screening process. The employee screening process consisted of a pre-printed employee roster that listed each employees name and job title/department, a column for temperatures to be written and a column for staff to deny symptoms. No symptoms were listed on the screening sheet. Facility documents titled Sunday Temp Log, Monday-Tuesday Temp Log revealed documents with employees pre-printed names and job title in two separate columns. The documents contained	F 880	posted and corrected. Education was provided to all unit managers on correct signs for enhanced droplet contact precautions and that they must be placed immediately on all resident□s door that are placed on this isolation. Residents and unit doors will remain closed during this isolation period. Education provided by administrator. Completion of this in service was 9/16/2020 with signatures of all administration nurses. Hall nurses and CNA will all be 100% educated on the signage, and importance of posting immediately with order is received for isolation due to COVID 19, also hall nurses will understand that the quarantine doors to COVID-19 unit must have Enhanced Droplet Contact Precautions signs posted on them at all times, doors also must remain closed at all times. Completion target date is 9/25/20 with a signature log of all staff. The SDC nurse will complete in-service. Education will be provided to all new staff during orientation with a signature of staff members that they understand the Enhanced Droplet Contact Precautions. This will include a printout on what enhanced droplet contact precaution entail, an example of enhanced droplet contact precaution sign for reference, illustration on how to put on and remove PPE. Enhanced Droplet Contact Precaution signs are now kept at nurses□ station for the availability for use by all staff placing a caddy on a resident door. Facility has signed a 6-month contract with an infection preventionist clinical consultant with RC Clinical Consulting	

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GLENBRIDGE HEALTH AND REHABILTATION CENTER	211 MILTON BROWN HEIRS ROAD BOONE, NC 28607

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F 880	Continued From page 23 two additional columns that were labeled "Temp" and "Denying Symptoms". 1 a. The employee daily screening log for 09/13/20 revealed Nurse #5 reported to work on 09/13/20 with a low-grade fever of 99.0 and symptoms listed as sore throat, headache, congestion, and swollen glands. The employee daily screening log for 09/16/20 revealed Nurse #5 reported to work on 09/16/20 afebrile with a temp recorded of 97.0 but reported a headache. An interview was conducted with Nurse #5 on 09/16/20 at 11:01 AM revealed she worked 100 hall on 09/13/20 on day shift. Nurse #5 reported she came to work and had a low-grade fever of 99.0 degrees and was symptomatic with a headache, sore throat, congestion, and her glands she recalled being swollen and documented this on the daily screening log. Nurse #5 revealed she was educated it was not necessary to report these symptoms to the supervisor since her fever was not greater than 101 degrees Fahrenheit. Nurse #5 reported she had been tested on 09/11/20 during the facility weekly testing and her results were pending so she worked the shift. Nurse #5 stated on 09/16/20 when she arrived at work, she was again assigned the 100 hall new patient unit and Nurse #5 asked Nurse #3 if the results had been returned for her weekly test since she had been having some symptoms. On 09/16/20, Nurse #5 reported she had a headache. Nurse #3 revealed Nurse #5's result on 09/11/20 had not yet been returned, she was not offered a rapid COVID-19 test, but a polymerase chain reaction (PCR) COVID-19 test was performed and Nurse #5 began her shift since she wasn't running a fever	F 880	who will provide in -services on 10/26 through 10/27 including topics: PPE for transmission base precautions, storage of mask, hand hygiene, screening and cleaning procedures for all employees in each department. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: DON or designee will complete an audit 2 times a day for 4 weeks, 1 time a day for 4 weeks, 3 times a week for two months. This will entail the auditor looking at all doors to all resident with a known COVID positive diagnosis, new admission with an unknown COVID status, or symptomatic resident with pending results will be identified and correct signage will be placed on doors. The Administrator or designee will present to QI committee will review the results of Audit Tool during monthly QA Meeting for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring for continued compliance for 3 months. Finding will be discussed at quarterly QA meeting. 2.Address how corrective action will be accomplished for those residents found to have been affected: An audit was completed and all admissions who were in the building on 9/15/20 and admitted within the last 14 days were placed on enhanced droplet-contact precautions.	

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F 880	Continued From page 24 on 09/16/20. It is unknown if Nurse #5 resulted positive for COVID-19 following being symptomatic and febrile. Nurse #5 had a COVID-19 PCR test performed on 09/11/20 which resulted as negative; however, results were not available on 09/16/20 when she was rapid tested and resulted as positive for COVID-19. An interview with Nurse #3 on 09/18/20 at 11:32 AM indicated she had not been made aware that Nurse #5 had been symptomatic on 09/13/20 and did not receive a rapid test for COVID-19 until Nurse #5 approached her on 09/16/20 requesting the results of her testing completed on 09/11/20 and told Nurse #3 that she had symptoms over the weekend and no test had been completed. Nurse #3 indicated she had not known to offer or perform a PCR test for any resident or staff who were symptomatic and had a negative result from a rapid test. An interview with the Infection Control (IC) Nurse/DON and the Administrator was conducted on 09/21/20 at 10:27 AM revealed neither the DON nor the Administrator were aware Nurse #5 had reported symptoms on 09/13/20 on the daily screening log without being reviewed by a supervisor on duty. They were also not aware Nurse #5 had not been rapid tested when symptomatic and allowed to work the shift or additional shifts since that date. The DON explained Nurse #5 should have received a rapid test on 09/13/20 and not allowed to report to her assigned hall until the test had a negative result. The failure occurred when the supervising nurse on duty failed to review daily employee screening logs for temperatures or reported signs and	F 880	Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All admitting resident with a known COVID positive diagnosis, with an unknown COVID status, or symptomatic resident with pending results will be identified and placed on enhanced droplet-contact precautions. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: medical record. Admission policy and procedures were reviewed and revised on 09/25/2020 to adhere to CDC guidance. Newly admitted or readmitted residents with COVID-19 who have met criteria to discontinue transmission-based precautions while in the hospital will be placed on regular units, in a private room. If a newly admitted resident has an onset of symptoms or remains symptomatic even after transmission- based precaution had been discontinued, resident will remain in single rooms, resident will not leave room if possible, and if needed will wear appropriate PPE. Staff will adhere to using all recommended COVID 19 PPE during care of resident under observation due to symptomatic. If a newly admitted or readmitted resident COVID-19 status is unknown resident will be placed in a single room on for 14 days of observation, all recommended COVID-19 PPE will be worn during care, which included, facemask or N95 respirator, eye	

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F 880	Continued From page 25 symptoms. The DON indicated she was unable to elaborate why the screening sheet had not been reviewed other than with the amount of COVID-19 positive cases in the facility, staff had been overwhelmed and not had the time. The DON explained she expected staff to report concerns to the supervisor if the staff member was febrile or experienced symptoms of COVID-19. 1b. The employee daily screening log for 09/15/20 revealed Nurse #1 reported to work afebrile with a temperature of 98.4 and no symptoms were listed on the log. A continuous observation was made on 09/15/20 between 11:00AM- 11:35 AM revealed Nurse #1 documenting on a laptop in the hallway. Nurse #1 had a slight cough and mentioned she did not feel well. She was wearing a face shield and a mask. An interview with Nurse #1 on 09/16/20 at 1:46 PM and a follow up interview on 09/17/20 at 11:16 AM revealed Nurse #1 had not felt well and called out of work on 09/14/20 when she reported she didn't feel well with symptoms including a headache, cough, fatigue, and overall weakness. Nurse #1 reported her symptoms to the on-call nurse for the 09/14/20 shift. Nurse #1 stated she was contacted later in the morning by the Director of Nursing (DON) asking if she was planning to come in later in the shift because she was needed. Nurse #1 indicated she told the DON she was not coming in that day. Later in the afternoon, Nurse #1 was again contacted this time by Nurse #2 who told Nurse #1 she needed to be at work on 09/15/20 unless she was running a fever due to staffing concerns. Nurse #1 reported she came to work on 09/15/20 and	F 880	protection, gloves, and gown. All new admissions will adhere to resident testing weekly per CDC guidance. If a resident refuses testing, the facility will have to monitor for signs and symptoms of COVID 19 and place them on enhanced droplet contact precautions following CMS guidelines. Facility has signed a 6-month contract with an infection preventionist clinical consultant with RC Clinical Consulting who will provide in -services on 10/26 through 10/27 including topics: PPE for transmission base precautions, storage of mask, hand hygiene, screening and cleaning procedures for all employees in all departments. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: An audit of enhanced droplet-contact precaution signage on the COVID unit and new admission rooms will be performed beginning on 9/25/2020 by the DON or Nurse Manager 2 times a day for four weeks, then one time a day for four weeks, then three times a week for two months. The auditor will compare a census for new admission within the last 14 days to ensure they are on precautions, and an order is in the chart. The Administrator or designee will present to QI committee will review the results of Audit Tool during monthly QA Meeting for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring for	

