STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455917	A. BUILDING _____ B. WING _____	**09/21/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DEER CREEK OF WIMBERLEY	**555 RANCH RD 3237 WIMBERLEY, TX 78676**

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 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide the necessary care and services to ensure that a resident received services to maintain good personal hygiene for 5 out of 15 residents (#4, #5, #8, #9, and #10) reviewed for Activities of Daily Living in that: Residents #4, #5, #8, #9, and #10 had not received a shower on their scheduled shower day and time (September 19th, 2020 on the 6 AM to 2 PM shift). This failure could place residents who required assistance with ADLs at risk of a decline in their health status and poor self-esteem. Findings included: Record review on 09/18/20 at 12:35 PM of Hall 100's shower schedule revealed that odd numbered rooms A bed are showered on Tuesday, Thursday, and Saturdays on the 6AM-2PM shift and the B bed is showered on the 2PM-10PM shift. Record review on 9/21/20 of the facilities Hall 100 Shower Sheet binder for September 2020, revealed the following: There were no shower sheets in the binder dated 9/2/20, 9/3/20, 9/4/20, 9/5/20, 9/11/20, 9/12/20. Review of Resident #9's electronic face sheet, revealed a [AGE] year old male who was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #9's MDS, dated [DATE], revealed a BIMS score of 15, indicating no cognitive deficits. Review of Resident #9's Care Plan, dated 8/27/20, revealed he required extensive assistance of one staff to provide (shower) as necessary. Observation and interview on 09/21/20 at 9:30 AM revealed Resident #9's appearance was unkempt and he verbalized that he had not received or was not offered a shower over the weekend of 9/19/20 and 9/20/20. Resident #9 stated I Probably needed one and if staff offered a shower, he would have taken one. Review of Resident #4's electronic face sheet, revealed an [AGE] year old who was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #4's MDS, dated [DATE], revealed a BIMS score of 15, indicating no cognitive deficits. Review of Resident #4's Care Plan, dated 8/19/20, revealed she requires assistance with ADL self-care performance and requires limited assistance with bathing/showering 3x/week and as necessary. Review of Resident #5's electronic face sheet, revealed a [AGE] year old female who was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #5's MDS, dated [DATE], revealed a BIMS score of 15, indicating no cognitive deficits. Review of Resident #8's electronic face sheet, revealed a [AGE] year old female who was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #8's MDS, dated [DATE], revealed a BIMS score of 15, indicating no cognitive deficits. Review of Resident #8's Care Plan, dated 9/16/20, revealed she had a an ADL self-care performance deficit. Review of Resident #10's electronic face sheet, revealed a [AGE] year old female who was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #10's MDS, dated [DATE], revealed a BIMS score of 12, indicating mild cognitive deficits. Review of Resident #10's Care Plan, dated 8/12/20, revealed she requires limited assistance by one staff with showering as necessary. In an interview on 09/19/20 at 1:50 PM CNA E said Resident #10 had refused a shower when he offered it to her and that usually when a resident refuses a shower he will document on the shower sheet the refusal and tell his charge nurse. CNA E said he had not had time to fill any shower sheets out and he had not informed his charge nurse of the refusal. In an interview on 09/19/20 at 1:55 PM with Resident #10 and CNA E, Resident #10 stated she had not refused a shower. At that time, Resident #10 was offered a shower by CNA E, Resident #10 replied she would take a shower, however she preferred a female to provide her a shower. In an interview on 9/19/20 at 10:30 AM CNA A stated the 100 hall is scheduled for four aides, but they usually only had three on the floor. He stated when this is the case, many residents do not get showers. In an interview on 9/19/20 at 1:00 PM CNA E stated he had only given room [ROOM NUMBER]A a bed bath today. CNA E also said he had not had time to give any other showers today. In an interview on 9/19/20 at 1:05 PM CNA F said she provided showers on the 100 hall. She said today residents in the A bed, odd number rooms were to receive showers from 6-2pm. She said she had been so busy she had not had time yet to give showers, but that she works a 16-hour shift and was going to provide showers this afternoon. In an interview on 09/19/20 at 1:08 PM RCS A said she was still in training and had not provided showers to residents. In an interview on 09/19/20 at 1:10 PM RCS B said she was still in training and had not provided showers. In an interview on 09/19/20 at approximately 2:00 PM, RN B said she had not received any communication for any Residents refusing showers for the 6AM-2PM shift today. RN B said CNAs will complete the shower sheets after showers are administered and she will sign off on them. She said she had not seen any today but sometimes it was later when the CNAs would have time to fill them out. In an interview on 09/19/20 at 2:40 PM DON said her expectation was