STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145557	A. BUILDING _____ B. WING _____	05/27/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ALDEN ESTATES OF BARRINGTON	1420 SOUTH BARRINGTON ROAD BARRINGTON, IL 60010

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

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This deficiency has two deficient practice statements: 1. Based on observation, interview and record review the facility failed to properly prevent the spread of infections such as COVID-19 and failed to implement infection control practices according to the Centers for Disease Control and Prevention (CDC) guidelines and facility policy on newly admitted or returning residents whose COVID-19 status was unknown, as evidenced by failures to: (A) prevent cohorting (imposed grouping of people, such as patients, potentially exposed to designated diseases) for four (R1, R2, R3 and R4) residents under monitoring due to possible exposure to COVID-19 during hospitalization with residents who were asymptomatic and confirmed negative from COVID-19; (B) ensure a nursing staff and a nurse practitioner donned appropriate personal protective equipment (PPE) per CDC's recommendation when entering the room of two (R1 and R2) residents which the facility determined should be under monitoring due to possible exposure to COVID-19 during hospitalization ; and, (C) prevent cohorting two (R1 and R2) residents with one of the residents being positive for [DIAGNOSES REDACTED] Pneumoniae (bacteria that normally live in the intestines and feces. These bacteria are harmless when they're in the intestines. But if they spread to another part of your body, they can cause severe infections). These practices resulted in an Immediate Jeopardy (IJ) to the health and safety of these residents who were at high risk of contracting the highly contagious COVID-19 and [DIAGNOSES REDACTED] Pneumoniae which may result in [MEDICAL CONDITION], serious adverse outcome and/or death. The IJ began on 5/8/20 when the facility cohorted R3 and R4 in one room after R3 was readmitted from the hospital with possible exposure to COVID-19 during hospitalization . The IJ was identified on 5/22/20. The Administrator and the Director of Nursing (DON) was notified of the IJ via telephone on 5/22/20 at 1:15pm. The IJ was removed on 5/25/20, based on the facility's implementation of an acceptable removal plan as verified on-site by the surveyor. Although the immediacy was removed, the facility remained out of compliance at the scope of pattern and a severity of potential for more than minimal harm that was not immediate jeopardy due to sustained compliance that has not been verified by the survey team and other noncompliance with infection control practices identified during the survey. Findings include: According to the Centers for Disease Control and Prevention, Create a plan for managing new admissions and readmissions whose COVID-19 status is unknown. Options include placement in a single room or in a separate observation area so the resident can be monitored for evidence of COVID-19. o All recommended COVID-19 PPE should be worn during care of residents under observation, which includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown. o Testing residents upon admission could identify those who are infected but otherwise without symptoms and might help direct placement of asymptomatic [DIAGNOSES REDACTED]-CoV-2-infected residents into the COVID-19 care unit. However, a single negative test upon admission does not mean that the resident was not exposed or will not become infected in the future. Newly admitted or readmitted residents should still be monitored for evidence of COVID-19 for 14 days after admission and cared for using all recommended COVID-19 PPE. Testing should not be required prior to transfer of a resident from an acute-care facility to a nursing home. o New residents could be transferred out of the observation area or from a single to a multi-resident room if they remain afebrile and without symptoms for 14 days after their last exposure (e.g., date of admission). Testing at the end of this period could be considered to increase certainty. A. Review of R1's, R2's, R3's and R4's current [DIAGNOSES REDACTED]. Sometimes the person can have both problems. The usual exchange between oxygen and carbon [MEDICATION NAME] in the lungs does not occur. As a result, enough