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F 000	INITIAL COMMENTS An unannounced complaint investigation was conducted 11/16/22 through 11/21/22. A total of 16 allegations were investigated and 2 were substantiated: . NC00194825, NC00194748, NC00194324, NC00193203. Event ID #G73R11. Intake NC00194748 resulted in Immediate Jeopardy. Immediate Jeopardy was identifed at: CFR 483.24 at tag F678 at a scope and severity J. The tag F 678 was constituted Substandard Quaily of Care. Immediate Jeopardy began on 10/23/2022 and was removed on 11/17/2022. A partial extended survey was conducted.	F 000		
F 678 SS=J	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and physician interview, the facility failed to operationalize effective systems so staff could respond to an emergency situation as needed for 1 of 3 residents (Resident #1) reviewed for cardiopulmonary resuscitation. When Resident # 1 required cardiopulmonary resuscitation (CPR) and suctioning, only chest compressions were	F 678	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal	12/9/22

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

Electronically Signed | 12/15/2022

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F 678	Continued From page 1 provided until emergency medical services arrived. EMS transported Resident # 1 to the hospital and given the extended cardiac arrest time of 32 minutes and the lack of neurologic responsiveness Resident #1 was intubated and admitted to the intensive care unit (ICU). Resident #1 was transitioned to comfort care and palliatively extubated. Resident #1 passed away on 10/26/22. Immediate Jeopardy began on 10/23/22 when Resident #1 who was a full code, was not provided airway ventilation as part of CPR, until EMS arrived on scene. The immediate jeopardy was removed on 11/17/22 when the facility provided and implemented an acceptable credible allegation for Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity level of an "D" (No actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure completion of education and monitoring systems put into place are effective. The findings included: The facility policy based on guidelines from the American Heart Association for Cardiopulmonary Resuscitation (CPR) dated April 2016 stated, "If an individual is found unresponsive, briefly assess for abnormal or absence of breathing. If sudden cardiac arrest is likely, begin CPR". The policy read the sequence of events were referred to as C-A-B (chest compressions, airway, breathing). Airway included to tilt the residents head back and lift the chin to clear the airway. Breathing included after 30 chest compressions to provide 2 breaths via ambu bag or manually	F 678	and state law. F 678 On 10/23/22 the facility failed to provide basic life support to include ventilation and suctioning. On 10/23/22 resident #1 required CPR and received chest compressions with no ventilation or suctioning until EMS arrived and transported resident #1 to the hospital where resident #1 was intubated and admitted to the intensive care unit. All other residents who have advanced directives that require a full code are at risk from suffering from the deficient practice. On 11/16/22, The DON and ADON completed an audit to determine all residents who have advanced directives that require full code. All residents identified to have advanced directives that require full code were assessed for signs or symptoms of cardiac arrest on 11/16/22 with no concerns found. On 11/16/22, an audit was performed by the DON on all crash carts to ensure they are unlocked and are complete with suctioning equipment and an Ambu bag. Both crash carts have been relocated to the nurses stations and are fully stocked, unlocked, and accessible to all staff. Both crash carts require a key to be locked. The keys to both crash carts were removed and secured by the DON to ensure the carts remain unlocked and	

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with a CPR shield.

Resident #1 was admitted into the facility on 10/23/22 with diagnoses which included chronic obstructive pulmonary disease (COPD), acute and chronic respiratory failure.

A nursing progress note dated 10/23/22 at 3:45 PM written by Nurse#1 revealed Resident #1 had just arrived at the facility by EMS. Resident #1 was alert and oriented with no pain. The resident had oxygen at 2 liters via nasal cannula and his medications were verified with the medical director.

Record review revealed an initial admission nursing assessment had not been completed for Resident #1.

The code status of Resident #1 was located under the "orders" tab in the electronic medical record. Resident #1 was a full code.

A nursing progress note dated 10/23/22 at 9:10 PM written by Nurse #2 revealed at 8:00 PM Resident #1 was alert and oriented with an oxygen saturation level of 96%. The note revealed around 9:15 PM Resident #1 began to complain of having trouble breathing. Nurse #2 increased the resident's supplemental oxygen to 3 liters via nasal cannula. Resident #1 began turning blue in color, had a faint pulse and became unresponsive. Life saving measure took place until Emergency Medical Services (EMS) arrived. Nurse #2 documented she called the on-call physician and Resident #1 left the facility for the hospital at 9:45 PM.