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F 880	Continued From page 26 checked her temperature and was afebrile but does not recall if she documented it on the sign in sheet on that day or not. Nurse #1 reported they were told to check their temperature and record their temperature at the start of the shift and there was an additional column to deny symptoms. There were no specified symptoms to confirm nor deny were listed on the daily screening sheet. Nurse #1 revealed she mentioned to the unit manager Nurse #2 that morning she was not feeling well but did not have a fever when she arrived to work therefore, she reported to her assigned hall. Nurse #1 worked the 200 hall COVID-19 overflow unit on 09/15/20 day shift. She reported after lunch time she started feeling worse and felt so hot she had to go outside for a minute to try to cool off because she felt as if she were going to vomit or pass out. Nurse #1 then texted Nurse #3 from outside the building alerting her that Nurse #1 felt she needed to be tested for COVID-19. Nurse #1 returned to the unit and approximately 30 minutes later Nurse #1 was tested by rapid testing. Nurse #1 revealed she returned to the unit for about 15-20 minutes before Nurse #2 approached her and notified her that she was COVID-19 positive per the rapid test and needed to leave the facility. An interview with Nurse #2 was conducted on 09/17/20 at 2:10 PM revealed she had contacted Nurse #1 on 09/14/20 between 5-7 PM to confirm if Nurse #1 would be at work on 09/15/20. She recalled Nurse #1 informing her she was still not feeling well but she would try to make it. Nurse #2 was unable to recall what symptoms of not feeling well Nurse #1 reported to her on 09/14/20. Nurse #2 revealed she did tell Nurse #1 the building needed her on schedule but did not elaborate further how that statement was conveyed to Nurse #1. Nurse #2 stated in the afternoon on	F 880	continued compliance for 3 months. Finding will be discussed at quarterly QA meeting. 3.Address how corrective action will be accomplished for those residents found to have been affected: Unit manager completed one on one in-service with nurse aide verbally 9/25/20 who was observed entering a resident room without changing her PPE, she was reeducated by unit manager on the importance, and when to remove PPE, how to remove, and hand hygiene per CDC guidelines. Nurse aid has not returned to work since incident, however, will not be able to return to work until a return demonstration is completed. A nurse also was visualized not performing hand hygiene between resident contact, this nurse has been one on one in serviced by administrator on 9/16/2020, one the importance of hand hygiene, when hand hygiene must be completed per CDC guidelines. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: A visual display of the process to put on and remove PPE had been posted on the COVID-19 unit and was placed throughout the building on 9/16/20. Unit mangers will complete PPE audit daily while there are active cases in the facility on all isolation rooms, and COVID-19 unit to ensure enough supply is in the isolation caddy□s during each shift including all PPE and alcohol-based hand rub. DON reviewed scheduling operations and	

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F 880	Continued From page 27 09/15/20 she was notified that Nurse #1 was again not feeling well and had a headache. An interview with the Infection Control (IC) Nurse/DON and the Administrator was conducted on 09/21/20 at 10:27 AM revealed neither the DON nor the Administrator were aware Nurse #1 had not felt well until after Nurse #2 and Nurse #3 made them aware Nurse #1 had been rapid tested on 9/15/20 and was positive for COVID-19 . The DON elaborated to say she was aware Nurse #1 was not feeling well on 09/14/20 and had called off from work, but the DON stated she was on vacation on 09/15/20 and was unaware Nurse #1 was still not feeling well and would expect Nurse #1 not to feel pressured to work a shift if she felt she was not well enough or felt she had symptoms of COVID-19. The DON indicated Nurse #1 should have reported she did not feel before she entered the facility for her shift on 9/15/20. The DON stated she expected nurses should know the signs and symptoms to self-assess themselves and report concerns accordingly, but no policy was in place for screening. The DON revealed Nurse #1 should have been asked to stay in her car and a rapid test should have been performed before her shift began. The DON indicated the daily screening sheets are reviewed on the following day by the ADON and kept for records, but was unable to elaborate when questioned if any staff reviewed the daily screening logs during the shift that occurred other than to say with the amount of cases the facility had, staff had been overwhelmed and had not had time. The DON reported staff had been educated to take and record their own temperature and deny symptoms. The DON did not indicate what symptoms staff were educated to be reporting on	F 880	implemented a policy to adhere to CDC staffing guidelines, ensuring staff will not be assigned to a COVID-19 positive and COVID-19 negative residents simultaneously during daily assignment. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: medical record. SDC and administrative nurse will complete a hand hygiene in-service that was started on 9/16/20 by the SDC nurse with 100% participation in each department and signatures of all staff who completed. Return demonstration will be completed and a competency check off will be performed on each staff member. Staff members who have not completed training and competency check off will be removed off the schedule if education is not completed by target completion date and will remain off the schedule until completion 10/30/20. SDC administrative nurse will complete 100% in-services to all staff members in each department of the importance of removing PPE when exiting a COVID-19 positive room. Training will be provided by SDC nurse and target date completion will be 9/25/2020. All staff members in each department must show returned demonstration of proper PPE removal, and hand hygiene. All staff will sign on completion of this task with an administration nurse witnessed signature. Staff members who have not completed training will be removed off the schedule if education is not completed by target completion date and will remain off the	

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F 880	Continued From page 28 the daily screening log. According to the DON, she felt this was an effective form of a screening process and logs were collected, reviewed, and stored by Nurse #9; however, the screening logs were not reviewed during the current shift being worked. 2. According to the facility document titled "Coronavirus 2020" dated February 2020 indicated in part: "rapid recognition, isolation, and appropriate management of a patient suspected of being infected is key to minimizing transmission. Residents are rapidly identified as potential COVID-19 by screening, exposure, and symptoms. Infection control precautions for probable and suspected cases of COVID-19 are to be immediately placed in a single occupancy private room with the door closed. If a N-95 mask is not available, staff will utilize contact and droplet precautions." During the entrance conference on 09/15/20, the Administrator revealed the 400 hall was a designated COVID-19 unit and the end of the 200 hall had been designated as a COVID-19 overflow unit to include rooms 211-220. There were 4 of the 10 rooms occupied on the end of the 200 hall overflow unit. A continuous observation made on 09/15/20 from 11:00 AM to 11:35 AM revealed no signage that indicated Enhanced Droplet Contact Precautions before entering the area on the end of the 200 hall designated as the COVID-19 overflow unit or on the doors of any resident room identified to be COVID-19 positive. There were three COVID-19 positive (Resident #1, #2, and #5) and three COVID-19 negative residents (Resident #3, #4, and #6) on the COVID-19 overflow unit. Resident #1 was single occupancy and Resident #2 and #5	F 880	schedule until completion. SDC administrative nurse will continue to educate all new staff on PPE procedures and hand hygiene during orientation, with returned demonstration and signature of staff members upon completion of this task. Facility has signed a 6-month contract with an infection preventionist clinical consultant with RC Clinical Consulting who will provide in -services on 10/26 through 10/27 including topics: PPE for transmission base precautions, storage of mask, hand hygiene, screening and cleaning procedures for all employees in all departments. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Unit mangers will complete PPE audit active COVID-19 positive, suspected COVID-19, unknown COVID-19 to include new admissions, and other Residents required Transmission-based precautions in the facility to ensure enough supply is in the caddy□s during each shift. Audits will be completed daily x 2 weeks, 3 x a week for 4 weeks and then 1 x a week for 4 weeks. The Administrator or designee will present to QI committee will review the results of Audit Tool during monthly QA Meeting for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring for continued compliance for 3 months. Finding will be discussed at quarterly QA	