for staff to provide showers as scheduled. She confirmed Hall 100 had a schedule of odd numbered rooms being on the Tuesday, Thursday, Saturday schedule. She said she had been aware residents were not receiving showers on their scheduled time but felt it had improved. In an interview on 09/19/20 at 2:43 PM Administrator said she was aware of a concern regarding showers not being offered. She said she did feel Hall 100 was adequately staffed, and improvements had been made with staffing recently. Interviews conducted from 09/18/20 thru 9/21/20 at multiple times throughout the investigation with LVN A, LVN B, LVN C, RN B and RN C revealed the shower sheets are how they monitored if a resident received a shower. In an interview on 9/21/20 at 4:12 PM CNA C stated she always works the 100 hall on the 2PM - 10PM shift. She stated they have three aides on the hall Monday - Thursday, and are able to get all of the showers completed. On Friday's, they only have two aides on the hall, and it is impossible to complete all of the showers. When showers are missed, the nurse is notified. In an interview on 9/21/20 at 4:23 PM CNA B stated she works the 100 hall on the 2PM - 10PM shift. She stated M-W-F are their heavier shower days. She stated with the three aides on the floor it is difficult to complete showers, but manageable. She stated on Friday's with only two aides, it is impossible. She confirmed residents often go without showers, especially on Friday's. She stated this had been an issue for longer than she can remember. In an interview on 09/21/20 at 5:00 PM DON said her expectation for monitoring showers is that the CNAs were to complete the shower sheets, turn them into their charge nurse and the charge nurse would sign off on them and place them in the Shower Sheet Binder at the nursing station. She said her assistant director of nursing is usually the one that follows up on the shower sheets and makes sure the schedule is being followed. She was not aware the Shower Sheet Binder had six days where shower sheets were not in the book. She said her expectation would be for the charge nurse to follow up with the CNAs if they did not receive shower sheets during their shift. In an interview on 09/21/20 at 5:30 PM Administrator said she was aware there had been a concern earlier in the month with a resident not receiving a shower. She said she depends on the DON and the ADON to ensure the residents are receiving showers. She said in the past when she also will talk with the resident herself and go to the staff member responsible for the shower and verbally tell them to provide the care being requested. Record review of the facility's policy titled Routine Resident Care, dated April 2005 Revised September 2011 revealed the following: Residents Receive the necessary assistance to maintain good grooming and personal/oral hygiene Guidelines 2. Showers, tub baths and or shampoos are scheduled at least twice weekly and more often as needed .
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.**

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 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure a resident who had a Foley catheter received appropriate treatment and services to prevent urinary tract infections for one of one residents (Resident #6) reviewed for Foley catheter care. Resident #6 was observed on 09/18/20 and 09/21/20 with Foley catheter tubing touching the floor while in her wheelchair. This failure could place residents with Foley catheters at risk for contamination and urinary tract infections. The findings include: Review of face sheet for Resident #6 revealed she was a [AGE] year-old female, admitted to the facility on [DATE] with the following [DIAGNOSES REDACTED]. Review of Resident #6's yearly MDS dated [DATE] revealed in Section H. Bowel and Bladder that Resident #6 had an indwelling catheter Review of care plan for Resident #6, dated 8/26/20 revealed: (Resident #6) has indwelling catheter Goal: (Resident #6) will be /remain free from catheter related trauma through review date .Intervention .Position catheter bag and tubing below the level of the bladder . Observation on 09/18/20 at 11:44 AM and again on 09/21/20 at 9:15 AM revealed Resident #6 was up in her wheelchair on Hall 100. Resident #6's Foley catheter tubing was touching the floor. In an interview on 09/18/20 at 12:00 PM, LVN B said Foley catheter tubing should not touch the floor. In an interview on 09/21/20 at 11:30 AM CNA D said a resident's Foley catheter tubing is not supposed to touch the floor. In an interview on 09/21/20 at 1:45 PM CNA A said a resident's Foley catheter tubing should not touch the floor, it is a pathway for an infection. In an interview on 09/21/20 at 3:40 PM LVN C said a resident's Foley catheter tubing should not drag the ground, it could cause an infection. In an interview on 09/21/20 at 5:00 PM, the DON said her expectation for Foley catheters is to make sure the bag is down draining to gravity, that it is off the floor. She said if the tubing touched the floor it would be considered dirty and leave the resident at risk for infection. Record review of the facility's policy labeled Indwelling Catheter Care dated December 2005 Revised 2009 stated, Care and maintenance of indwelling catheters is essential to prevent infection .