oxygen cannot reach the heart, brain, or the rest of the body. This can cause symptoms such as shortness of breath, a bluish tint in the face and lips, and confusion. The most concerning complication of COVID-19 is acute hypoxaemic (with abnormally low amount of oxygen in the blood, especially arterial blood) [MEDICAL CONDITION] requiring ventilation). R1, R2, R3 and R4 were all dependent on mechanical ventilator (a machine that helps a patient breathe (ventilate) when they cannot breathe on their own). Further review of the current [DIAGNOSES REDACTED]. R1, R3 and R4 also had diabetes mellitus (A disease that makes the person more susceptible to developing infections, as high blood sugar levels can weaken the person's immune system defenses. In addition, some diabetes-related health issues, such as nerve damage and reduced blood flow to the extremities, increase the body's vulnerability to infection.). 1) Review of R4's Census Record revealed that R4 had a room change on 3/20/20. R3 and R4 became roommates on 3/20/20 and continued as such until 5/5/20 when R3 was transferred to the hospital. Review of R3's Census Record revealed that R3 was readmitted to the facility on [DATE] and returned to his previous room which he shared with R4. Review of R3's current, completed and discontinued physician orders [REDACTED]. Review of R3's current care plans, including resolved and cancelled items on the care plan, revealed that there was no indication that R3 was put on contact and droplet isolation precautions when he was readmitted to the facility on [DATE]. Per CDC guidelines, R3 should have been on contact and droplet precautions from 5/9/20 until 5/22/20. Observation on 5/21/20 at 4:56pm revealed that R3 was not on any isolation precautions. Review of the Isolation Tracking Form dated 5/22/20 revealed that R3 was not on the list of residents that were on transmission based precautions. In an interview with the DON on 5/27/20 at 4:30pm, when asked about cohorting R3 and R4 on 5/8/20 when R3 returned from the hospital, the DON did not make any comment. 2) Observation on 5/21/20 at 3:28pm, revealed that R1 and R2 shared the same room. Review of R1's current, completed and discontinued physician orders [REDACTED]. Review of R1's physician order [REDACTED]. Per CDC guidelines, R1 should be on contact and droplet precautions from 5/14/20 until 5/27/20. Review of R2's Census Record revealed that R2 was admitted to the facility on [DATE] and would have been off quarantine (a period or place of isolation in which people that have arrived from elsewhere or been exposed to infectious or contagious disease are placed) and off contact and droplet precautions on 5/14/20 (the day when R1 was put on contact and droplet precautions). Review of R2's Progress Notes from 4/29/20 until 5/13/20 revealed no indication that R2's contact and droplet precautions should have been extended after 5/13/20 until R1 was cohorted with R2 in one room and caused unnecessary possible re-exposure of R2 to COVID-19. In an interview with the Administrator and the DON on 5/22/20 at 1:15pm, when asked why R1 and R2 were cohorted in one room when R2 would have been off contact and droplet precautions, the DON stated, (There was) no room available for a female ventilator. Review of R1's Progress Notes also revealed that R1 was sent to the emergency roiagnom on [DATE] for a CT (computerized tomography) scan (combines a series of X-ray images taken from different angles around your body and uses computer processing to create cross-sectional images of the bones, blood vessels and soft tissues inside your body) after a fall incident. In an interview with the DON on 5/27/20 at 4:30pm, when asked if there was a need to reset the number of days for R1 to be on contact and droplet precautions, the DON agreed and stated, It doesn't take 24 hours to get [MEDICAL CONDITION] so anyone that goes out and comes back would have to be put on contact and droplet precautions. 3) Observation on 5/21/20 at 4:56pm, revealed that R3 and R4 shared the same room. Further observation revealed that there was no isolation set-up outside of R3's and R4's room and there was no sign indicating that these residents were on contact and droplet isolation precautions. Review of R4's Census Record revealed that R4 was transferred to the hospital on [DATE], readmitted to the facility on [DATE] and returned to his previous room which he shared with R3. Review of R3's Census Record revealed that R3 was readmitted from the hospital on [DATE] and the facility failed to put