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F 880	Continued From page 29 were roommates in a COVID-19 positive room. Resident #3 was in a single occupancy room and Resident #4 and #6 were roommates in a COVID negative room. There were 2 yellow wet floor signs placed in the hallway and were sitting side by side in the center of the hallway next to each other outside of rooms 209 and 210. Neither of these signs had anything posted that indicated you were entering a COVID-19 area. The rooms on the 200 hall were all semi-private; however, some rooms only had one resident occupying them. A nurses' note dated 09/13/20, Resident #1 resulted positive for COVID-19. A progress note written by the Nurse Practitioner (NP) dated 09/14/20 NP indicated Resident #2 had a cough and was positive for COVID-19. A lab documentation dated 09/10/20, Resident #3 was negative for COVID-19. A rapid testing log revealed Resident #5 was tested and resulted in a positive test on 09/13/20. A review of a lab documentation dated 09/14/20 with a resulting date of 09/18/20, Resident #5 was positive for COVID-19. An interview with NA #1 on 09/15/20 at 12:25 PM revealed she was working the 200 Hall COVID-19 overflow unit which included room 211-220. NA #1 was wearing full PPE to include a gown, gloves, face mask, and a face shield. NA #1 stated the unit had 3 residents identified to be COVID-19 positive. (Resident #1, #2, and #5.) NA #1 indicated Resident #3 had been exposed by her former roommate but had tested negative for COVID-19 and NA #1 acknowledged there were no signage posted on the doors of any rooms on	F 880	meeting 4.Address how corrective action will be accomplished for those residents found to have been affected: N95 mask that were not stored correctly were immediately discarded. Employees were provided a new N95. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Employees who were working the COVID unit in the facility were educated on 9/15/20 on Reuse and Storage of N95 Respirator Facility Policy for proper storage of N95 masks per CDC guidance. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: medical record. All staff in each department were 100% in serviced on storage method using a labeled paper bag with staff member name and will be place on a table designated for used PPE with target completion date of 9/25/20 entailing staff signatures when in-service is completed. Staff will place all N95 masks in a paper bag and labeled with staff members name, these bags will be changed out once a week unless soiled prior to weeks end bag will be discarded and replaced immediately. DON has revised PPE storage policy to adhere to CDC guideline on 9/22/20. Facility has signed a 6-month contract with an infection preventionist clinical	

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F 880	Continued From page 30 her unit that indicated any form of isolation precautions. NA #1 explained the yellow wet floor signs in the floor marked the start of the COVID-19 overflow unit but agreed there was no signage that indicated it was a COVID-19 unit nor a cart outside the unit to don clean PPE before entering the unit. NA #1 further said she leaves her resident doors always open so that she can see her residents to include COVID-19 positive residents. An interview with Nurse #1 on 09/16/20 at 1:46 PM revealed she was assigned to work the 200 hall COVID-19 overflow unit on 09/15/20 which included the lower portion of 200 hall from room 211-220. Nurse #1 was wearing a gown, face mask, and a face shield. Nurse #1 acknowledged there was no signage to indicate Enhanced Droplet Contact Precautions on any door on the unit and there were no signage that indicated the entrance into the designated COVID-19 overflow unit. Nurse #1 stated 2 yellow wet floor signs indicated where the COVID-19 overflow unit with rooms 211-220 were. Nurse #1 explained Resident #1, #2, and #5 were positive for COVID-19. Nurse #1 explained she had been taught to wear full PPE which included a gown, gloves, face mask and a face shield when caring for each resident on the 200 hall COVID-19 overflow unit and to change the gown and gloves between each resident. An interview with the DON was conducted on 09/21/20 at 10:27 AM revealed she was the Infection Preventionist and was unaware the need for Enhanced Droplet Contact Precautions. The DON stated she had researched what personal protective equipment (PPE) was required for COVID-19 resident care and had decided Droplet	F 880	consultant with RC Clinical Consulting who will provide in -services on 10/26 through 10/27 including topics: PPE for transmission base precautions, storage of mask, hand hygiene, screening and cleaning procedures. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: A audit will be completed daily by the DON or designee on the COVID unit to ensure N95 storage is correct. The audit will be completed until there no further active cases. The Administrator or designee will present to QI committee will review the results of Audit Tool during monthly QA Meeting for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring for continued compliance for 3 months. Finding will be discussed at quarterly QA meeting 5.Address how corrective action will be accomplished for those residents found to have been affected: The nurse who reported symptoms was rapid tested during the shift and sent home related to positive result. Nurses were educated on the importance to report symptoms at the start of each shift if noted Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Staff and Facility were tested for COVID-19 according to testing schedule that week. Address what measures will be put into place or systemic changes made to	

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F 880	Continued From page 31 Precautions was the most appropriate form of isolation. The Droplet Precaution signage only indicated a mask was to be worn when caring for the resident and did not include the use of a gown, gloves, mask, and face shield. The DON indicated she was unaware there was no isolation precaution signage outside the doors of resident rooms who had been identified as COVID-19 positive on the 200 hall COVID-19 overflow unit nor signage outside the COVID-19 care unit to reveal the entrance to the COVID-19 care unit where full PPE to include a gown, gloves, mask, and face shield were required. The DON explained she was not aware the wet-floor signs were the only markers to indicate the entrance to the COVID-19 overflow unit. The 200 hall COVID-19 overflow unit was initiated by the DON, the on-call nurse, and unit supervisor. The DON indicated she was aware there were both residents positive and negative for COVID-19 on the 200 overflow unit. The DON elaborated that she expected these units to be supplied with PPE so that staff were not required to request supplies throughout the shift. An interview with the Administrator was conducted on 09/15/20 at 4:00 PM revealed she was unaware the 200 hall COVID-19 overflow unit did not have signage to indicate isolation on the doors. The Administrator stated she was unaware of the need for signage titled Enhanced Droplet Contact Precautions for COVID-19 precautions. The Administrator explained she was aware there were two wet floor signs to separate the general community population on the 200 hall from the COVID-19 positive overflow unit on the end of the 200 hall. She understood there were both residents positive and negative for COVID-19 on the unit. She stated they currently had adequate	F 880	ensure that the deficient practice will not recur: Facility will complete a 100% in services conducted by SDC nurse to all staff in each department on reporting signs and symptoms if experiencing prior to their shift, or immediately if on shift with new onset of cough, shortness of breath, fever or chills, muscle or body aches, vomiting or diarrhea, new loss of taste or smell and a temperature greater than 100 degrees Fahrenheit. Staff must report this to on call nurse and/or DON target date of completion 9/25/2020. In-service will entail signatures of all staff in each department who understand the procedure of reporting illnesses. The facility has reviewed the current screening log process and implemented a new screening method and policy effective 9/25/2020 to ensure staff members and facility are adhering to the CDC reporting and screening guidelines. The Employee and a second witness will complete the screening log. The witness (screener) is responsible to complete a screening tool that includes employee name, temperature, if the employee has or has had in the past 14 days any symptoms such as: cough, new loss of taste, sore throat, muscle or body aches, diarrhea, fever, shortness of breath or difficulty breathing, chills, new loss of smell, nausea or vomiting, headache, fatigue, or congestion or runny nose and if the employee has traveled internationally or have been on a cruise within the last 14 days on each employee at the start of the shift. If employee answers yes to any of	

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F 880	Continued From page 32 supply of PPE to include gowns, gloves, and face shields, but had limited supplies of KN95 and N95 masks. 3. According to a facility document titled Coronavirus 2020 dated February 2020 indicated only essential personnel should enter the room of a resident on COVID-19 precautions and should don PPE to include a gown, N-95 respirator or surgical mask if N-95 unavailable, eye protection and gloves. A nurses' note dated 09/13/20, Resident #1 resulted positive for COVID-19. The rapid testing log confirmed Resident #1 was tested and resulted in a positive test on 09/13/20. A progress note written by the Nurse Practitioner (NP) dated 09/14/20 NP indicated Resident #2 had a cough and was positive for COVID-19; however, the rapid testing log revealed Resident #2 was tested and resulted in a positive test on 09/13/20. A rapid testing log revealed Resident #5 was tested and resulted in a positive test on 09/13/20. A review of a lab documentation dated 09/14/20 with a resulting date of 09/18/20, Resident #5 was positive for COVID-19. An additional continuous observation and interview on 09/15/20 at 12:07PM to 12:25PM revealed Nurse #1 entered the room of Resident #1 wearing full PPE. She sat the tray down on the overbed table. Nurse #1 exited the room, removed her gown and gloves and discarded them. Nurse #1 then donned clean gloves and a gown without washing her hands or using hand sanitizer and obtained a tray from a staff member who handed her the tray from the other side of	F 880	the questions on the screening tool this nurse will then have the employee exit the facility and wait in their vehicle for further direction for administrative nurse to perform a rapid test and report the findings of screening tool to on call administrative nurse. If the employee is not symptomatic, both employee and screener will sign screen tool. This will be placed in a folder at the time clock. This process will be completed at the start of all shifts. Target completion of this is 9/25/2020. Administrator or designee upon arrival will collect all screening sheets and compare to the schedule on given day to ensure staff is adhering to protocol. For Administrative Office staff who enter the building from the front entrance the front receptionist will complete screening tool with the Administrative staff and the receptionist will be trained on signs and symptoms per CDC guidelines of COVID 19 by the SDC nurse, this receptionist will understand the importance of this role, and have a clear understanding of what is expected. Target completion of this is 9/25/2020 Symptoms of COVID-19 that are listed on the CDC website including: cough, shortness of breath, fever or chills, muscle or body aches, vomiting or diarrhea, new loss of taste or smell illustration has been posted at the time clock on 9/22/2020 as a visual alert. If a staff member is symptomatic with a new onset while on shift will immediately be removed from resident care areas and complete a rapid test, and not return to	

