STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365687	A. BUILDING _____ B. WING _____	07/31/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ARBORS AT MARIETTA	**400 SEVENTH STREET MARIETTA, OH 45750**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the unprecedented global pandemic that resulted in the Presidential declaration of a State of National Emergency dated [DATE], The Department of Health and Human Services, Center for Medicare and Medicaid (CMS) Memo QSO ,[DATE]-ALL dated [DATE], Nursing Home Guidance from the Centers for Disease Control (CDC), record review, review of a facility investigation and timeline, COVID-19 testing log and infection control log and review of facility policy and procedures, observations and interviews with staff and local health department staff, the facility failed to implement effective and recommended infection control practices including the adequate monitoring and prevention of the transmission of COVID-19 in the facility. The facility also failed to report suspected and confirmed cases of COVID-19 to the local health department timely. This resulted in Immediate Jeopardy on [DATE] when State tested Nursing Assistant (STNA) #10 was instructed to come to work after reporting he had a fever for the past two days. The STNA began working (on [DATE] at 1:44 P.M.) on the second floor of the facility and then went and worked on the COVID-19 A unit until 1:39 A.M. when he was sent home ill with a fever of 101.2 degrees Fahrenheit. The STNA subsequently tested positive for COVID-19 with results received on [DATE]. The facility failed to perform an investigation/contact tracing to determine those residents or staff the STNA had contact with for exposure to COVID-19 or notify the local health department of the positive case. Further investigation revealed Resident #2, had exposure to STNA #10 on the afternoon of [DATE] and early morning of [DATE]. On [DATE] Resident #2 developed symptoms of COVID-19, however these symptoms were not communicated to the physician and no COVID-19 testing was performed. The resident expired on [DATE]. On [DATE] STNA #11 tested positive for COVID-19. The facility failed to perform an investigation/contact tracing to determine those residents or staff the STNA had contact with for exposure to COVID-19 or notify the appropriate local health department of the positive case. Further investigation revealed Resident #1 may have had direct contact with STNA #11 and had also resided in a room with Resident #2, developed symptoms of COVID-19 on [DATE] but was not tested until [DATE] (with positive results noted). The lack of current effective infection control practices and implementation of effective infection control policies and procedures placed all residents at risk for harm, complications and/or death related to the facilities failure to control the spread of COVID-19 throughout the facility. The facility census was 118. On [DATE] at 4:14 P.M., the Administrator and Director of Nursing (DON) were notified Immediate Jeopardy began on [DATE] when STNA #10 worked, providing direct resident care while having symptoms of COVID-19. The STNA subsequently tested positive for COVID-19. The facility failed to timely and adequately determine which staff or residents STNA #10 had contact with to implement infection control precautions. The facility failed to determine which staff or residents STNA #11 had contact with to implement infection control precautions after this STNA tested positive for COVID-19 on [DATE]. In addition, the facility failed to timely identify symptoms and staff/resident exposure involving Resident #1 resulting in the resident contracting COVID-19. Resident #2 subsequently passed away and was not tested to confirm COVID, however it was suspected. The Immediate Jeopardy was removed on [DATE] when the facility implemented the following correction actions: On [DATE] at 8:30 P.M. a whole facility house audit for all residents and staff was completed by the Infection Control Nurse to identify potential residents exposed to a positive COVID-19 staff member. No new residents were identified with signs and symptoms of COVID-19 at this time. On [DATE] at 10:17 P.M. all suspected and positive COVID-19 cases (staff and residents) were reported to the local health department by the Director of Nursing via email on [DATE] at 10:17 P.M. and [DATE] at 3:02 P.M. with additional information requested by the local health department. On [DATE] at 9:30 P.M. the Director of Clinical Services educated the Administrator, Director of Nursing and Infection Control Nurse regarding requirements for notifying the local health department of any suspected or confirmed cases of COVID-19 staff members or residents. On [DATE] at 10:00 P.M. the Director of Clinical Services educated the Medical Director, Administrator, Director of Nursing and Infection Control Nurse related to contact tracing through guidance from the local health department related to staff testing positive for COVID-19. On [DATE] at 1:31 P.M. the Medical Director, Administrator and Director of Nursing reviewed and revised the facility infection control plan regarding the pandemic and related