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) R3 on contact and droplet precautions from 5/9/20 until 5/22/20. Review of R3's Progress Notes from 5/8/20 until 5/21/20 revealed no indication that R3's contact and droplet precautions (if was appropriately put in place by the facility) should have been continued after the 14-day quarantine period until R3 was cohorted with R4 in one room and caused unnecessary possible re-exposure of R3 to COVID-19. Review of R4's current care plans revealed under Focus, (R4) is with isolation precautions COVID 19 Exposure, COVID 19 [MEDICATION NAME] until 6/3/20, initiated on 5/23/20. The type of isolation precautions was not specified. Review of R4's current physician orders [REDACTED]. Review of R4's physician order [REDACTED]. Per CDC guidelines, R4 should be on contact and droplet precautions from 5/22/20 until 6/4/20. In an interview with the Administrator and the DON on 5/22/20 at 1:15pm, when asked why R3 and R4 were cohorted in one room, the DON stated, (There were) no other rooms available. Review of the facility's Interim Guidance on Admission/Readmission to Long Term Care Facilities last updated on 5/8/20 revealed under Policy, The facility is committed to reducing the spread and transmission of COVID-19 and will continue to follow all guidance and recommendations from CDC, state and local health departments. This guidance will be followed when admitting/readmitting patients from the hospital or other referral source, unless otherwise directed by their local health department. Further review of the same policy and procedure revealed under Admission Guidance - New Admissions or Returning Residents Where the COVID-19 Status is Unknown, .At time of admission, the resident will be admitted to a single room within the designated facility transition area and will remain a contact/droplet precautions for 14 days from the date of admission. Contact/droplet precautions can be discontinued, and the resident can be moved to a regular unit after 14 days providing the resident has been afebrile for 72 hours and has improvement in respiratory symptoms, if applicable . B. Review of R1's and R2's current care plans revealed that both residents were on contact and droplet isolation precautions related to possible exposure to COVID-19 during hospitalization . 1) Observation on 5/21/20 at 3:28pm, revealed that Registered Nurse (RN)1 went inside R1's and R2's (roommates) room to do his initial shift rounds. RN1 was only wearing an N95 mask. RN1 was not wearing any eye protection nor was RN1 wearing gown. In an interview with the Administrator, Assistant Administrator, DON and Nurse Consultant on 5/21/20 at 5:43pm, when told about the observation of RN1 going inside R1's and R2's room only wearing an N95 mask, the Administrator stated, (Wearing) a Mask is acceptable (if he was just doing rounds). The DON added, There's a certain amount of feet, about three feet (staff members were allowed to just wear mask). Review of the facility's Infection Prevention and Control Manual - Transmission-Based Precautions dated 2019, revealed under Droplet Precautions, .in contrast to contact transmission, respiratory droplets carrying infectious pathogens transmit infection when they travel directly from the respiratory tract of the infectious individual to susceptible mucosal surfaces of the recipient .which would require facial protection . Further review of the same policy and procedure revealed, Infectious agents for which Droplet Precautions are indicated .include .[DIAGNOSES REDACTED] (severe acute respiratory syndrome)-Associated coronavirus . The same policy and procedure indicated, .A single resident room is preferred for residents who require Droplet Precautions .The maximum distance for droplet transmission is currently unresolved, but the area of defined risk based on epidemiological findings is approximately 3-10 feet . 