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F 880	Continued From page 33 the yellow wet floor signs and delivered the meal tray to Resident #2 Nurse #1 was then observed to exit the room of Resident #2, doff her gloves and used alcohol-based hand rub (ABHR). Nurse #2 did not remove her gown before she obtained the meal tray for Resident #3 and delivered it. Nurse #1 then exited the room, doffed her gown and gloves and used ABHR. She donned a clean gown and gloves and delivered a meal tray to Resident #4 then exited the room and doffed her gown and gloves and used ABHR. NA#1 who was wearing full PPE to include a gown, gloves, face shield, and a mask obtained and delivered the meal tray of Resident #5 NA #1 began setting up the tray when Resident #4 began to complain that she received the wrong meal. NA #1 then exited the room of Resident #5 wearing full PPE and entered the room of Resident #4 to address her concern. NA #1 touched Resident #4 and asked her about her concern. NA #1 then picked up Resident #4's tray from her bedside table, removed the liquids and the exposed plastic utensils and laid them on the overbed table placed in front of Resident #4. NA #1 exited the room carrying the tray and unwanted food and discarded it in the trash in the adjacent room being used as a soiled utility room. NA #1 then removed all her PPE and performed hand hygiene with ABHR. An interview with Nurse #1 was conducted on 09/16/20 at 1:46 PM revealed she had been educated to change gloves and perform hand hygiene between residents and when in isolation care areas. Nurse #1 indicated she had not thought about changing gloves each time and performing hand hygiene during meal tray delivery. Nurse #1 confirmed Resident #1, #2, and #5 were positive for COVID-19 via testing.	F 880	the hall until afebrile and has a negative test result. All administrative nurses signed an in-service on rapid testing while a staff member is in a facility completed by the DON on 9/23/2020, including that a staff member with a pending staff rapid test does not return to the hall, and if positive will immediately leave the facility. Facility has signed a 6-month contract with an infection preventionist clinical consultant with RC Clinical Consulting who will provide in -services on 10/26 through 10/27 including topics: PPE for transmission base precautions, storage of mask, hand hygiene, screening and cleaning procedures. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: A audit will be completed daily by administrator or designee to ensure screening log are completed, this will take place: daily times 4 weeks, three times a week for 4 weeks, and one time a week for 4 weeks. The Administrator or designee will present to QI committee will review the results of Audit Tool during monthly QA Meeting for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring for continued compliance for 3 months. Finding will be discussed at quarterly QA meeting 6. Address how corrective action will be accomplished for those residents found to have been affected: Facility discontinued the use of the cleaning product that was used on the floor throughout the facility	

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F 880	Continued From page 34 Nurse #1 stated Resident #3 was not identified to be COVID-19 positive but had a recent known exposure from her former roommate. Nurse #1 identified Resident #4 and #5 not to be COVID-19 positive. An interview was conducted with NA#1 on 09/15/20 at 12:25 PM revealed she should have removed her gown and gloves, performed hand hygiene, and donned a clean gown and gloves when she exited Resident #5's room and before she entered Resident #4's room to address her concerns. NA #1 reported she had been taught when she was first coming to work about the use of PPE when in an isolation care area. NA #1 indicated she left Resident #5's room and entered Resident #4's room without thinking about changing PPE. An interview was conducted with Nurse #9 on 09/21/20 at 9:46 AM revealed PPE should be changed between each resident interaction on the COVID-19 overflow care unit due to both residents with both positive and negative test results residing together. An interview with the DON/Administrator on 09/21/20 at 10:27 AM revealed PPE including gowns and gloves should be changed and hand hygiene performed between each resident interaction on the COVID-19 overflow unit. 4. According to the facility document titled "Coronavirus 2020" dated February 2020 indicated in part: rapid recognition, isolation, and appropriate management of a patient suspected of being infected is key to minimizing transmission. Residents are rapidly identified as potential COVID-19 by screening, exposure, and	F 880	that was not EPA approved. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Administrator educated Maintenance Director and Housekeeping supervisor on the requirement to use chemicals EPA approved to kill COVID-19 Administrator provided a list of EPA approved chemicals to kill the COVID-19 virus to environmental services director then ordered a product immediately. Facility will use disinfectant cleaner #2 with approved contact surface time on the floor until a different EPA approved product arrives. The Housekeeping Manager received training on 9/21/20 of EPA approved chemicals and is responsible for ensuring the housekeeping staff is using cleaning and disinfecting products are on the EPA approved list. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Administrator reviewed and revised cleaning policy and procedures on 9/24/20 to adhere to CDC recommendation, also including that cleaning assignment will only be performed by trained housekeeping staff. Housekeeping staff will be in-serviced on 9/25/20 by housekeeping supervisor and/or prior to taking next assignment on correct surface contact times for bathroom cleaner #3 and disinfectant cleaner #2 and proper cleaning procedures with chemicals used. Return demonstration will be completed with signature of staff member and	

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F 880	Continued From page 35 symptoms. Infection control precautions for probable and suspected cases of COVID-19 are to be immediately placed in a single occupancy private room with the door closed. If a N-95 mask is not available, staff will utilize contact and droplet precautions. A memo written by the DON and dated 03/17/20 indicated new admissions must be placed in a private room, placed on contact isolation for a period of 14 days, respiratory and temperatures assessments every shift, and isolation precautions may be discontinued after a 14 day period if the resident was asymptomatic. A memo written and signed by the DON and Administrator dated 03/19/20 indicated new admissions will not be placed on isolation unless an elevated temperature and cough is noted and ordered by the physician. An observation of the 100 hall unit on 09/15/20 between 10:45 AM- 11:00 AM revealed Nurse #6 exited Resident #7's room. Resident #7 was a new admission from the hospital on 09/04/20. Resident #7's door did not contain signage to indicate he was on Enhanced Droplet Contact Precautions. Nurse #6 was wearing only a facemask when she exited the room. Additionally, Resident #8 was also a new admission to the facility on 09/09/20 and had no signage to indicate Enhanced Droplet Contact Precautions which required full PPE to include a gown, mask, face shield, and gloves when in the room. An interview on 09/15/20 at 3:15 PM revealed Nurse #6 stated the facility had never placed any new admission on isolation since the start of the COVID-19 pandemic. She stated she had not	F 880	witnessed supervisor when in-service is completed, and task is done correctly. A 100% in-service of all staff in all departments who work in the COVID-19 unit will be completed on 9/25/2020 that includes the correct surface contact times for bathroom cleaner #3 and disinfectant cleaner #2 and proper cleaning procedures with chemicals used. Return demonstration will be completed with signature of staff member and witnessed supervisor when in-service is completed, and task is done correctly. Housekeeping staff will not be able to return to work until training is completed. Education will be provided to all new staff during orientation that include all product used in the facility and the correct surface contact time for each chemical. Administrator reviewed and revised cleaning policy and procedures on 9/24/20 to adhere to CDC recommendation, also including that cleaning assignment will only be performed by trained housekeeping staff. Facility has signed a 6-month contract with an infection preventionist clinical consultant with RC Clinical Consulting who will provide in -services on 10/26 through 10/27 including topics: PPE for transmission base precautions, storage of mask, hand hygiene, screening and cleaning procedures. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Housekeepers will be audited by facility housekeeping supervisor, or environmental services director for	

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F 880	Continued From page 36 been educated on Enhanced Droplet Contact Precaution isolation and the need to wear full PPE in rooms where new admissions were located or residents who are on an additional 14 day observation post COVID-19 positive testing results if they had isolation precautions posted on the door. An interview with Nurse #5 on 09/16/20 at 11:01 AM revealed she worked the 100 hall new admission observation unit. Nurse #5 indicated new admissions were not placed under any form of isolation for 14 days following admission to the facility. Nurse # 5 indicated she was only educated to wear a mask when in the room of new admissions unless they had a known positive COVID-19 test result. Nurse #5 stated she monitored new admissions for elevated temperatures and signs and symptoms of COVID-19 but did not wear additional PPE when caring for new admission residents. Interview with the DON/ Administrator on 09/21/20 at 10:27 AM revealed since the start of COVID-19 pandemic their corporate company insisted the facility continue taking new admissions and their corporate office decided it was acceptable practice to only observe for signs and symptoms and temperature checks without placing new admissions on isolation precautions. The DON acknowledged the memo dated 03/19/20 that was provided to staff that educated new admissions would not be placed on isolation at the time of entry to the facility. A signed copy of the memo was in the facility's emergency preparedness COVID-19 binder. An additional undated document indicated the screening process for admissions would include temperature checks and respiratory assessments	F 880	corrected usage of EPA chemical and following the proper kill time for each chemical. Audit will be conducted 3 times a week for 4 weeks, then 1 time a day for 4 weeks, and then 1 time a week until for 3 months. The Administrator or designee will present to QI committee will review the results of Audit Tool during monthly QA Meeting for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring for continued compliance for 3 months. Finding will be discussed at quarterly QA meeting.	