On 11/16/22 at 3:35 PM an interview with Nurse

keys are no longer accessible for staff use.

On 11/16/22, education was provided to the Administrator, Director of Nursing (DON), and the Assistant Director of Nursing (ADON) by the Corporate Consultant, Regional Director of Operations, regarding emergency procedures and cardio-pulmonary resuscitation.

On 11/16/22, after being reeducated as outlined above, education for all staff including agency staff, was completed in person or via phone by the Administrator, DON, ADON or designee. The education consisted of the following:

" The need to Maintain equipment and the supplies necessary for CPR/BLS are in the facility at all times. It is the Director of Nurses responsibility to ensure equipment is maintained and supplies necessary for CPR/BLS are accessible to staff at all times.

" Crash carts are to remain stored at the nurses□ station unlocked, and be equipped with suctioning equipment and an Ambu bag.

" The facility□s procedure for administering CPR shall incorporate the steps covered in the Emergency Cardiovascular Care or facility BLS training material.

" If the first responder is not CPR-certified, that person will call 911 and follow the 911 operator□s instructions until a CPR-certified staff member arrives.

" If an individual is found unresponsive,

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F 678	Continued From page 3 #1 revealed she had received Resident #1 as a new admission during her shift on 10/23/22. She stated he was alert and oriented when he came into the facility and had shown no signs of distress. An interview conducted with Nurse #2 on 11/16/22 at 11:05 AM revealed on 10/23/22 she came on shift at 7:00 PM and received report from Nurse #1 that Resident #1 was a new admission and was doing well. She stated she completed rounding and saw Resident #1 at 7:45 PM laying in bed in no distress. The interview revealed she was completing her medication pass when she went into his room around 8:30 and Resident #1 stated to her that he was having trouble breathing. She stated she placed the pulse oximetry monitor on his finger and his oxygen saturation level would not show on the pulse oximetry meter which meant his oxygen level was low. Nurse #2 asked Resident #1 if he had a history of COPD but then noticed the resident was turning blue in color around his face and fingers. She stated she immediately looked into his mouth to make sure there was nothing impeding his airway. Nurse #2 then laid the resident back onto the bed and began chest compressions while yelling for help from another nurse. She stated Nurse Aide #1 came into the room and she stated she needed the crash cart. Nurse #3, Nurse #4, and Nurse #5 also entered the room. She stated someone brought the crash cart into the room however it was locked, and the nurses did not know where the key was located. Nurse #3 stayed with her to rotate chest compressions. Nurse #5 ran out of the room to find the key to the crash cart and Nurse #4 went to call emergency medical services. Resident #1	F 678	briefly assess for abnormal or absence of breathing. If sudden cardiac arrest is likely, begin CPR by: a. Facility nurse will instruct a staff member to activate the emergency response system (code) and call 911. b. Facility nurse will instruct a staff member to bring the crash cart to the code location. c. Facility nurse will verify or instruct a staff member to verify the DNR or code status of the individual. d. Clinical staff to Initiate the basic life support (BLS) sequence of events. " The BLS sequence of events is referred to as C-A-B (chest compressions, airway, breathing). Director of Nursing, or designee, shall audit crash carts to ensure they unlocked, are complete with suctioning equipment and Ambu, and are accessible to all staff 5 times weekly x 4 weeks and 1 time per week x 8 weeks for a total of 12 weeks to ensure that each crash cart remains unlocked, complete with suctioning equipment, an Ambu bag, and are accessible to all staff. Findings shall be reported to QAPI committee; audits will continue at discretion of QAPI commitee. Completion Date 12/9/2022	