2) Observation on 5/21/20 at 4:59pm, revealed that the Nurse Practitioner (NP) was talking to R1 and was on a squatting position right next to R1's bed. The NP was wearing gloves, mask, goggles and hair cap but was not wearing gown. In an interview with the Administrator, Assistant Administrator, DON and Nurse Consultant on 5/21/20 at 5:55pm, when told about the observation of the NP not wearing gown while talking to R1, the Administrator stated, She should have worn a gown. Review of the facility's Infection Prevention and Control Manual - Transmission-Based Precautions dated 2019, revealed under Contact Precautions, .Healthcare personnel caring for residents on Contact Precautions should wear a gown and gloves for all interactions that may involve contact with the resident or potentially contaminated areas in the resident's environment . Further review of the same policy revealed under Procedure for Contact Precautions: .Gowns, 1. Don gown upon entry into the room .5. Gowns should also be worn when body contact with environmental surfaces and items in the room that may be contaminated is anticipated . C. Observation on 5/21/20 at 3:28pm, revealed that R1 and R2 shared the same room. Review of R1's current care plans initiated on 5/14/20 revealed, (R1) is receiving oral antibiotic therapy for DX (diagnosis) of Klesibella (sic) PNA (pneumonia) ([DIAGNOSES REDACTED] pneumonia is a prominent nosocomial pathogen that accounts for up to 10% of all hospital-acquired infections. It is a frequent cause of ventilator-associated pneumonia) . Review of R2's current care plans revealed that R2 did not have the same kind of infection. Review of R2's current [DIAGNOSES REDACTED]. In an interview with the Administrator and the DON on 5/22/20 at 1pm, when asked why R1 and R2 were sharing the same room when R1 was positive for [DIAGNOSES REDACTED] Pneumoniae while R2 was not, the DON stated, We don't put residents positive for [DIAGNOSES REDACTED] (Pneumoniae) on isolation precautions. According to CDC's article titled, Healthcare Facilities: Information about CRE (Carbapenem-resistant [MEDICATION NAME] - one example is [DIAGNOSES REDACTED] Pneumoniae), Carbapenem-resistant [MEDICATION NAME] (CRE) are a serious threat to public health. Infections with CRE are difficult to treat and have been associated with mortality rates of up to 50% for hospitalized patients. Healthcare facilities should: .Ensure precautions are implemented for CRE colonized or infected patients. These include: Whenever possible, place patients currently or previously colonized or infected with CRE in a private room with a bathroom and dedicate noncritical equipment (e.g., stethoscope, blood pressure cuff) to CRE patient. Have and enforce a policy for using gown and gloves when caring for patients with CRE . According to the scientific article, [MEDICAL CONDITION] Infection published in 2017 in the journal Understanding [MEDICAL CONDITION] Pathology by Richard Kradin et al, noted that [DIAGNOSES REDACTED] pneumonia generally occurs in patients who are immunocompromised due to age, [MEDICATION NAME] abuse, or diabetes mellitus. It is a common ventilator-associated pneumonia. Like the pneumococcus, [DIAGNOSES REDACTED] classically produce a lobar pneumonia, with an unexplained predilection for the upper lobes. Infection produced hemorrhagic necrosis, micro-abscesses, and cavity formation. IMMEDIACY REMOVAL: Based on observation, interview and record review, it was determined the IJ that began on 5/8/20 was removed on 5/25/20. The facility completed all items submitted on the approved IJ removal plan. The following information provided by the facility was used to determine that the Immediate Jeopardy had been removed: Interview with the DON/Infection Preventionist revealed that room changes were made to provide a single room for each of the newly admitted or readmitted residents which included R1, R2, R3 and R4. Other previous admissions were reviewed and room changes and/or transfer to other facilities and/or discharge to home were conducted to ensure that newly admitted or readmitted residents whose COVID-19 status was unknown were not cohorted with other residents. The Administrator, Medical Director, DON and the Interdisciplinary Team (IDT) conducted a review of the Admission/Readmission to Long Term Facilities; COVID-19 IDPH Interim Guidance; Transmission Based Precautions; and, Infection Control Standards according to CDC guidelines. No revisions to any existing policy and procedure were made according to the DON/Infection Preventionist. Interviews were conducted with nursing, respiratory, therapy, housekeeping and administrative staff. Each employee was asked regarding his/her understanding of the current policy and procedure to assure staff fully understood