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but did not include a 14- day isolation period following admission.

5. An undated memo indicated surgical masks could be reused in between patient rooms not on droplet precautions. Masks can be worn until visibly soiled, difficult to breath, or do not provide proper sealed fit when using N-95 masks. Masks should not be touched without performing hand hygiene and were not to be removed in resident care areas. Surgical mask and N-95 masks can be reused if put in a breathable container (paper bag is recommended) and not wiped or laundered. The container should be labeled with the staff members name. Masks are always to be worn when in the building.

An observation made of the 100 hall unit on 09/15/20 at 3:00 PM revealed Nurse #7 who was orienting on the 100 hall unit with Nurse #6. Nurse #7 was wearing cloth face covering that he had provided himself. Nurse #7 was in a resident care area during the observation.

An interview was conducted with Nurse #7 on 09/15/20 at 3:05 PM revealed he was on orientation and unaware he was unable to wear a cloth mask in a resident care area. Nurse #7 indicated the mask was a cloth mask but had a built-in respirator included. Nurse #7 had not received on facility-based training on PPE or COVID-19 by the facility but had received training from his agency that masks were always to be worn when inside the facility.

An interview with Nurse #3 on 09/15/20 at 3:15 PM revealed Nurse #7 was a new agency nurse and felt he was not aware he could not wear his own mask. She was unaware if the mask

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contained a respirator behind the cloth covering. An interview with the DON on 09/21/20 at 10:27 AM revealed Nurse #7 was an agency nurse who was unaware he was not allowed to wear his own mask. The DON indicated prior to the outbreak in August 2020, the facility had allowed staff to wear cloth face coverings throughout the facility and did not mandate surgical mask or higher form of face coverings. The DON stated she was not aware staff were continuing to provide their own face coverings at the time of the survey. There is no policy for allowing staff to provide their own mask and she was unaware any staff were continuing to provide their own mask since the COVID-19 outbreak in August 2020. She indicated the facility had previously had cloth masks made but had transitioned to surgical mask or higher since the outbreak in August 2020. The DON explained all new employees receive training on PPE and Transmission-Based Precautions on hire.

An interview with the Administrator on 09/15/20 at 3:45 PM revealed she was unaware Nurse #7 was wearing his own cloth mask and that staff should not wear their own face coverings in the facility since the COVID-19 outbreak had occurred.

6. A facility document titled "Coronavirus 2020" dated February 2020 indicated a surgical mask was to be placed on a resident during any transport.

An observation on 09/15/20 at 1:40 PM revealed Resident #7 was not observed to wear a mask when he exited the 100-hall unit general population where he resided, traveled through the 200 hall residential care unit, through an adjacent

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corridor, and onto the 300 hall residential care unit.

An interview was conducted on 09/15/20 with Nurse #6 who indicated she was unaware Resident #7 had exited the unit to the smoking area and was not wearing a mask.

An interview with the DON on 09/21/20 at 10:27 AM revealed Resident #7 should have worn a mask if he left his room. The DON stated Resident #7 was not compliant with care but was alert and oriented and should have been educated on the use of PPE.

An interview with the Administrator on 09/15/20 at 2:00 PM revealed Resident #7 was an uncompliant resident who had been admitted and he should have worn a mask if he exited the unit.

7. According to the facility document titled "Coronavirus 2020" dated February 2020 indicated in part: rapid recognition, isolation, and appropriate management of a patient suspected of being infected is key to minimizing transmission. Residents are rapidly identified as potential COVID-19 by screening, exposure, and symptoms. Infection control precautions for probable and suspected cases of COVID-19 are to be immediately placed in a single occupancy private room with the door closed. If a N-95 mask is not available, staff will utilize contact and droplet precautions.

An observation was made on 09/15/20 at 4:30 PM revealed no signage to indicate Enhanced Droplet Contact Precautions on the exterior or interior doors of the entrance of the designated COVID-19 unit 400 hall. No signage was posted

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in the unit to designate any resident was on any form of isolation or what PPE should be worn per the Centers for Disease Control and Prevention.

An interview with Nurse #2 on 09/15/20 at 4:30 PM revealed Nurse #2 was unaware of the need for posted signage on the unit that indicated Enhanced Droplet Contact Precautions or signage to illustrate what PPE should be worn when caring for COVID-19 patients.

An interview with the DON and the Administrator was conducted on 09/21/20 at 10:27 AM revealed they were unaware the need for Enhanced Droplet Contact Precautions. The DON stated she had researched what personal protective equipment (PPE) was required for COVID-19 resident care and had decided Droplet Precautions was the most appropriate form of isolation; however, no signage had been posted in the 400 Hall COVID-19 unit. The Droplet Precautions signage felt to be appropriate only indicated a mask was to be worn when caring for this resident and did not include the use of a gown, gloves, mask, and face shield. The DON indicated she was unaware there was no isolation precaution signage outside the doors of resident rooms who had been identified as COVID-19 positive on the 400 hall COVID-19 unit nor signage outside the COVID-19 care unit to reveal the entrance to the COVID-19 care unit where full PPE to include a gown, gloves, mask, and face shield were required.

8. An undated facility document indicated surgical masks and N95 masks should be stored in a breathable container (paper bag is recommended) and not wiped or laundered. Label the container with the staff member's name

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for reuse.

An observation on 09/15/20 at 4:30 PM revealed eight (8) N-95 masks laying on a two-shelf metal cart in the hallway of the COVID-19 unit. The masks were placed in a side by side fashion with the face portions of the used masks touching one another. They contained staff names but were not separated in paper bags. There were 5 used face shields placed together on this cart as well. The face shields were not contained or stored in bags and were exposed to the environmental air in the COVID-19 unit.

An interview with Nurse #2 on 09/15/20 t 4:30 PM revealed these mask were used masked that belonged to staff members who had worked the COVID-19 unit and they were placed on the metal cart at the end of their shift in order to be re-used on the next shift the staff member worked.

An interview with DON/ Administrator on 09/21/20 at 10:27 AM indicated they were unaware masks were stored together and should have been separated from one another. The DON stated mask touching one another would be cross-contamination. The DON was aware masks could be stored separately in paper bags for reuse.

9. According to a facility document titled Coronavirus 2020 dated February 2020 indicated only essential personnel should enter the room of a resident on COVID-19 precautions and should don PPE to include a gown, N-95 respirator or surgical mask if N-95 unavailable, eye protection and gloves. The policy did not address the removal and/or changing of PPE nor did it address hand hygiene.

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An observation on 09/15/20 at 4:30 PM revealed Nurse #2 was on the COVID-19 designated unit. Resident # 9 and Resident #10 were propelling themselves in their room on the COVID unit. Resident #9 spoke to Nurse #2 and handed her the television remote. Nurse #2 wearing a gown, mask, face shield, and gloves entered the room of Resident #9 and #10 and touched Resident #9 and her wheelchair. She walked around Resident #9 and placed the remote on the overbed table and exited the room. Nurse #2 was not observed to remove her gloves or perform hygiene as she stood in the hallway speaking to the surveyor. Resident #9 and Resident #10 were both wheeling themselves to the exit door of the room, Resident #9 begins to roll herself out of the room in her wheelchair. Resident #10 was self-propelling closely behind Resident #9 as she hands Nurse #2 the television remote for the second time. Nurse #2 begins pushing Resident #9's wheelchair backwards back into the room. She spoke to Resident #10 and gently touched her and pushed her wheelchair backwards. Nurse #2 then assisted Resident #9 back in her room and discussed the remote before she placed it on the overbed table for the second time then exited the room.