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began to have white foam around his mouth. Nurse #2 stated a suction canister was located on the top of the crash cart but the tubing to the suction was located inside of the cart so she could not suction Resident #1's mouth. She stated nothing on the crash cart was helpful to her in a time of need. Nurse #2 stated the ambu bag to provide airway support to the resident was also locked in the crash cart. Nurse #3 returned to the room and assisted Nurse #2 in 5 rounds of chest compressions until EMS arrived. She stated she had one of the NAs to go get a nebulizer machine but once it was in the room the machine malfunctioned and would not work. She stated Resident #1 had oxygen in his nose at 3 liters via nasal cannula during the incident. She stated once EMS arrived, they took over with the resident in the room for approximately 30 minutes before transporting him to the hospital. Nurse #2 stated she was an agency nurse and had never used the crash cart in the facility prior to that night. She stated she had no idea the cart was kept locked and nobody in the facility had told her where the key was located. The interview revealed she still worked in the facility and did not know where the crash cart key was located. She stated she was extremely upset after the incident and called the Unit Manager #1 to explain to her what had happened. She stated she told the Unit Manager #1 that she felt she didn't have the proper equipment to save Resident #1's life and knew she hadn't done everything possible in a time of need. She stated Unit Manager #1 apologized to her and stated she would do some education with the staff. Nurse #2 stated she never received any education following the incident.

An interview was conducted with Nurse #4 on

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11/16/22 at 11:21 AM. Nurse #4 stated she was working on the 200 hall on the night of 10/23/22. She stated she had just completed her medication pass between 8:30-9:00 PM and went to the nurse's station when someone came out of Resident #1's room and yelled there was a code. Nurse #4 stated she got up and ran to the room to see how she could help. She stated she saw Nurse #2 laying the resident back onto the bed, calling his name and began giving chest compressions to the resident and she left the room to call EMS. She stated the nurses could not use the crash cart because it was locked and nobody in the building knew where the key was located. She stated they later learned there was another crash cart in the building that was unlocked but it had been covered with Halloween decorations at the time of the incident and nobody saw it. She stated she had never had to run a code in the building, and she had worked there since June 2022. The interview revealed Nurse #2 did not have access to an ambu bag or suction supplies. She stated by the time a Nurse Aide obtained an ambu bag EMS had arrived in the building. Nurse #4 stated during orientation she did not remember the crash cart being discussed.

An interview was conducted with Nurse #3 on 11/16/22 at 1:21 PM. Nurse #3 stated he was in the television room of the facility when he saw Nurse #4 looked panicked. He went to Resident #1's room and saw Nurse #2 doing chest compressions. He stated he stayed with Nurse #2 and when she became tired, he would take over doing chest compressions. He stated Nurse #5 came in the room stating she could not find the crash cart key so he went to look for it and she took his place. The interview revealed the nurses

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completed approximately 15 minutes of chest compressions before EMS arrived. He stated a staff member brought in the crash cart but they couldn't use it because it was locked. Nurse #3 stated they did not have access to an ambu bag or suctioning. The interview revealed he and a NA had gone to central supply to get the suction tubing and an ambu bag but by that time EMS arrived in the building. Nurse #3 stated he observed Resident #1 to be blue in color with white foam around his mouth. He stated there was another crash cart in the building, but he didn't work on that hall and he wasn't aware of it. He stated it was covered with decorations and they couldn't see it.

An interview conducted on 11/16/22 at 11:43 AM with Nurse #5 revealed she was getting ready to go on her break around 8:30 PM on 10/23/22 and went down the 100 hall to see if they needed anything when she realized there was a code. Upon entering the room, she saw Nurse #2 and Nurse #3 initiating chest compressions on Resident #1. She stated they asked her where the key to the crash cart was, so she went out of the room and back to the nurse's station to find it. The interview revealed Nurse #4 was on the phone with EMS. She stated she looked everywhere she knew and could not find the crash cart key. Nurse #5 went back to the room and asked what the nurses needed. She stated they needed suction tubing, so she took over doing chest compressions for Nurse #3 and he went to find the tubing and crash cart key. She stated in total the nurses completed 5 rounds of chest compressions prior to EMS arrival. The interview revealed following the incident they learned the crash cart key was taped to the bottom of a drawer in the nurse's station after

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they called Unit Manager #1 to tell her what had happened. She stated she was agency and didn't know where anything was in the facility. Nurse #5 stated she felt incompetent by not being able to take care of Resident #1 because she was not properly oriented to the facility.