his/her responsibilities regarding infection prevention. In addition to the review of the facility's current policies and procedures, the facility's recent employee in-service provided was reviewed. Based on the review, all staff completed the mandatory training on Appropriate PPE for Contact and Droplet Precautions, Infection Control Practices, CDC's Guidelines and Facility's Infection Control Policy and Procedure with special attention to prevention of COVID-19 and other types of infection transmission. Staff Competency on Donning and Doffing PPE was also assessed. The nurse practitioner and nursing staff who were involved in the noncompliance related to PPE were provided individual education and competency assessed individually. The in-service training and staff competency assessment were started on 5/22/20 and completed for all staff by 5/25/20. The Nurse Consultant provided the in-service training and re-education of all the management employees regarding the Admission/Readmission Criteria for Long Term Care on 5/22/20. On 5/22/20, Quality Assurance Tools were developed for Admission/Readmission including Room Changes and Appropriate PPE when Entering Transmission Based Precautions Room. These QA Tools were being utilized by the Administrator and IDT on a daily basis starting on 5/22/20 and will be used daily for 60 days which will be reduced to three times per week for 30 days, then weekly for 30 days and monthly, thereafter. Random spot-checks of newly admitted or readmitted residents were being conducted to ensure compliance with the Admission/Readmission Guidelines on not cohorting residents with unknown COVID-19 status. Between 10:30am and 4:30pm, random observations of staff were conducted which revealed that all staff members were donning appropriate PPE per CDC's recommendation when they were entering residents' rooms on transmission based precautions. Random interviews of staff were also conducted which revealed that all staff members were knowledgeable of the facility's policies and procedures related to Admission/Readmission Criteria and Appropriate PPE to be Used When Entering Transmission Based Precautions Room. Random observations of residents on droplet and contact precautions revealed that the residents were not cohorted with another resident except when both residents had the same infection. 2. Based on observation, interview and record review the facility failed to properly prevent the spread of infections such as COVID-19 as evidenced by failures to: (A) follow

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) infection control practices related to the use of glucometer (medical device used to measure sugar levels in the blood) for six (R5, R6, R7, R8, R9 and R10) residents; (B) perform hand hygiene when delivering meal tray for 17 (R9, R11, R12, R13, R14, R15, R16, R17, R18, R19, R20, R21, R22, R23, R24, R25 and R26) residents; (C) properly clean and disinfect a mechanical lift after resident use for three (R27, R28 and R29) residents; and, (D) ensure that pulse oximeter (medical device used to measure pulse rate and oxygen saturation level) and blood pressure (BP) cuff shared among residents were properly cleaned and disinfected after resident use for four (R30, R31, R32 and R33) residents. Findings include: A. Review of R5's, R6's, R7's, R8's, R9's and R10's current [DIAGNOSES REDACTED]. In addition, some diabetes-related health issues, such as nerve damage and reduced blood flow to the extremities, increase the body's vulnerability to infection.). 1) Observation of RN2 on 5/21/20 at 11:02am, revealed RN2 used the Assure Platinum glucometer to check R5's blood sugar in R5's room. Without using any barrier to protect the blood glucose test strip case and glucometer from contamination by the surface of R5's over-bed table, RN2 sat the glucometer and blood glucose test strip case on R5's over-bed table. After checking R5's blood sugar, RN2 went back to the medication cart and sat the glucometer and blood glucose test strip case on top of the medication cart without using a barrier. RN2 wiped the glucometer with a Clorox Healthcare Hydrogen Peroxide wipe for eight seconds. Using the same wipe, RN2 wiped the blood glucose test strip case for three seconds and sat both the glucometer and the blood glucose test strip case on top of the medication cart without using any barrier. The blood glucose test strip case and the