An interview with Nurse #2 on 09/15/20 at 4:30 revealed Nurse #2 acknowledged she had touched both the resident and environmental surfaces in the resident room on a COVID-19 unit without changing her gloves or performing hand hygiene. Nurse #2 admitted by not removing her gloves, performing hand hygiene, and donning clean gloves she had cross-contaminated surfaces and increased the risk of spread of the COVID-19 virus. Nurse #2 stated she should have removed her gloves, performed hand

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hygiene, and donned clean gloves between each interaction with a resident or surface.

An interview with the DON/Administrator on 09/21/20 at 10:27 AM revealed Nurse #2 should have changed her gloves and performed hand hygiene after contact with a resident on the COVID-19 care unit. The DON indicted Nurse #2 cross-contaminated both the residents and by touching surfaces in Resident #9 and #10 without changing PPE. The DON revealed gloves should have been removed and hand hygiene performed.

10. A handwritten list of chemical and usage provided by the Housekeeping Supervisor on 09/15/20 at 5:00 PM revealed the following chemicals were used in the facility: disinfecting bathroom cleaner (Cleaner #1); hard surface disinfectant cleaner (Cleaner #2); and a floor cleaner (Cleaner #3).

The United Stated Environmental Protection Agency (EPA- responsible for the protection of human health and the environment such as air, water, and land and enforcement of environmental laws) website for approved chemicals to kill COVID-19 did not list the floor cleaner as an approved chemical.

An undated facility document for COVID-19 discharge isolation cleaning procedures does not include chemicals used or required surface contact times for chemicals used in the cleaning of resident rooms.

An observation on 09/15/20 between 10:45 AM-10:58 AM revealed Housekeeper #1 was assigned and working the 200 hall General

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Population Unit. She was observed wearing a mask and a face shield in the hallway next to her housekeeping cart. She entered Resident #11's to provide cleaning services to resident rooms. Resident #11 was observed to have a Droplet Precautions sign posted. Housekeeper provided cleaning services and exited the room and proceeded to the next room on the unit.

An interview with Housekeeper #1 on 09/16/20 revealed she had been assigned to clean the 200 hall general population unit on 09/15/20 day shift. She acknowledged she cleaned the room of Resident #11; however, when asked her cleaning products and procedure Housekeeper #1 verbalized she used Cleaner #2 to clean general hard surfaces such as the bedside tables, nightstands, sink counters, and mirrors. Housekeeper #1 indicated she used Cleaner #1 to clean surfaces in the bathroom, and Cleaner #3 to mop the floors in resident rooms. When asked how long she allowed Cleaner #1 and #2 to stay on a surface before she rinsed it, Housekeeper #1 indicated she allows the Cleaner #2 to remain on the surfaces approximately 10-15 seconds. Housekeeper #1 revealed she allowed Cleaner #1 to stay on the bathroom surfaces approximately 10 seconds before wiping away. Housekeeper #1 indicated she filled her mop bucket with this product. Housekeeper #1 was not aware that Cleaner #3 was not an EPA approved chemical to kill the COVID-19 virus or that the contact time according to EPA guidelines for Cleaner #2 and Cleaner #1 must be left on surfaces for 10 minutes to be effective to kill the COVID-19 virus. Housekeeper #1 revealed she had worked as a housekeeper for many years and had been using the same chemical and cleaning procedures since she started in the

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facility. Housekeeper #1 revealed the only changes to the cleaning procedure since March 2020 was the use of added PPE and frequency of cleaning of high traffic surfaces.

11. The EPA website for approved chemicals to kill COVID-19 indicated Cleaner #1 and Cleaner #2 must have a surface contact time of 10 minutes to be effective to kill the COVID-19 virus.

An undated memo titled "Cleaning Protocol for Resident Rooms" did not indicate the correct surface contact time for Cleaner #1 or Cleaner #2.

A continuous observation was made on 09/15/20 between 11:00 AM - 11:35 AM revealed Nurse Aide #1 was working the 200 hall COVID-19 overflow unit and was wearing full PPE to include a gown, mask, face shield, and gloves while cleaning all the doorknobs of both COVID-19 and non-COVID-19 resident and handrails on the 200 hall unit. She was not observed to change gloves between COVID-19 positive and negative resident rooms on the 200 hall during this cleaning procedure.

An interview with NA #1 at 12:25 PM revealed she had performed cleaning procedures using cleaner #2 to include the resident doorknobs on her unit. NA #1 explained she applied it and immediately dried it off with a cloth and was not aware of the correct surface contact time of 10 minutes. NA #1 acknowledged she was wearing full PPE to include a gown, gloves, mask, and a face shield while performing this task. NA #1 stated she realized she had potentially cross-contaminated the doorknobs of residents negative for COVID-19 by not changing gloves

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after cleaning the doorknobs of resident positive for COVID-19 given that Resident #4 who is negative for COVID-19 is an active resident who moves about in her room and in the hallway throughout the day. NA #1 revealed the nurse and/or NA assigned to the COVID-19 overflow unit was assigned to clean the resident rooms after a recent turnover in housekeeping secondary to refusals to clean COVID-19 positive resident care areas, but NA #1 revealed she was only shown the chemicals but was not educated on the contact surface time.

An interview with the (Nurse #9) Staff Development Coordinator/Assistant Director of Nursing on 09/21/20 at 9:46 AM revealed staff should have been educated to clean surfaces in and around negative resident rooms prior to cleaning surfaces and items in COVID-19 positive care areas. Nurse #9 indicated staff should remove PPE to include gown and gloves between each room on the unit. Nurse #9 revealed she had not provided any education on cleaning procedures or chemicals used and was unable to verify if staff received this training. Nurse #9 indicated she was unsure of the correct surface time for Cleaner #1 or Cleaner #2.

An interview with the DON/Administrator on 09/21/20 at 10:27 AM revealed staff were expected to change PPE between resident rooms on the COVID-19 overflow unit due to both COVID positive and negative resulted residents residing on the unit. The DON stated she expected staff to clean the negative care areas before staff proceeded to areas with residents who are positive for COVID-19. The DON indicated she was unsure of the correct surface time for Cleaner #1 or Cleaner #2.

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F 880	Continued From page 47 An interview with Housekeeper #2 on 09/18/20 at 12:22 PM revealed she was a housekeeper assigned to the 300 hall unit (general population) in the facility. She indicated she was educated to wear a mask and gloves when cleaning resident rooms and a gown and a face shield should be worn when cleaning any isolation rooms in the facility. Housekeeper #2 revealed she used Cleaner #1, Cleaner #2, and Cleaner #3 while cleaning resident rooms. Housekeeper #2 indicated she allowed Cleaner #1 and Cleaner #2 to remain on surfaces for less than 5 minutes before rinsing. Housekeeper #2 indicated she used Cleaner #3 when she mopped floors and was not aware it was not an approved chemical listed on the EPA website to kill the COVID-19 virus. Housekeeper #2 indicated housekeeping staff were no longer required to clean resident rooms on designated COVID-19 care units but believed they were being assigned to the nursing assistants on the unit. Housekeeper #2 indicated the only known changes made to the cleaning procedures were the use of added PPE and frequency high traffic areas should be cleaned. An interview with Nurse #10 on 09/16/20 at 11:50 AM revealed hall nursing staff were assigned to clean the rooms of residents on the COVID-19 unit. Nurse #10 indicated she received training on the evening of 09/15/20 by the Housekeeping Supervisor on cleaning procedures and which chemicals were to be used and listed Cleaner#1, Cleaner #2, and Cleaner #3. Nurse #10 explained the she had not been educated on contact surface time required for Cleaner #1 or Cleaner #2 and was unaware Cleaner #3 was not an approved chemical listed on the EPA website to kill the COVID-19 virus.	F 880		

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An interview with Nurse #11 on 09/16/20 at 1:29 PM revealed he was assigned to work the 200 hall COVID-19 overflow unit on 09/14/20 day shift. Nurse #11 indicated he was aware nursing staff were to clean resident rooms on the COVID-19 overflow units as of 09/13/20. He was aware that the chemical used were Cleaner #1, Cleaner #2, and Cleaner #3. Nurse #11 however was unable to verbalize the required contact surface time for Cleaner #1 or Cleaner #2 were 10 minutes or that Cleaner #3 was not an approved product listed on the EPA website effective to kill the COVID-19 virus.

An interview with Nurse #1 on 09/16/20 at 1:43 PM revealed she was aware that nursing staff had been assigned to clean the resident rooms on both the 400 hall COVID-19 units and the 200 hall COVID-19 overflow unit. Nurse #1 indicated she had been assigned to work the 200 hall COVID-19 overflow unit on 09/15/20 and witnessed NA #1 perform cleaning tasks during the shift but explained she had not received education on the cleaning procedure, or the chemicals used. Nurse #1 vocalized she was unsure the correct surface contact time for Cleaner #1 or Cleaner #2 was 10 minutes and Nurse #1 was unaware Cleaner #3 was not an approved chemical on the EPA list used to kill COVID-19.