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that respiratory care was provided, consistent with professional standards of practice, for two of three residents (Resident #11 and Resident #13) reviewed for respiratory care and services, in that: A. Oxygen Tubing not dated, stored or replaced properly, and the humidification bottle was not filled with water while in use for Resident #11. B. Oxygen Tubing not dated, stored or replaced properly for Resident #13. This failure could place residents who receive respiratory care and services at risk for respiratory complications. The findings included: A) Review of face sheet for Resident #11 revealed he was an [AGE] year-old male, admitted to the facility on [DATE] with the following [DIAGNOSES REDACTED]. Review of quarterly MDS dated [DATE] for Resident # 11 Section O. Special Treatments C. Oxygen Therapy; indicated Resident #11 received oxygen therapy. Review of Care plan for Resident #11, updated on 6/29/2020, revealed Resident #11 had [MEDICAL CONDITION] Goal: (Resident #11) will display optimal breathing patterns daily through review date. Intervention/Task: .Oxygen Settings: 02 via N/C (nasal cannula) as ordered . Observation on 09/18/20 at 1:00 PM revealed Resident #11's oxygen tubing was undated, and the nasal cannula connected to the oxygen concentrator was lying on the floor. There was no storage bag on or near the oxygen concentrator. The humidification bottle attached to the oxygen tubing was empty and dated 09/12/2020. Observation on 09/19/20 at 1:10 PM revealed Resident #11's oxygen tubing to be draped across the oxygen concentrator next to his bed, undated and unbagged. The humidification bottle remained empty and dated 9/12/20. Observation on 09/21/20 at 9:30 AM revealed Resident #11's humidification bottle was empty with a date of 09/12/2020. B) Review of face sheet for Resident #13 revealed he was an [AGE] year-old male, admitted to the facility on [DATE] with the following [DIAGNOSES REDACTED]. Review of Significant Change MDS dated [DATE] for Resident # 13 Section O. Special Treatments C. Oxygen Therapy; indicated Resident #13 received oxygen therapy. Review of Care plan for Resident #13, dated 06/01/2020 revealed Goal (Resident #13) has altered cardiovascular status related to [MEDICAL CONDITION], Hypertension Goal: (Resident #13) will be free from complications of cardiac problems through the review date Interventions: Oxygen Settings: 02 via N/C as ordered. 02 @ 2L via NC (nasal cannula) as needed for SOB (shortness of breath) . Observation on 09/18/20 at 10:00 AM revealed Resident #13's oxygen tubing, undated, to be lying on the floor next to Resident #13's bed. There was no storage bag observed on or near the oxygen concentrator Observation on 09/21/20 at 4:00 PM revealed Resident #13's oxygen tubing was undated and hanging over his bedrail with the nasal cannula touching the floor. In an interview on 09/21/20 at 11:30 AM CNA D said oxygen tubing if not on the Resident should be stored in a plastic bag not on the floor. If found on the floor, the oxygen tubing should be replaced. In an interview on 09/21/20 at 1:45 PM CNA A said if oxygen tubing is found on the floor it should be thrown away and notify the nurse. In an interview on 09/21/20 at 3:40 PM LVN C said oxygen tubing should be stored in a bag at the resident's bedside, if found on the floor it should be thrown away. She said oxygen tubing and the humidification bottles should be dated and the tubing should be changed out every week, on Sundays and the night nurse is the one responsible to do that. In an interview on 09/21/20 at 5:00 PM DON stated oxygen tubing should be stored in a plastic bag if not in use by the resident. She said it was not okay for the oxygen tubing to touch the floor. She said the oxygen tubing should be dated and changed every week, and that this is set to be changed on Sundays. She said the humidification bottles are changed when they become empty. She said if oxygen tubing is observed on the floor it needs to be thrown away as it would be considered dirty. She stated she provided CNA H with an N95 mask and made sure she was educated about the requirement to wear an N95 mask while on the isolation hall. Record review of the facilities policy labeled Oxygen Storage & Assembly, dated April 2005 and Revised June 2007 did not identify the storage of the oxygen tubing or indicate how often the tubing should be changed.