to the medical directors COVID-19 testing protocol which stated as needed Tylenol orders would be discontinued, staff would alert the primary care physician of a change of condition, residents whose temperature was 99.0 degrees Fahrenheit or higher would be communicated to the primary care physician for further direction and the resident would be placed on transmission (isolation) precautions. On [DATE] a plan for high touch areas to be cleaned every four hours by housekeeping staff was implemented. On [DATE] a plan for all resident ' s vital signs including temperature and oxygen saturation to be obtained every four hours. Any resident who had a temperature of 99.0 or higher or oxygen saturation of 90% or less would be reported to the physician for further direction and the resident would be placed on transmission (isolation) based precautions. On [DATE] a plan for the Director of Nursing/designee to review the clinical alert report four times a day five times a week for three months then weekly for two months then randomly thereafter to ensure temperatures of 99.0 or greater or oxygen saturation of 90% or less were addressed with the primary care physician for direction. On [DATE] a plan for the Infection Control Nurse to add employees and resident's being tested for COVID-19 to the COVID-19 log was implemented. The Infection Control Nurse would then complete contact tracing. On [DATE] a plan for the Director of Nursing /designee to review the log during the daily clinical meeting five times a week for two months then weekly for four weeks then randomly thereafter validating contact tracing was completed. The results of these reviews will be discussed in quality assessment/performance improvement (QAPI) meetings for compliance and further recommendations. On [DATE] a plan for the Infection Control Nurse to contact the Director of Nursing and Administrator immediately as positive COVID-19 staff members are identified to ensure residents who have been potentially exposed are placed in quarantine for fourteen days and monitored for signs and symptoms including vital signs and pulse oximetry every four hours. On [DATE] a plan for the Director of Nursing /designee to review the positive COVID-19 staff and staffing schedule validating the residents who were potentially exposed were placed on quarantine for fourteen days and monitored for signs and symptoms to include vital signs and oxygen saturation every four hours. Monitoring will occur daily five times a week for two months then weekly for one month then randomly thereafter. Results of review will be discussed in QAPI meetings for compliance and further recommendations. On [DATE] a plan for the Medical Director, Administrator, Director of Nursing and Infection Control Nurse to review the infection control plan regarding the pandemic policies and procedures weekly in QAPI meeting was implemented. On [DATE] a plan for the Regional Director of Clinical Services to attend QAPI meetings weekly for four months then randomly thereafter validating policies and procedures was implemented. On [DATE] a plan for the Director of Nursing and the Infection Control Nurse to notify the local health department collaboratively via email with a follow up phone call as suspected and or confirmed COVID-19 staff members or residents were identified was implemented. On [DATE] a plan for the Administrator to also contact the local health department via email with follow up phone call as the COVID-19 log identified newly suspected or confirmed COVID-19 staff members or residents validating notification on going was implemented. Beginning on [DATE] at 8:30 P.M. the Infection Control Nurse initiated staff training. Licensed nurses (18 Registered Nurses, 28 Licensed Practical Nurses, 2 Medication Techs, 14 housekeepers, 82 State tested Nursing

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 -** Many	(continued... from page 1) Assistants, eight Administration staff, two social service staff, five respiratory staff, a therapist, one medical record staff, eight therapy staff and three activity personal) were educated via telephone and in person on the signs and symptoms of COVID-19 and related to the need to notify the physician of these signs/symptoms. On [DATE] at 4:00 P.M. the Infection Control Nurse educated staff (including 18 Registered Nurses, 28 Licensed Practical Nurses, 2 Medication Techs, 14 housekeepers, 82 State tested Nursing Assistants, eight Administration staff, two social service staff, five respiratory staff, one therapist, one medical record staff, eight therapy staff and three activity personal related to updated COVID policies and procedures. On [DATE] a plan for the Director of Nursing /designee to review the twenty-four-hour report and progress note report in the daily clinical meeting on an ongoing basis to validate the physician was updated with residents showing signs and symptoms of COVID-19 was implemented. Although the Immediate Jeopardy was removed on [DATE], the facility remained out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility was still in the process of implementing their corrective actions and monitoring to ensure on-going