An interview with Nurse #2 on 09/17/20 at 2:10 PM revealed Nurse #2 was aware nursing staff assigned to the COVID-19 care areas were to perform cleaning procedures in resident rooms. Nurse #2 was unaware of which chemicals were to be used, contact surface times, or that Cleaner #3 was not an approved chemical on the EPA website to kill the COVID-19 virus.

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F 880	Continued From page 49 An interview with Nurse #9 on 09/21/20 at 9:49 AM revealed Nurse #9 was aware that nursing staff assigned to the COVID-19 unit were to clean resident rooms; however, stated she had not provided any education to nursing staff on cleaning procedure, cleaning products, contact surface times or what PPE were required. An interview with the DON and Administrator on 09/21/20 at 10:27 AM revealed both were aware nursing staff had been assigned to clean the resident rooms in the COVID-19 care areas after housekeeping staff were refusing to clean COVID-19 resident care areas which resulted in high staff turnover. Each indicated they had not provided education to the nursing staff on the cleaning procedure, chemicals used in cleaning and correct surface contact times, as well both vocalized they were unaware Cleaner #3 was not on the EPA website as an approved chemical to kill the COVID-19 virus. The DON was unable to verify if the Housekeeping Supervisor had performed a demonstration for Nursing staff. The DON indicated her understanding was that the nursing staff assigned to night shift would be responsible for the heavy cleaning in the COVID-19 care areas. The DON revealed she had made the decision to have the hall nursing staff assigned to the COVID-19 care units clean the resident rooms after the Housekeeping Supervisor presented with a high turnover rate due to Housekeeping staff refusing to clean rooms of residents positive for COVID-19. Attempts were made times three to contact the Housekeeping Supervisor and messages were left; however, the housekeeping supervisor did not return calls for an interview.	F 880		

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The Administrator was notified by phone of the Immediate Jeopardy on 09/22/20 at 7:26 PM. On 09/25/20 at 3:22 PM, the facility provided the following credible allegation of Immediate Jeopardy removal:

The Removal Plan for Immediate Jeopardy for F880:

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance
1. Facility failed to identify Residents with COVID-19 by not placing them on Enhanced Droplet Contact Precautions.

All resident who were on isolation that had a droplet precaution sign instead of Enhanced Droplet Contact Precautions were at risk due to the original sign did not include gown, however the gown was included in PPE provided.

All residents that required enhanced contact droplet precautions did not have signage on doors per CDC guidance.

Facility failed to update policy and procedures including placing COVID-19 positive resident on enhanced droplet contact precaution, and not droplet precautions. Facility failed to adhere to current isolation/precaution signs policy and procedure by not ensuring all effected resident doors and unit entryways were identified correctly using signage.

2. Facility failed to reeducate staff on the importance of removing Personal Protective Equipment (PPE) between Residents who are COVID-19 positive and COVID-19 negative residents when an overflow COVID-19 unit was made if they had to assist in care in another room.

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F 880	Continued From page 51 Staff should not be assigned COVID-19 positive and COVID-19 negative residents. The facility failed to surveillance staffing to ensure a staff member was not taking care of a COVID-19 negative resident and a COVID-19 positive resident while working the overflow unit. The resident who was COVID-19 negative was put at risk when staff member entered room wearing contaminated PPE. There was also an observation of Nurse #1 not performing hand hygiene after removing gloves. Facility failed to surveillance the storage of the N95 respirator masks that were being reused by nursing staff to ensure staff was adhering to CDC guidelines. 3. The Facility failed to ensure staff were asymptomatic when on duty. During facility investigation it was identified nurse called out on 9/14/2020 with respiratory symptoms and stated her asthma had worsened since wearing the mask. Employee was asked during the day if she was able to return to work, employee stated no she is still coughing and wheezing, and feels bad. This nurse responded ok thank you. Employee was then contacted and asked if she thinks she will be returning to work tomorrow by a different staff member, employee then stated yes, if she feels better. Employee then returned to work on 9/15/2020 and stated she had a 98.4 and put a zero in the symptom column. Staff however had a cough presented while on shift. Staff member failed to report symptoms imminently during shift on 9/15/20 until she was outside later in her shift and texted an administrative nurse asking if she could be rapid tested. Administrative staff failed to follow up on symptoms on 9/14/20 prior to employees next scheduled day.	F 880		

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Another employee documented headache, sore throat, congestion, and her glands were swollen she did not report her symptoms since she only had a low-grade temperature. Staff member failed to imminently report symptoms to on call nurse and/or DON as instructed. Facility failed to review screening log to ensure all staff members who documenting present symptoms are immediately removed from assignment. Residents who were included in nurse's assignment were potentially placed at risk, while symptomatic nurse was on duty.

4. The Facility failed to ensure staff were using chemicals approved and listed on the EPA website. Facility was not using correct EPA approved chemicals when cleaning the floors of the facility, residents were potentially placed at risk due to improper disinfecting method. During facility investigation it was revealed that environmental services director was not educated on the EPA approved list and did not ensure all chemicals that facility was using were EPA approved.

5. The Facility failed to educate housekeeping staff on proper use of cleaning chemicals. Due to staff members not using correct method when cleaning hard surfaces in the facility, residents were potentially placed at risk due to improper disinfecting method. Upon facility investigation staff members were not aware of proper contact surface time for disinfectant cleaner #2 and bathroom cleaner #3.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete

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1. Unit managers posted the Enhanced Droplet Contact Precaution signs on all resident doors that are under this precaution, also quarantine door to COVID-19 unit has posted signage. This was completed by each unit supervisor and 100% audit was completed on 9/16/2020 to ensure all signage was posted and corrected. Education was provided to all unit managers on correct signs for enhanced droplet contact precautions and that they must be placed immediately on all resident's door that are placed on this isolation. Doors will remain closed during this isolation period. Education provided by administrator. Completion of this in service was 9/16/2020 with signatures of all administration nurses.

Hall nurses will all be 100% educated on the signage, and importance of posting immediately with an isolation caddy explain when a new order is received for isolation due to COVID 19, also hall nurses will understand that the quarantine doors to COVID-19 unit must have Enhanced Droplet Contact Precautions signs posted on them at all times, doors also must remain closed at all times. Completion target date is 9/25/20 with a signature log of all staff. The SDC nurse will complete in-service. Education will be provided to all new staff during orientation with a signature of staff members that they understand the Enhanced Droplet Contact Precautions. This will include a printout on what enhanced droplet contact precaution entail, an example of enhanced droplet contact precaution sign for reference, illustration on how to put on and remove PPE. Enhanced Droplet Contact Precaution signs are now kept at nurses' station for the availability for use by all staff placing a caddy on a resident door. Quarantined resident

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who are testing COVID-19 negative, however with an order placing them on Enhanced Droplet Contact Precaution due to symptoms or exposure will always have sign posted on door.

Staff continues to use PPE including, Facemask, eye protection including goggles or face shield, gown, gloves and perform hand hygiene through the duration of active COVID-19 in facility.

Admission policy and procedures was reviewed and revised on 09/25/2020 to adhere to CDC guidance. Newly admitted or readmitted residents with covid-19 who have met criteria to discontinue transmission-based precautions while in the hospital will be placed on regular units, in a single room. If a newly admitted resident has an onset of symptoms or remains symptomatic even after transmission- based precaution had been discontinues, resident will remain in single rooms, resident will not leave room if possible, and if needed will wear appropriate PPE. Staff will adhere to using all recommended COVID 19 PPE during care of resident under observation due to symptomatic. If a newly admitted or readmitted resident COVID-19 status is unknown resident will be placed in a single room on for 14 days of observation, all recommended COVID-19 PPE will be worn during care, which included, facemask or N95 respirator, eye protection, gloves, and gown. All new admissions will adhere to facility wide resident testing weekly. If new resident is without symptoms and afebrile for 14 days from last exposure if resident been asymptomatic, or the date of the onset of symptoms.

2. Unit manager completed one on one in-service with nurse aide verbally 9/25/20 who was observed entering a resident room without

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changing her PPE, she was reeducated by unit manager on the importance, and when to remove PPE, how to remove, and hand hygiene per CDC guidelines. Nurse aid has not returned to work since incident, however, will not be able to return to work until a return demonstration is completed. A visual display of the process to put on and remove PPE had been posted on the COVID-19 unit, now has been placed throughout the building. All overflow positive resident on 200 have been moved into the COVID-19 unit located on 400 hall as of 9/18/2020.