An interview conducted on 11/16/22 at 11:59 AM with NA #1 revealed she was walking down the hall when she heard Nurse #2 say there was a code. She stated she went looking for the crash cart but when they got it to the room it was locked. The interview revealed she left the room and began looking for the key to the cart. She stated after she could not find the key, she remembered she had seen a ambu bag in the supply room so she went and got it. NA #1 stated by the time she got back to Resident #1's room EMS had arrived in the building.

On 11/16/22 at 12:05 PM an interview was conducted with Unit Manager #1. She stated Nurse #2 called her and said they had to send Resident #1 out of the facility. She stated the nurse told her the resident had coded and the staff could only do chest compressions. Nurse #2 asked her where the key for the crash cart was located, and she instructed her it was taped to the bottom of a drawer in the nurses station and there was another cart on 100 hall. Unit Manager #1 stated to her that she did not know where the crash cart key was located during the code. She stated the key had been there for years and she thought it was odd out of the 4 nurses working that night that nobody knew where it was located. The interview revealed the staff were oriented to the facility by her and she stated she usually completed the orientation training. She stated the orientation consisted of telling the nurses where

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the crash cart was located along with the key.

An interview conducted on 11/16/22 at 12:15 PM with the Director of Nursing (DON) revealed she was alerted to the situation by Unit Manager #1 on 10/23/22. She stated Unit Manager #1 had been the on-call staff member working that night when staff called her stating they could not find the crash cart key. The DON explained the crash cart was locked because residents would get into it and the key had been in the same location for over a year. She stated agency staff received a packet with information in it for orientation and are shown around the facility. The DON stated she did not directly speak with Nurse #2 about the incident or ask about details of what had happened because she felt like Unit Manager #1 handled the situation. She stated Unit Manager #1 had went around asking everyone if they knew where the crash cart was located and if they did not know she would show them. The DON stated there was no written documentation of a in-service.

On 11/16/22 at 1:03 PM an interview was conducted with the Medical Director (MD). During the interview he stated that during CPR giving chest compressions alone would not be 100% effective. He stated there had been changes in CPR techniques, but ventilation was important to a successful resuscitation. The interview revealed a full code status meant full scope of CPR including chest compressions and airway support. The Medical Director further stated an emergent situation was not the time to be looking for a key. The interview revealed Resident #1 was admitted on the evening of 10/23/22 and discharged on the same date within a few hours of being in the

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facility.

Review of the hospital records dated 10/23/22 revealed Resident #1 arrived at the hospital intubated without sedation and unresponsive. Resident #1 was diagnosed with profound encephalopathy affecting basic brain functions that control wakefulness, breathing, heartbeat and temperature. Resident #1 displayed no organized neurologic activity, had a blown pupil on the left side and a negative head computed tomography (CT). The report read given the extended cardiac arrest time of 32 minutes per emergency medical services and Resident #1's lack of neurologic responsiveness he was admitted to the Intensive Care Unit. Resident #1 was transitioned to comfort care on 10/26/22 and palliatively extubated with the family at bedside. Resident #1 passed on 10/26/22 at 1:45 PM.

The Emergency Medical Services (EMS) was unable to locate the report from 10/23/22.

The facility Administrator was notified of the immediate jeopardy on 11/16/22 at 5:30 PM.

o Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance

* On 10/23/22 the facility failed to provide basic life support to include ventilation and suctioning.

* On 10/23/22 resident #1 required CPR and received chest compressions with no ventilation or suctioning.

*All other residents who have advanced directives

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that require a full code are at risk from suffering from the deficient practice.

On 11/16/22, The DON and ADON completed an audit to determine all residents who have advanced directives that require full code. All residents identified to have advanced directives that require full code were assessed for signs or symptoms of cardiac arrest on 11/16/22 with no concerns found.