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, 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 for four of fifteen residents (Residents #6, #11, #13, and #14) reviewed for infection control. A. Oxygen Tubing not dated, stored or replaced properly for Resident #11 B. Oxygen Tubing not dated, stored or replaced properly for Resident #13 C. CNA H was not wearing appropriate N95 mask while working with residents on the isolation hall. D. Resident #6 observed on 09/18/20 and 09/21/20 with Foley catheter tubing touching the floor while in her wheelchair. E. D. Soiled gauze bandage was on the floor at the foot of Resident #14's bed. These failures could place residents at risk for healthcare-acquired infections. Findings include: A) Review of face sheet for Resident #11 revealed he was an [AGE] year-old male, admitted to the facility on [DATE] with the following [DIAGNOSES REDACTED]. Review of quarterly MDS dated [DATE] for Resident # 11 Section O. Special Treatments C. Oxygen Therapy; indicated Resident #11 received oxygen therapy. Review of Care plan for Resident #11, updated on 6/29/2020, revealed Resident #11 has [MEDICAL CONDITIONS] Goal: (Resident #11) will display optimal breathing patterns daily through review date. Intervention/Task: .Oxygen Settings: 02 via N/C (nasal cannula) as ordered . Observation on 09/18/20 at 1:00 PM revealed Resident #11's oxygen tubing was undated, and the nasal cannula connected to the oxygen concentrator was lying on the floor. There was no storage bag on or near the oxygen concentrator. The humidification bottle attached to the oxygen tubing was empty and dated 09/12/2020. Observation on 09/19/20 at 1:10 PM revealed Resident #11's oxygen tubing to be draped across the oxygen concentrator next to his bed, undated and unbagged. The humidification bottle remained empty and dated 9/12/20. Observation on 09/21/20 at 9:30 AM revealed Resident #11's humidification bottle was empty with a date of 09/12/2020. B) Review of face sheet for Resident #13 revealed he was an [AGE] year-old male, admitted to the facility on [DATE] with the following [DIAGNOSES REDACTED]. Review of Significant Change MDS dated [DATE] for Resident # 13 Section O. Special Treatments C. Oxygen Therapy; indicated Resident #13 received oxygen therapy. Review of Care plan for Resident #13, dated 06/01/2020 revealed Goal (Resident #13) has altered cardiovascular status related to [MEDICAL CONDITION], Hypertension Goal: (Resident #13) will be free from complications of cardiac problems through the review date Interventions: Oxygen Settings: 02 via N/C as ordered. 02 @ 2L via NC (nasal cannula) as needed for SOB (shortness of breath) . Observation on 09/18/20 at 10:00 AM revealed Resident #13's oxygen tubing, undated, to be lying on the floor next to Resident #13's bed. There was not a storage bag observed on or near the oxygen concentrator Observation on 09/21/20 at 4:00 PM revealed Resident #13's oxygen tubing was undated and hanging over his bedrail with the nasal cannula touching the floor. C) Observation and Interview on 9/19/20 at 2:20 PM revealed CNA H exited from a resident's room on the isolation hall wearing a red cloth face mask. In an interview CNA H said she did not have an N95 mask on and but that she did have access to one in the supply room. She was not aware an N95 mask was required while working on the isolation hall.

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) Observation and interview on 09/19/20 at 2:22 PM revealed RN A obtained a N95 mask from a brown paper bag in the PPE (Personal Protective Equipment) Room that belonged to a different employee. In an interview, RN A said she did grab the N95 mask from another employee's bag, however she knew it had not been used. RN A said she had not noticed CNA H not wearing an N95 mask, and it was a requirement to wear an N95 mask on the isolation hall. According to FDA.gov, An N95 respirator is a respiratory protective device designed to achieve a very close facial fit and very efficient filtration of airborne particles. Note that the edges of the respirator are designed to form a seal around the nose and mouth. Surgical N95 Respirators are commonly used in healthcare settings and are a subset of N95 Filtering Facepiece Respirators (FFRs), often referred to as N95s. The similarities among surgical masks and surgical N95s are: They are tested for fluid resistance, filtration efficiency (particulate filtration efficiency and bacterial filtration efficiency), flammability and biocompatibility. They should not be shared or reused. (Accessed 09/22/20 https://www.fda.gov/medical-devices/personal-protective-equipment-infection-control/n95-respirators-surgical-masks-and-face-masks) In an interview on 09/19/20 at 2:30 PM DON said all staff were required to wear an N95 facemask if they entered a resident's room on the isolation hall. She said CNA H had just returned from leave and was not sure if she had been instructed about wearing an N95 mask. D) Review of face sheet for Resident #6 revealed she was a [AGE] year-old female, admitted to the facility on [DATE] with the following [DIAGNOSES REDACTED]. Review of Resident #6's yearly MDS dated [DATE] revealed in Section H. Bowel and Bladder that Resident #6 had an indwelling catheter Review of care plan for Resident #6, dated 8/26/20 revealed: (Resident #6) has indwelling catheter Goal: (Resident #6) will be /remain free from catheter related trauma through review date .Intervention .Position catheter bag and tubing below the level of the bladder . Observation on 09/18/20 at 11:44 AM and again on 09/21/20 at 9:15 AM revealed Resident #6 was up in her wheelchair on Hall 100 with her Foley catheter tubing touching the floor. E) Review of face sheet for