A nurse also was visualized not performing hand hygiene between resident contact, this nurse has been one on one in serviced by administrator on 9/16/2020, one the importance of hand hygiene, when hand hygiene must be completed per CDC guidelines.

SDC administrative nurse will complete 100% in-services to all staff members in each department of the importance of removing PPE when exiting a COVID-19 positive room. Training will be provided by SDC nurse and target date completion will be 9/25/2020. All staff members in each department must show returned demonstration of proper PPE removal, and hand hygiene. All staff will sign on completion of this task with an administration nurse witnessed signature. Staff members who have not completed training will be removed off the schedule if education is not completed by target completion date and will remain off the schedule until completion.

DON reviewed scheduling operations and implemented a policy to adhere to CDC staffing guidelines, ensuring staff will not be assigned to a COVID-19 positive and COVID-19 negative resident.

SDC administrative nurse will continue to

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educate all new staff on PPE procedures and hand hygiene during orientation, with returned demonstration and signature of staff members upon completion of this task.

SDC administrative nurse will complete a hand hygiene in-service that was started on 9/16/20 by the SDC nurse with 100% participant in each department and signatures of all staff who completed. Return demonstration will be completed and a competency check off will be performed on each staff member. Staff members who have not completed training and competency check off will be removed off the schedule if education is not completed by target completion date and will remain off the schedule until completion.

Unit mangers will complete PPE audit daily while there are active cases in the facility on all isolation rooms, and COVID-19 unit to ensure enough supply is in the caddy's during each shift. All staff will adhere to proper storage of N95 per CDC guidance. All departments will be 100% in serviced on storage method of with target completion date of 9/25/20 entailing staff signatures when in-service is completed. Staff will place all N95 masks in a paper bag and labeled with staff members name, these bags will be changed out once a week. DON has revised PPE storage policy to adhere to CDC guideline on 9/22/20.

3. DON posted another memo 9/22/2020 at the time clock to all staff ensuring that they must report if experiencing any sign and symptoms of COVID-19 that is listed on the CDC website including: cough, shortness of breath, fever or chills, muscle or body aches, vomiting or diarrhea, new loss of taste or smell, and a temperature greater than 100 degrees Fahrenheit

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while working assignment. Facility will complete a 100% in services to all staff in each department on reporting signs and symptoms if experiencing prior to their shift, or immediately if on shift with new onset of cough, shortness of breath, fever or chills, muscle or body aches, vomiting or diarrhea, new loss of taste or smell and a temperature greater than 100 degrees Fahrenheit. Staff must report this to on call nurse and/or DON target date of completion 9/25/2020. Inservice will entail signatures of all staff in each department who understand the procedure of reporting illnesses.

The facility has reviewed the current screening log process and implemented a new screening method and policy effective 9/25/2020 to ensure staff members and facility are adhere to the CDC reporting and screening guidelines. DON will assign the 100-hall rehab nurses to screen all employees. He or she is responsible to complete a screening tool that includes employee name, temperature, if the employee has or has had in the past 14 days any symptoms such as: cough, new loss of taste, sore throat, muscle or body aches, diarrhea, fever, shortness of breath or difficulty breathing, chills, new loss of smell, nausea or vomiting, headache, fatigue, or congestion or runny nose and if the employee has traveled internationally or have been on a cruise within the last 14 days on each employee at the start of the shift. If employee answers yes to any of the questions on the screening tool this nurse will then have the employee exit the facility and wait in their vehicle for further direction for administrative nurse to perform a rapid test and report the findings of screening tool to on call administrative nurse. If the employee is not symptomatic, both employee and assessing

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nurse will sign screen tool. This will be placed in a folder at the time clock. This process will be completed at the start of all shifts. Assigned nurses to screen employees will be trained on signs and symptoms per CDC guidelines of COVID 19 by the SDC nurse, this nurse will understand the importance of this role, and have a clear understanding of what is expected. Target completion of this is 9/25/2020. SDC nurse upon arrival will collect all screening sheets and compare to the schedule on given day to ensure staff is adhering to protocol. All nurse who have the possibility to be assigned to complete screening will be trained by SDC nurse on screening process and when to report. For Administrative Office staff who enter the building from the front entrance the front receptionist will complete screening tool with the Administrative staff and will be trained on signs and symptoms per CDC guidelines of COVID 19 by the SDC nurse, this receptionist will understand the importance of this role, and have a clear understanding of what is expected. Target completion of this is 9/25/2020.

Dietary staff will be educated by their supervisor by 9/25/2020 to understand that prior to reporting to work assignment they must have the 100-nurse complete screening assessment. If any of these employees answer yes to any of the questions on screening tool, they will be asked to exit the facility and wait on further instruction for administrative nurse to perform rapid testing. The 100 hall nurse screener will follow same protocol and call the on-call administrative nurse to report findings of screening tool.

Symptoms of COVID-19 that are listed on the CDC website including: cough, shortness of

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breath, fever or chills, muscle or body aches, vomiting or diarrhea, new loss of taste or smell illustration has been posted at the time clock on 9/22/2020 as a visual alert.

If a staff member is symptomatic with a new onset while on shift will immediately be removed from resident care areas and complete a rapid test, and not return to the hall until afebrile and has a negative test result. All administrative nurses will sign an in-service on rapid testing while a staff member is in a facility completed by the DON, including that a staff member with a pending staff rapid test does not return to the hall, and if positive will immediately leave the facility.

4. Upon immediate discovery of floor cleaner #1 being used on floors and not being on the EPA list of approved chemicals to kill COVID-19 virus Administrator educated Maintenance Director and Housekeeping supervisor on the requirement to use chemicals EPA approved to kill COVID-19

Administrator provided a list of EPA approved chemicals to kill the COVID-19 virus to environmental services director then ordered a product immediately. Facility will use disinfectant cleaner #2 with approved contact surface time on the floor until a different EPA approved product arrives.

The Housekeeping Manager received training on 9/21/20 of EPA approved chemicals and is responsible for ensuring the housekeeping staff is using cleaning and disinfecting products are on the EPA approved list.

Administrator reviewed and revised cleaning policy and procedures on 9/24/20 to adhere to CDC recommendation, also including that cleaning assignment will only be performed by trained housekeeping staff.

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F 880	Continued From page 60 5. Housekeeping staff will be in-serviced on 9/25/20 by housekeeping supervisor and/or prior to taking next assignment on correct surface contact times for bathroom cleaner #3 and disinfectant cleaner #2 and proper cleaning procedures with chemicals used. Return demonstration will be completed with signature of staff member and witnessed supervisor when in-service is completed, and task is done correctly. A 100% in-service of all staff in all departments who work in the COVID-19 unit will be completed that includes the correct surface contact times for bathroom cleaner #3 and disinfectant cleaner #2 and proper cleaning procedures with chemicals used. Return demonstration will be completed with signature of staff member and witnessed supervisor when in-service is completed, and task is done correctly. Housekeeping staff will not be able to return to work until training is completed. Education will be provided to all new staff during orientation that include all product used in the facility and the correct surface contact time for each chemical. Administrator reviewed and revised cleaning policy and procedures on 9/24/20 to adhere to CDC recommendation, also including that cleaning assignment will only be performed by trained housekeeping staff. The Facility alleges Immediate Jeopardy to be removed 9/25/2020. On 10/09/2020, the facility's credible allegation for Immediate Jeopardy removal was validated by the following: Review of staff in-service training records for each department which included	F 880		

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F 880	Continued From page 61 agency staffing. The topic of trainings received included hand hygiene; enhanced droplet contact precautions form of transmission-based precautions to include signage postings, personal protective equipment, cleaning chemicals with correct usage, storage of N-95 masks, and screening of temperature and symptom procedures for both employees and visitors. Employee screening logs were reviewed for accuracy which revealed temperatures were recorded and screening questions answered as well as an additional check-off sheet audited by the Administrator to ensure each employee on the schedule had completed a screening sheet daily. Interviews with facility and agency staff revealed they received training and were able to verbalize the procedures in place by the facility for PPE usage and storage of N-95 masks, enhanced droplet contact precautions, importance of proper signage, cleaning chemicals and the correct cleaning process, and employee screening. Observations in the COVID-19 unit revealed staff wore PPE for Enhanced Droplet Contact Precautions to include a gown, gloves, mask, face shield, and foot covers and performed hand hygiene between each resident and when gloves were removed. The facility's date of Immediate Jeopardy removal of 09/25/20 was validated.	F 880		