compliance. Finding include: Review of the Department of Health and Human Services, Centers for Medicare & Medicaid (CMS) Memo QSO ,[DATE]-ALL dated [DATE] revealed The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America ' s health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). As part of CMS guidance the Focused Infection Control Survey was made available to every provider in the country to make them aware of Infection Control priorities during this time of crisis, and providers and suppliers may perform a voluntary self-assessment of their ability to meet these priorities. The QSO Memo included additional instructions to Nursing Homes. We are disseminating the Infection Control survey developed by CMS and CDC so facilities can educate themselves on the latest practices and expectations. We expect facilities to use this new process, in conjunction with the latest guidance from CDC, to perform a voluntary self-assessment of their ability to prevent the transmission of COVID-19 .We also encourage nursing homes to voluntarily share the results of this assessment with their state or local health department Healthcare-Associated Infections (HAI) Program. Furthermore, we remind facilities that they are required to have a system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility, and when and whom possible incidents of communicable disease or infections should be reported (42 CFR 483.80(a)(2)(i) and (ii). 1. On [DATE] at 1:44 P.M. STNA #10 began his regularly scheduled shift working on the second floor (non-COVID unit) of the facility. At some point during the shift, the STNA also worked on the A hall, the facility COVID-19 unit. Although the facility had a COVID-19 unit on this date, there were no residents residing on the A unit with positive COVID-19 test results. Resident #2 resided on the COVID unit due to being readmitted to the facility from the hospital on [DATE] as a precautionary/quarantine measure due to an unknown COVID status. STNA #10 left the facility ill, with a temperature of 101.2 on [DATE] at 1:39 A.M. A COVID-19 test was obtained on this date with positive results reported on [DATE]. After the facility reviewed the staffing schedule and assignment sheets and investigation, they determined STNA #10 had been assigned to care for Resident #2 on the COVID unit/A hall during his shift from [DATE] until he left the facility ill on [DATE] at 1:39 A.M. Review of Resident #2's closed medical record revealed the resident was originally admitted to the facility on [DATE] and re-admitted [DATE] with [DIAGNOSES REDACTED]. Review of Resident #2's current orders, for [DATE] revealed orders for oxygen two liters per minute to keep oxygen levels greater than 90. There was an order to monitor for signs and symptoms of respiratory infections (fever, cough, shortness of breath, fatigue, muscle and body aches, headaches, new loss of taste or smell, congestion, runny nose, sore throat, nausea, vomiting, diarrhea, and low oxygen saturation) every shift. Notify physician if new signs and symptoms every shift, if new signs or symptoms present document in the progress notes and notify physician. On [DATE] a new order was received to check temperature every 2 hours. Prior to this order on [DATE] there were no orders to check temperature. Review of a progress note, dated [DATE] revealed the resident's main goal was to remain in long term care facility. Per therapy documentation, the resident required dependent assistance with upper and lower body dressing as well as dependent assistance with upper and lower body bathing. He required maximum to substantial assistance with all transfers and requires partial assistance with transfers. The resident was non-ambulatory. The resident's brief interview for mental status score (BIMS) on [DATE] was eight which indicated the resident had moderate cognitive impairment. Review of Resident #2's electronic vital sign records revealed the following: On [DATE] the resident's temperature was 100.1 degrees Fahrenheit, [DATE] -99.0, [DATE]- 99.5, 99.5, and 99.1, [DATE]- 99.0 and 99.3 and on [DATE]- 99.2 and 99.9. The resident did not have a temperature check on [DATE] or [DATE]. Further review revealed the resident's oxygen saturation level was only checked one time in July on [DATE] and it was 92% on room air. Review of progress notes dated [DATE] to [DATE] revealed no evidence the physician was notified of temperatures greater than 99.0 nor were the elevated temperatures noted in the progress notes. Review of Resident #2's medication administration and treatment record, dated [DATE] revealed on [DATE] the resident received Tylenol 325 milligrams (mg) two tablets for a temperature of 99.5. Further review revealed droplet isolation was discontinued on [DATE], the resident did not have any fever, and there was no evidence an oxygen level was obtained every shift per orders to monitor for respiratory infections (see above order). Review of progress note, dated [DATE] revealed Resident #2 was moved from the COVID-19 unit to a room on the F-hall (a non-COVID unit) with a roommate, Resident #1. Review of a change of condition assessment, dated [DATE] revealed Resident #2 had declined. He