On 11/16/22, an audit was performed by the DON on all crash carts to ensure they are unlocked and are complete with suctioning equipment and an Ambu bag. Both crash carts have been relocated to the nurses' stations and are fully stocked, unlocked, and accessible to all staff. Both crash carts require a key to be locked. The keys to both crash carts were removed and secured by the DON to ensure the carts remain unlocked and keys are no longer accessible for staff use.

o 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

0n 11/16/22, education was provided to the Administrator, Director of Nursing (DON), and the Assistant Director of Nursing (ADON) by the Corporate Consultant, Regional Director of Operations, regarding emergency procedures and cardio-pulmonary resuscitation.

On 11/16/22, after being reeducated as outlined above, education for all staff including agency staff, was completed in person or via phone by the Administrator, DON, ADON or designee. The

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education consisted of the following:
" The need to Maintain equipment and supplies necessary for CPR/BLS in the facility at all times. It is the Director of Nurses responsibility to ensure equipment is maintained and supplies necessary for CPR/BLS are accessible to staff at all times.
" Crash carts are to remain stored at the each nurses' station unlocked, and be equipped with suctioning equipment and an Ambu bag.
" The facility's procedure for administering CPR shall incorporate the steps covered in the Emergency Cardiovascular Care or facility BLS training material.
" If the first responder is not CPR-certified, that person will call 911 and follow the 911 operator's instructions until a CPR-certified staff member arrives.
" If an individual is found unresponsive, briefly assess for abnormal or absence of breathing. If sudden cardiac arrest is likely, begin CPR by:
a. Facility nurse will instruct a staff member to activate the emergency response system (code) and call 911.
b. Facility nurse will instruct a staff member to bring the crash cart to the code location.
c. Facility nurse will verify or instruct a staff member to verify the DNR or code status of the individual.
d. Clinical staff to Initiate the basic life support (BLS) sequence of events.
" The BLS sequence of events is referred to as "C-A-B" (chest compressions, airway, breathing).

Alleged IJ removal date is 11/17/22.

The credible allegation was verified on 11/21/22 as evidenced by observations, staff interviews and record review. Interviews were conducted with the nursing staff to confirm in-services were

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F 678	Continued From page 12 completed on how and when to conduct CPR, how and when to request assistance with CPR and where to find the crash carts. Observations were made of the unlocked crash carts and supply audits were competed. The facility's immediate jeopardy removal dated of 11/17/22 was validated.	F 678		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 880		12/9/22

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F 880	Continued From page 13 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff	F 880	Preparation and/or execution of this plan	

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F 880	Continued From page 14 interviews, the facility failed to implement their policy for Personal Protective Equipment (PPE) when 1 of 4 staff members (Nurse Aide #3) failed to change her mask and disinfect her goggles after providing care to a COVID-19 positive resident and before providing care to a COVID-19 negative resident reviewed for infection control practices. The facility's policy and procedure did not specifically address what to do with personal protective equipment when non-dedicated staff members transitioned care from a COVID positive resident to a COVID negative resident. The findings included: The facility's policy entitled: Coronavirus Disease (COVID-19) - Using Personal Protective Equipment/Source Control read as follows under Policy Interpretation and Implementation read in part: "If personal protective equipment is used during the care of a resident for which a NIOSH-approved respirator or facemask is indicated for personal protective equipment (PPE) (i.e., NIOSH approved particulate respirators with N95 filters or higher during the care of a resident with COVID-19 infection, facemask during care of a resident on Droplet Precautions), they should be removed and discarded after the resident care encounter and new one should be donned." An observation of the 100 hall on 11/21/22 at 9:40 AM revealed rooms 104, 105, 107, 109, 110, 112 and 117 all were on enhanced droplet contact precautions for COVID-19 and were COVID-19 positive. A continuous observation from 9:45 AM to 9:59 AM revealed NA #3 went into room 107 to provide care to resident who was COVID-19 positive. The Nurse Aide (NA) donned a gown,	F 880	of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. F880 The facility failed to 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. Based on observation, record reviews, and staff interviews, the facility failed to implement their policy for personal protective equipment, (PPE) when 1 of 4 staff members (Nurse Aide #3) failed to change her mask and disinfect her googles after providing care to a Covid -19 positive resident and before providing care to Covid -19 negative resident. Facility provided immediate one to one education to Nurse Aide #3 regarding facility covid policy, the donning and doffing of PPE, and the importance of following infection control practices. All residents who are covid negative are at risk as result of deficient practice. To ensure the deficient practice does not reoccur:	