Resident #14 dated 09/21/20 revealed he was a [AGE] year old male, admitted to the facility on [DATE] with the following [DIAGNOSES REDACTED]. Review of Significant Change MDS dated [DATE] for Resident # 14 indicated Section B. Hearing Speech Vision B0600 2. No Speech .Section C Cognition indicated that Resident #14 was severely impaired. Review of Care plan for Resident #14, dated 05/07/2020 revealed the following:(Resident #14) has several pressure ulcers on .L heel, R ankle, R outer heel .Goal: (Resident #14's)pressure ulcer will show signs of healing and remain free from infection by/through review date .Interventions: .Administer treatments as ordered and observe for effectiveness . Observation and interview on 09/21/20 at 9:20 AM revealed a soiled gauze bandage at the foot of Resident #14's bed with handwritten initials NB and a date of 09/19/20. The soiled bandage was retrieved by LVN B and she stated it looked like an old dressing but couldn't say for sure, she did say it should have been disposed of in the trash. In an interview on 09/18/20 at 12:00 PM, LVN B said foley catheter tubing should not touch the floor. In an interview on 09/21/20 at 11:30 AM CNA D said oxygen tubing if not on the Resident should be stored in a plastic bag not on the floor. If found on the floor, the oxygen tubing should be replaced. CNA D said a resident's foley catheter tubing is not supposed to touch the floor. In an interview on 09/21/20 at 1:45 PM CNA A said if oxygen tubing is found on the floor it should be thrown away and notify the nurse. CNA A said a resident's foley catheter tubing should not touch the floor, it is a pathway for an infection. CNA A also said if required to care for a resident on the isolation hall, an N95 mask is required. In an interview on 09/21/20 at 3:40 PM LVN C said oxygen tubing should be stored in a bag at the resident's bedside, if found on the floor it should be thrown away. She said oxygen tubing and the humidification bottles should be dated and the tubing should be changed out every week, on Sundays and the night nurse is the one responsible to do that. She said a resident's foley catheter tubing should not drag the ground, it could cause an infection. She said if a staff member is working on the isolation hall an N95 mask is required. In an interview on 09/21/20 at 5:00 PM, the DON stated oxygen tubing should be stored in a plastic bag if not in use by the resident. She said it was not okay for the oxygen tubing to touch the floor. She said the oxygen tubing should be dated and changed every week, and this is set to be changed on Sundays. She said the humidification bottles are changed when they become empty. She said if oxygen tubing is observed on the floor it needs to be thrown away as it would be considered dirty. The DON said her expectation was for foley catheters to make sure the bag is down draining to gravity, that it is off the floor. She said if the tubing touched the floor it would be considered dirty and leave the resident at risk for infection. The DON also stated soiled gauze dressings should be disposed of in the trash and should not be left on the floor at the foot of a residents' bed. The DON said CNA H does not usually work the isolation hall and that she went on 09/19/20 and provided CNA H with an N95 mask and made sure she was educated about the requirement to wear an N95 mask while on the isolation hall. Record review of the facilities policy labeled Oxygen Storage & Assembly, dated April 2005 and Revised June 2007 did not identify the storage of the oxygen tubing or indicate how often the tubing should be changed. Record review of the facility's policy labeled Indwelling Catheter Care dated December 2005 Revised 2009 stated, Care and maintenance of indwelling catheters is essential to prevent infection . Record review of the facility's policy labeled Standard Precautions, dated 2012 and revised 02/2018, it stated .Personal Protective Equipment (PPE) . I. PPE is provided to all employees. . II. The type of PPE should be appropriate for the procedure being performed and the type of exposure anticipated . Record review of the facility's COVID-19 plan labeled Sava Senior Care LLC Investigation (PUI) for 2019-nCoV, dated 09/17/20 stated . .Staff use of Personal Protective Equipment .The center should ensure that all staff is using appropriate PPE when they are interacting with residents to the extent PPE is available N95 respirators A and B teams and direct care staff caring for suspected or confirmed COVID-19 residents . Record review of the Nursing Facility Emergency Rules for COVID-19, issued on August 4th, 2020 states . (i) All NF (nursing facility) staff must wear a facemask while in the facility. Staff who are caring for COVID-19 positive residents and those caring for residents with unknown COVID-19 status must wear an N95 mask, gown, gloves, and goggles or a face shield. All facemasks and N95 masks must be in good functional condition as described in the COVID-19 Response for Nursing Facilities, and worn appropriately, completely covering the nose and mouth, at all times.