glucometer were visibly wet for approximately 10 seconds after RN2 wiped them with the disinfecting wipe. 2) Observation of RN2, on 5/21/20 at 11:10am, revealed RN2 used the unsanitized Assure Platinum glucometer to check R6's blood sugar in R6's room. Without using any barrier to protect the glucometer and blood glucose test strip case from contamination by the surface of R6's over-bed table, RN2 sat the glucometer and blood glucose test strip case on top of the over-bed table. After checking R6's blood sugar, RN1 went back to the medication cart and sat the glucometer and blood glucose test strip case on top of the medication cart without using a barrier. RN2 wiped the glucometer with a Clorox Healthcare Hydrogen Peroxide wipe for 10 seconds. Using the same wipe, RN2 wiped the blood glucose test strip case for three seconds and sat both the glucometer and blood glucose test strip case on top of the medication cart without using any barrier. The blood glucose test strip case and the glucometer were visibly wet for approximately 10 seconds after RN2 wiped them with the disinfecting wipe. 3) Observation of RN3, on 5/21/20 at 11:15am, revealed RN3 used the Assure Platinum glucometer to check R7's blood sugar in R7's room. After checking R7's blood sugar, RN3 went back to the medication cart and RN3 wiped the glucometer with the Clorox Healthcare Hydrogen Peroxide wipe for 10 seconds. The glucometer was visibly wet for approximately 15 seconds after RN3 wiped it with the disinfecting wipe. 4) Observation of RN3 on 5/21/20 at 11:23am, revealed RN3 used the Assure Platinum glucometer to check R8's blood sugar in R8's room. Without using any barrier to protect the glucometer from contamination by the surface of R8's over-bed table, RN3 sat the glucometer case on top of the over-bed table. After checking R8's blood sugar, RN3 went back to the medication cart and wiped the glucometer with the Clorox Healthcare Hydrogen Peroxide wipe for five seconds. The glucometer was visibly wet for approximately 15 seconds after RN3 wiped it with the disinfecting wipe. 5) Observation of Licensed Practical Nurse (LPN)1, on 5/21/20 at 11:34am, revealed LPN1 used the Assure Platinum glucometer to check R9's blood sugar in R9's room. After checking R9's blood sugar, LPN1 went back to the medication cart and wiped the glucometer with the Clorox Healthcare Hydrogen Peroxide wipe for 10 seconds. The glucometer was visibly wet for approximately 10 seconds after LPN1 wiped it with the disinfecting wipe. LPN1 sat the glucometer on top of the medication cart without using any barrier. 6) Observation of LPN2, on 5/21/20 at 11:39am, revealed LPN2 used the Assure Platinum glucometer to check R10's blood sugar in R10's room. After checking R10's blood sugar, LPN2 went back to the medication cart and wiped the glucometer with the Clorox Healthcare Hydrogen Peroxide wipe for 10 seconds. The glucometer was visibly wet for approximately 10 seconds after RN3 wiped it with the disinfecting wipe. In an interview with the Administrator, Assistant Administrator, DON and Nursing Consultant on 5/21/20 at 5:11pm, when told about the observation of nursing staff sitting the glucometer and blood glucose test strip case on residents' over-bed tables and medication cart without using any barrier, the Nursing Consultant stated, There should be a barrier (between surfaces and the glucometer and blood glucose test strip case). When asked about the contact time (also known as the wet time and the time that the disinfectant needs to stay wet on a surface in order to ensure efficacy) of the Clorox Healthcare Hydrogen Peroxide wipe, the Nurse Consultant stated, Our policy says one minute. Review of the facility's Assure Platinum Blood Glucose Monitoring policy and procedure dated 3/20 revealed under Procedure: .12. After each use clean/disinfect outside of the meter with disinfectant wipes: a. All surfaces of Blood Glucose Monitoring Machine if visibly soiled need to be physically cleaned to remove gross soil with one wipe and then a second wipe to disinfect the surface; b. If using Clorox Hydrogen Peroxide Cleaner Disinfectant wipes or Oxivir 1, treated surface of the Blood Glucose Monitoring Machine (must) remain visibly wet for a full 1 minute. Use additional wipes if needed to assure continuous 1 minute wet contact time. Allow to air dry . Further review of the same policy and procedure revealed that the