was not eating or taking medications. On [DATE] he had headache and nosebleed. Review of the infection control log for [DATE] revealed no evidence Resident #2 was included on the log for any type of infection or related to COVID-19. Interview on [DATE] at 8:06 A.M. and 1:22 P.M., with the Medical Director (MD), who was also Resident #2's physician revealed any change of condition warranted testing for COVID-19. The MD stated he was not aware STNA #10 had worked on the COVID unit and possibly provided care to Resident #2. He was not aware Resident #2 had a temperature greater than 99 degrees (as noted above) nor had this been reported/communicated to him. The MD reported himself and his Nurse Practitioner had told staff repeatedly they wanted notified of any resident having a temperature greater than 99 degrees. He stated he had also asked the facility to discontinue all Tylenol orders and told staff they would need to call for approval to give Tylenol. During the interview, the MD revealed it would be his expectation that all residents on A hall should have been quarantined an additional 14 days after exposure to STNA #10 who tested positive for COVID-19. The MD revealed Resident #2 should have been tested for COVID-19 and he regretted he did not order a test. During the interview, the MD revealed the local health department (LHD) had contacted him with concerns they had regarding this resident and another resident because both residents had symptoms of COVID-19 and were not tested and then subsequently expired. The MD stated he did not feel comfortable changing death certificates at this time without these resident ' s having actual COVID-19 positive test results. The MD again verified no COVID test had been completed for Resident #2. On [DATE] at 9:38 A.M. interview with the DON revealed STNA #10 had worked on the second floor on [DATE]. Following the identification of STNA #10 testing positive, there was no facility investigation/contact tracing completed to determine which residents or staff STNA #10 had direct contact with on the second floor to implement infection control measures to prevent the spread of COVID-19. Interview on [DATE] at 9:09 A.M., 11:52 A.M. and 1:10 P.M. with the Director of Nursing (DON) revealed after reviewing Resident #2's medical record with the MD it was determined Resident #2 should have been tested for COVID. The DON verified the resident had a temperature (as noted above) and verified his oxygen level was only checked once in [DATE] on [DATE]. The DON reported the oxygen levels should have been checked daily and documented on the treatment records. The DON verified the resident's temperatures were not reported to the physician, nor was there documented evidence to support notification. She had spoken to the MD and he wanted all low-grade temperatures checked for COVID moving forward. The DON verified STNA #10 had also worked midnight shift on the COVID unit [DATE] into the morning of [DATE] at which time he left and went to the emergency room due to being ill. The DON stated STNA #10 had originally self-reported his COVID-19 test was negative, but she later received a call from the local health department notifying her the STNA had tested positive for COVID-19. The DON revealed she did not investigate to see who the STNA had been in contact with (resident or staff wise) and just implemented every two-hour temperature checks per the nurse practitioners orders. During the interview, the DON also confirmed Resident #2 was not included on the infection control log and should have been based on his re-admission on [DATE] and symptoms. Interview on [DATE] at 3:02 P.M., with STNA #10 revealed on [DATE] he worked part of the shift on the second floor (C and D units/non-COVID units) then he went to the COVID A unit and worked until around 2:00 A.M., when his temperature spiked to 101.2. He stated he had told the facility he had been running a temperature (,[DATE].6) for the last two days prior to his shift and the scheduler told him to come to work, if his temperature was under 100.4 degrees, he could work. The STNA stated he had just recently returned from a vacation as well. The STNA revealed on [DATE] before leaving for work his temperature was 100 degrees and when he got to work it was 98.6. The STNA revealed around 2:00 A.M. his temperature was up to 101.2 degrees. The supervisor sent him home and he went to the local emergency room . He stated