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F 880	Continued From page 15 and gloves and with N95 mask and goggles went into the room. NA #3 exited the room after providing care, doffed her gloves and gown, sanitized her hands and proceeded down the hall and into room 119 who was not on enhanced contact precautions and was COVID-19 negative with the same mask and goggles that had not been cleaned and provided care to the resident. NA #3 failed to change her mask and clean her goggles when going from a COVID-19 positive resident to a COVID-19 negative resident. An interview on 11/21/22 at 10:24 AM with NA #3 revealed she had taken care of the resident in room 107 who was COVID-19 positive and then the resident in room 119 who was COVID-19 negative. NA #3 further revealed she should have changed her mask and cleaned her goggles when exiting room 107 who was COVID-19 positive and before entering room 119 who was COVID-19 negative but had not done so. An interview on 11/21/22 at 11:29 AM with the Director of Nursing (DON) who also served as the Infection Preventionist revealed NA #3 should have changed her mask, cleaned her goggles and sanitized her hands after exiting room 107 and before entering room 119. The DON stated there were plenty of personal protective equipment (PPE) supplies and were provided in bins outside each room on enhanced contact precautions for COVID-19 and NA #3 should have cleaned her goggles and changed her mask after exiting room 107. The DON further stated any time staff transitioned care from a COVID positive resident to a COVID negative resident they should change their mask, clean their goggles or face shield and sanitize their hands prior to entering the COVID negative resident's	F 880	All staff were immediately re-educated by the Director of Nursing, (DON) or designee on 11-21-22 on the Covid 19 Outbreak precautions including but not limited to the changing of mask, cleaning of goggles, and the importance of infection control. The DON added signage to the infection control carts that store clean PPE and are located outside the door of resident's who are on isolation/precautions to guide/remind staff of the PPE donning that is required to enter the resident's room and the required PPE doffing when exiting the resident's room which includes but is not limited to changing their mask and the cleaning/disinfecting of goggles with alcohol pads to decontaminate their soiled eyewear per facility policy. On 12-6-22 all staff were re-educated again on Covid 19 – Outbreak Precautions, the importance of infection control, and watched videos from the Centers for Disease Control and Prevention, (CDC) on the Proper techniques for Donning and Doffing of PPE to ensure all staff understand the facility Covid 19 – Outbreak Precautions, and how to don and doff PPE properly to prevent deficient practice from recurring. Facility Management has verified all employees in all departments have been trained and are represented on the training sign in sheets. A copy of the facility's Covid 19 –	

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F 880	Continued From page 16 room. She indicated if the policy did not address the use of PPE between COVID positive and COVID negative residents they would need to ensure it was updated to reflect the most current infection control guidelines. An interview on 11/21/22 at 11:45 AM with the Administrator revealed staff had just been educated on the proper use of PPE in COVID-19 positive rooms and what to do when working between COVID-19 positive and negative residents. The Administrator stated they would follow up with NA #3 and provide one on one education to ensure she understood proper procedures with PPE.	F 880	Outbreak Precautions has been added to the facility's orientation packet for education of new hires, which includes agency, and contract employees. This education will be completed by the DON, or facility designee. It will be the responsibility of each Department Head to ensure all employees working in their department have been educated and are following facility's Covid 19 outbreak precautions correctly. Facility management to include department heads, will make daily rounds to ensure staff are following facility Covid 19 – Outbreak Precautions and that signage remains in place. The Director of Nursing, or designee, shall randomly conduct donning/doffing audits on 5 employees 5x/week for 4 weeks, then 1 employee at random weekly for 8 weeks and document the results of these audits for a total of 12 weeks to ensure staff don and doff PPE appropriately and are knowledgeable and following the facilities Covid 19 Outbreak Precautions. The DON will review the results of the random audits and those findings shall be reported to QAPI committee; audits will continue at discretion of QAPI committee. The DON will be responsible for the implementation of the acceptable plan of correction. Corrective action was completed on 12-9-22	