policy did not address the use of a barrier or liner for the glucometer to protect it from contamination from environmental surfaces. According to a Centers for Disease Control and Prevention (CDC) article titled, Guidelines for Environmental Infection Control in Health-Care Facilities published on 6/6/03 under Recommendations - Environmental Services on subsection Cleaning and Disinfecting Strategies for Environmental Surfaces in Patient Care Areas, .3. Use barrier protective coverings as appropriate for noncritical surfaces that are 1) touched frequently with gloved hands during the delivery of patient care; 2) likely to become contaminated with blood or body substances . B. Review of the current [DIAGNOSES REDACTED]. Review of R16's and R26's current [DIAGNOSES REDACTED]. 1) Observation of nursing assistant (NA)1 on 5/21/20 at 11:50am revealed that NA1 was delivering a meal tray to R11's, R12's, R13's, R14's, R15's, R16's, R17's and R18's rooms. Further observation revealed that NA1 entered these residents' rooms and assisted in setting up the lunch trays on residents' over-bed tables. NA1 went in and out of the residents' rooms without performing hand hygiene. 2) Observation of the Unit Manager on 5/21/20 at 11:50am revealed that the Unit Manager was delivering a meal tray to R9's, R19's and R20's rooms. Further observation revealed that the Unit Manager entered these residents' rooms and assisted in setting up the lunch trays on residents' over-bed tables. The Unit Manager went in and out of the residents' rooms without performing hand hygiene. In an interview with the Unit Manager on 5/21/20 at 2:31pm, when asked about the need to perform hand hygiene in between rooms when delivering meal tray to residents' rooms, the Unit Manager stated, I forgot to do it. 3) Observation of NA2 on 5/21/20 at 11:50am revealed that NA2 was delivering a meal tray to R21's, R22's, R23's and R24's rooms. Further observation revealed that NA2 entered these residents' rooms and assisted in setting up the lunch trays on residents' over-bed tables. NA2 went in and out of the residents' rooms without performing hand hygiene. 4) Observation of NA3 on 5/21/20 at 11:50am revealed that NA3 was delivering a meal tray to R25's and R26's rooms. Further observation revealed that NA3 entered these residents' rooms and assisted in setting up the lunch trays on residents' over-bed tables. NA3 went in and out of the residents' rooms without performing hand hygiene. In an interview with the DON, Nurse Consultant, Administrator and Assistant Administrator on 5/21/20 at 5:21pm, when asked of their expectations of nursing staff when delivering meal tray to residents' rooms, the DON stated, (Nursing staff should perform) hand hygiene in between rooms. Review of the facility's Hand Washing and Hand Hygiene policy and procedure dated 3/19 revealed under Purpose: Appropriate hand hygiene is essential in preventing the spread of infectious organisms in healthcare settings. Further review of the same policy and procedure revealed, 1. Hand hygiene must be performed after touching .contaminated items. Specific examples include but are not limited to: .c) Before touching medication or food to be given to a resident .g) After touching any item or surface that may have been contaminated with blood or body fluids, excretions or secretions . C. Review of the current [DIAGNOSES REDACTED]. Further review of the current [DIAGNOSES REDACTED]. Sometimes the person can have both problems. The usual exchange between oxygen and carbon [MEDICATION NAME] in the lungs does not occur. As a result, enough oxygen cannot reach the heart, brain, or the rest of the body. This can cause symptoms such as shortness of breath, a bluish tint in the face and lips, and confusion. The most concerning complication of COVID-19 is acute hypoxaemic [MEDICAL CONDITION] requiring ventilation). R27 and R28 were both dependent on respirator (ventilator - a machine that takes over the body's breathing process when disease has caused the lungs to fail and provides mechanical ventilation by moving breathable air into and out of the lungs, to deliver breaths to a patient who is physically unable to breathe, or breathing insufficiently). Review of the current [DIAGNOSES REDACTED]. 1) Observation on 5/21/20 at 12:25pm revealed that NA4 used the sling mechanical lift to transfer R27 to a geri-chair (medical recliner chair designed to allow s