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On the COVID unit staff were required to wear a paper mask, gown, gloves, and eye wear except for when caring for a COVID positive resident which would require a face shield in addition to the other PPE. 2. Record review revealed Resident #1 was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. Review of Resident #1's orders, for [DATE] revealed to monitor for signs and symptoms of respiratory infections (fever, cough, shortness of breath, fatigue, muscle and body aches, headaches, new loss of taste or smell, congestion, runny nose, sore throat, nausea, vomiting, diarrhea, and low oxygen saturation). Notify physician if new signs and symptoms every shift, if new signs or symptoms present document in the progress notes and notify physician. Review of Resident #1's medication and treatment records dated July, 2020 indicated the resident had no respiratory signs and symptoms (fever or headaches) except on [DATE], however the progress notes indicated he had complaints of headaches on [DATE]. Review of Resident #1's temperature dated [DATE] to [DATE] revealed on [DATE] the resident's temperature was 99.4 and 99.3, [DATE]- 99.1, [DATE]- 99.0 and 99.3, [DATE]- 99.1 and 99.1, [DATE]- 99.5, [DATE]- 99.0, 99.0. 99.0, [DATE]- 99.3, 99.3, 99.7, [DATE] -99.4, 99.1, 99.4, 99.4, 99.1 and [DATE]- 99.0. Review of Resident #1's progress notes dated [DATE] revealed the resident had complaints of shoulder pain. An x-ray was ordered of the shoulder and it was negative. On [DATE] the resident was not able to feed himself due to the shoulder pain. On [DATE] the resident was tested for COVID-19 due to low grade fever and complaints of headache. On [DATE] chest x-ray showed pneumonia and the resident was ordered antibiotics. There was no evidence the physician was notified of low-grade temperatures from [DATE] until [DATE]. There was no evidence the resident was on any type of isolation until [DATE] when his test results returned. Review of the facility undated investigation for Resident #1 revealed the resident resided on the third floor and had no roommate. On [DATE] the resident had a low-grade temperature of 99.3 and complaints of a headache. The resident was moved to the COVID unit (A-hall). The investigation revealed three STNA's were going to be sent for COVID testing because they had worked with Resident #1. However, there was no evidence which staff were interviewed or which staff provided care to Resident #1. Review of the infection control log dated ,[DATE] revealed Resident #1 had headache and a temperature. He was put on droplet isolation precautions on [DATE]. However, the log failed to contain documentation of the resident being tested for COVID or the results. Interview on [DATE] at 11:12 A.M., with the Director of Nursing (DON) revealed Resident #1 required two staff assistance for activities of daily living. The DON also confirmed the resident had not left his room except occasionally he would go out the nurse's station. During the interview, the DON revealed STNA #11 who tested positive for COVID on [DATE] (last worked on [DATE]) worked on the third floor (where Resident #1 resided). The DON also stated Resident #1 did have a roommate, Resident #2 who expired on [DATE]. During the interview, the DON revealed the facility had not determined how Resident #1 had contracted COVID-19 while residing in the facility. Interview on [DATE] at 8:06 A.M. and 1:22 P.M., with the Medical Director (MD), who was also Resident #1's physician revealed it was unknown where Resident #1 contacted COVID-19. It could have possibility been from his roommate, Resident #2 or the STNA who tested positive who worked on the same floor. The MD indicated he would need to work with the facility to update the policies and procedures. 3. Interview on [DATE] at 12:29 P.M. with the DON revealed the list of suspected cases and the COVID-19 testing log provided to the surveyor to review was inaccurate. There were six residents (#5, #6, #7, #8, #9 and #10) not on the log/list who should have been. Also, information was also not correct related to the number of staff on quarantine after being exposed to Resident #1. On Monday [DATE] the DON revealed she had two staff come forward and report they had direct contact with Resident #1 and the facility put these two staff members on quarantine due to their age and being high risk for COVID-19. Interview on [DATE] at 2:29 P.M., with Certified Nurse Practitioner (CNP) revealed she had concerns with the facility not using dedicated staff or wearing PPE appropriately on the COVID unit, however it had improved since a resident had tested positive. The CNP also revealed staff had been leaving the COVID unit and coming out to the nurse ' s station to type and they were not using N95 masks. She was not aware residents were not being tested for COVID before admission to the facility. She had thought Resident #2 had been tested already. She was not notified Resident #2 had a temperature and he should have been tested . She had recommended hospice services for Resident #2 due to the facility reporting he was declining. Residents with a temperature over 99 should be tested as well as anyone being discharged from the COVID unit. She stated the residents should have been quarantined after being exposed to the positive staff members. The CNP stated this weekend she started pulling the temperature logs up from home and noticed there was a few residents with temperatures greater than 99 so she called the facility and testing was ordered on those residents. She had told the DON the unit manager should be checking the temperatures logs daily and reporting anything over 99. The CNP revealed two or three week ago the MD and herself discontinued all the as needed Tylenol due to staff administering Tylenol for temperatures and not notifying them of the temperatures. She stated she had spoke to the DON and volunteered to help the facility develop new policies and procedures. Review of the facilities Coronavirus Surveillance policy dated [DATE] revealed residents would be monitored for signs and symptoms of coronavirus illness: fever, cough, shortness of breath. The physician would be notified immediately, if evident. Staff shall follow established procedures when COVID-19 is suspected. Considerations for managing residents with suspected or confirmed COVID-19 infection. Test for COVID-19 in accordance with current CDC guidelines, collaborate with local health department. Increase monitoring of all residents when COVID-19 is suspected or confirmed. Review of the facility policy from the American Health Care Association Steps to Limit COVID-19 Spread and Outbreaks in Long Term Care dated [DATE] revealed: Implement physical distancing among your staff and use source control mask (source control mask that can include cloth mask are not the same as surgical masks or N-95 and not a substitute for the use in transmission-based precautions during care.) at all time for all people in the building. Ensure symptom checks for all residents and staff. Consider checking residents for symptoms or respiratory illness and fever two or three times daily and track monitoring steps. Limit the number of different staff going into each resident ' s room and increase efficiency of tasks performed. Implement protocols for cohorting ill residents with dedicated staff. Assign staff to specific residents, and only those residents. Implement, or increase if already in place, transmission-based precautions. Staff wear all recommended PPE (gown, gloves, eye protection, N-95 or facial masks for all resident, regardless of presence of symptoms. If a resident leaves their room require them to wear a facemask, perform hand hygiene, limit movement in the facility, and use social distancing. Isolation for all residents. Review of the facility COVID-19 memo, dated [DATE] revealed a screening test should be run before running a COVID-19 test per the Corporate Medical Director. Also contact your medical director for any additional guidance specific to your facility. PPE for staff for COVID-19 positive or suspected cases include respirator or face mask, gown, gloves, and eye protection. Refer to links attached for CDC recommendations. Guidelines for staff include to stay home if you are sick. Monitoring for residents include increase monitoring to every four hours if a positive case in noted in the facility and complete a set a vital signs and respiratory assessment every ,[DATE] hours. Review of the CDC guidelines for older adults dated [DATE] revealed people at any age with, [MEDICAL CONDITIONS] and serious heart condition were at an increased risk for COVID-19. Symptoms may appear ,[DATE] days after exposure. In older adults ([AGE] years and older), normal body temperatures can be lower than in younger adults. If an older adult experiencing fever or other symptoms (headaches, fatigue, sore throat, nausea, vomiting, diarrhea, or new loss of taste or smell) and wanted to get tested , they should call their healthcare provider. If caring for a patient aged 65 or older, be aware that a single reading higher than 100.0 degrees F, multiple readings above 99 F, or rise in temperature greater than two degrees F above the patient's normal (baseline) temperature may be sign of infection. Further review of CDC guidelines revealed if you had close contact (six feet for greater than 15 minutes, direct contact (touching, hugged, or kissed) with a positive person the patient should quarantine for 14 days after the last contact day with the person. Review of the CDC health care personnel (HCP) who worked with symptoms consistent with COVID-19 or in the 48 hours prior to symptom onset revealed: Prioritize these HCP for [DIAGNOSES REDACTED]-CoV-2 testing. Exclude HCP with COVID-19 from work until they have met all return to work criteria. Determine which residents received direct care from and which HCP had unprotected exposure to HCP who worked with symptoms consistent with COVID-19 or in the 48 hours prior to symptom onset. Residents who were cared for by these HCP should be restricted to their room and be cared for using all recommended COVID-19 PPE until results of HCP COVID-19 testing are known. If the HCP is diagnosed with [REDACTED]. Exposed HCP should be assessed for risk and need for work exclusions. If testing is available,

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 3) asymptomatic residents and HCP who were exposed to HCP with COVID-19 should be considered for testing (see information on testing below). If testing identifies infections among additional HCP, further evaluation for infections among residents and HCP exposed to those individuals should be performed as described above. Review of the CDC residents with new-onset suspected or confirmed COVID-19 revealed: Ensure the resident is isolated and cared for using all recommend COVID-19 PPE. Place the resident in a single room if possible pending results of [DIAGNOSES REDACTED]-CoV-2 testing. Cohorting residents on the same unit based on symptoms alone could result in inadvertent mix