STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295017	A. BUILDING _____ B. WING _____	04/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HORIZON HEALTH AND REHABILITATION CENTER	660 DESERT LN LAS VEGAS, NV 89106

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** Based on observation, interview, record review, and document review, the facility failed to ensure a safe and sanitary environment was maintained and residents were assessed in order to prevent the spread of communicable disease, specifically not following policies, processes or guidelines related to the novel coronavirus (COVID-19) for 17 of 18 sampled residents (Resident #'s 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 16, 17 and 18). Findings include: A facility policy titled Infection Control Prevention and Control Policies and Procedures, dated ,[DATE] with reference to CDC (Center for Disease Control) documented: a) If possible, do not place patients/residents with epidemiologically significant organisms with patients/residents who are immunocompromised, have wounds, or invasive devices. Droplet lsolation: b) Patient/Resident Placement Place the patient/resident in a private room, if possible. When a private room is not available, place the patient/resident in a room with a patient(s)/resident(s) who has active infection with the same microorganism but with no other infection (cohorting). When a private room is not available and cohorting is not achievable, maintain spatial separation of at least 3 feet between the infected patient/resident and other patients/residents and visitors. Wear a mask when working within 3 feet of the patient/resident. The facility policy titled Isolation Precautions Including Standard/Universal Precautions dated [DATE], documented the transmission-based precautions would be applied based on the epidemiology of the infectious disease syndrome. The policy indicated gloves should be changed between task and procedure on the same resident after having contact with contaminated materials. The policy documented non-critical equipment should be disinfected after being used. The policy revealed the appropriate placement of the resident was a significant component of the infection control program. When possible, residents with highly transmissible disease should be placed in a private room. CDC Guidelines documented facilities should consider implementing a respiratory protection program that is compliant with the Occupational Safety and Health Administration (OSHA) respiratory protection standard for employees if not already in place. The program should include medical evaluations, training, and fit testing. Additionally, the guidelines indicated as a measure to limit HCP exposure and to conserve Personal Protective Equipment (PPE), facilities could consider designating entire units within the facility, with dedicated HCP, to care for patients with known or suspected COVID-19. Dedicated means that HCP are assigned to care only for these patients during their shift. The Centers for Medicare and Medicaid Services (CMS) document titled COVID-19 Long-Term Care Facility Guidance dated [DATE], documented the Nursing Homes should immediately ensure compliance with all CMS and the Centers for Disease Control and Prevention (CDC) guidance related to infection control. In accordance with previous CDC guidance, every resident should be assessed for symptoms and have their temperature checked every day. The Guidance indicated the facilities should separate residents who have COVID-19 from patients and residents who do not, or have an unknown status, and implement consistent assignment, or have separate staffing to provide care for COVID-19-positive and COVID-19-negative patients. The U.S Department of Labor Guidance on Preparing Workplaces for COVID-19 dated [DATE], and provided by the facility, revealed employees were obligated to provide their workers with PPE needed to keep them safe while performing their duties. The guidance documented workers including those employees who worked within 6 feet of positive or suspected of being infected with COVID-19 residents, needed to use N-95 respirators or better approved by the National Institute for Occupational Safety and Health (NIOSH) under a respiratory protection program that included fit-testing, training and medical exam. Safe Environment- Resident assessment: Resident #6 (R6) R6 was admitted on [DATE], with [DIAGNOSES REDACTED]. R6's room was in the upper section of the 59A - 63B Hallway, close to the Resident Care Manager's (RCM) office and the Nurse's station. Nurses Progress Notes dated [DATE], documented R6 had a temperature of 100.3 degrees Fahrenheit with coughing and sneezing. The Vitals Report revealed R6's temperature on [DATE] was 98.9 degrees Fahrenheit (F). The medical record lacked documented evidence the resident's temperature levels were checked from [DATE] through [DATE]. There were no vital signs documented for blood pressure, pulse, respiratory rate nor Oxygen saturation levels for the resident. The resident had not been placed on isolation precautions. Nurses progress notes dated [DATE], documented R6's lips were purple, had difficulty breathing with a 91% Oxygen saturation on two liters of Oxygen via nasal cannula. The resident was transferred to an acute care hospital for [MEDICAL CONDITION] and was admitted to the Intensive Care Unit. Notification received from the Administrator dated [DATE], revealed R6 tested positive for the novel coronavirus (COVID-19). R6 expired on [DATE] at the hospital. Resident #8 (R8) (Roommate of R6) R8 was admitted on [DATE] and readmitted on [DATE], with [DIAGNOSES REDACTED]. R8's room was in the upper section of the 59A - 63B Hallway, close to the RCM's office and the Nurse's station. The medical record lacked documented evidence R8 was transferred to a dedicated quarantine area in the facility for a possible COVID-19 exposure, after the facility was informed R8's roommate had tested positive for COVID-19. R8 was placed on isolation in the same room on the same unit with other residents with no known exposure to [MEDICAL CONDITION]. No dedicated staff were assigned to this area. A Nurse's Progress Note dated [DATE], revealed R8 was on contact isolation as of [DATE]. The resident was not demonstrating signs and symptoms of fever, cough, loss of appetite or shortness of breath. A Physician order [REDACTED]. A Nurse's Progress Note dated [DATE], revealed R8 remained on isolation and remained asymptomatic. A Physician order [REDACTED]. On [DATE] at 3:08 PM, R8 was in bed inside the room. There were no signs posted outside the resident's room or anywhere near the resident's room to indicate R8 was on droplet precautions. On [DATE] at 3:36 PM, the Infection Preventionist indicated R8 was not on isolation due to not showing any symptoms for the past 72 hours. Isolation had been discontinued for the resident. The Infection Preventionist confirmed being aware R8's roommate had tested positive for COVID-19. The Infection Preventionist indicated R8 did not need to be quarantined in a separate area in the facility because R8 remained on isolation in their own room. R8 had remained in the same unit with other residents who had not been known to have been exposed to [MEDICAL CONDITION] and without dedicated staff members. The Infection Preventionist indicated not being aware of the physician order [REDACTED]. A Microbiology Result dated [DATE], documented R8 was tested on [DATE]. R8 tested positive for COVID-19. Resident #9 (R9) R9 was admitted on [DATE] and readmitted on [DATE], with [DIAGNOSES REDACTED]. R9's room was in the middle section of the 53A - 58B Hallway. A Nurse's Progress Note dated [DATE] at 7:34 PM, documented R9 had a temperature of 101.7 degrees F. A physician order [REDACTED]. A Physician Assistant's Note dated [DATE], documented given the COVID-19 pandemic, the resident was examined from the door, a nurse was at the bedside. A Nurse's Progress Note dated [DATE], documented R9 had a urine infection and pneumonia and would be started on antibiotics. Physician Notes dated [DATE] - [DATE], documented given the COVID-19 pandemic, the resident was examined from the door. A Nurse's Progress Note dated [DATE], documented R9 was started on intravenous [MEDICATION NAME] antibiotic for a urinary tract infection. A Nurse's Progress Note dated [DATE], late entry on [DATE], revealed R9 was placed in a single room for an active infection, symptomatic as manifested by fever, increased work of breathing and required Oxygen at four liters. Nurse's Progress Notes on [DATE], documented R9 had increased work of breathing, respiratory rate was 28 breaths per minute, on Oxygen at five liters, oxygen saturation of 84%, and was afebrile. R9 was transferred to the acute care hospital and admitted to the Intensive Care Unit. A Physician order [REDACTED]. Notification was received from the Administrator dated [DATE], revealed the resident tested positive for COVID-19. Resident #10 (R10) (Roommate of R9) R10 was admitted on

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) [DATE] and readmitted on [DATE], with [DIAGNOSES REDACTED]. R10's room was in the middle section of the 53A - 58B Hallway. A Nurse's Progress Note dated [DATE], late entry on [DATE] documented R10 was on isolation for observation and monitoring secondary to exposure to respiratory symptoms. The resident would be monitored for changes in oxygen saturation, temperature, changes in appetite, bowel regime and nausea. The medical record lacked documented evidence R10 was transferred to a dedicated quarantine area in the facility for a possible COVID-19 exposure. R10 was placed on isolation in the same room on the same unit with other residents with no known exposure to [MEDICAL CONDITION]. No dedicated staff were assigned to this area. A Physician order [REDACTED]. A Nurse's Progress Note dated [DATE], documented a physician order [REDACTED]. The test kit was scheduled to arrive on [DATE]. A Physician order [REDACTED]. A Physician Assistant Note dated [DATE], documented a COVID-19 test was ordered to rule out the infection secondary to R10 having been exposed to a roommate who had tested positive for COVID-19. The resident was examined from the door because no personal protective equipment was available. A Nurse's Progress Note dated [DATE], documented laboratory results received which detected COVID-19. A Physician order [REDACTED]. Resident #11 (R11) R11 was admitted on [DATE], with [DIAGNOSES REDACTED]. R11's room was in the lower section of the 31A - 36B Hallway, close to the Administrator's office and the Rehabilitation Department. The Vitals Report revealed R11's Oxygen saturation levels: [DATE] - 88% on room air [DATE]- 89% on room air The medical record lacked documented evidence the Certified Nursing Assistant reported R11's Oxygen saturation levels to the nurse or the physician was notified. A Nurse Progress Notes dated [DATE] at 7:00 AM, documented R11's Oxygen saturation was 76% at room air. The resident was given Oxygen via nasal canula and the physician was notified. The resident was placed on six liters of Oxygen and saturation level went up to 92%. A Nurse Progress Note dated [DATE] at 11:55 AM, documented the physician saw the resident who was on four liters of Oxygen with an oxygen saturation level of 85%. The physician ordered to send the resident to the acute care hospital. A Physician order [REDACTED]. A Nurse Progress Note dated [DATE], documented the resident was admitted to the Intensive Care Unit at the acute care hospital. Notification was received from the Administrator dated [DATE], revealed R11 tested positive for COVID-19 virus. Resident #16 (R16) (Roommate of R11) R16 was admitted on [DATE] and readmitted on [DATE], with [DIAGNOSES REDACTED]. R16's room was in the lower section of the 31A - 36B Hallway, close to the Administrator's office and the Rehabilitation Department. The medical record lacked documented evidence R16 was transferred to a dedicated quarantine unit due to possible exposure after R16's roommate had tested positive for COVID-19. R16 remained in isolation in the same room, on the same unit with other residents not known to have been exposed to the COVID-19 virus. No dedicated staff were assigned to this area. Resident #13 (R13) R13 was admitted on [DATE], with [DIAGNOSES REDACTED]. R13's room was in the upper section of the 59A - 63B Hallway, close to the RCM office. A Nurse's Progress Note dated [DATE], documented R13 had an elevated temperature of 100.6 F, was hypoxic and had altered mental status. The medical record lacked documented evidence R13 was transferred to a dedicated quarantine area. A Physician order [REDACTED]. A Microbiology Results Report dated [DATE], revealed COVID-19 was detected for R13. Resident #17 (R17) (Roommate of R13) R17 was admitted on [DATE] and readmitted on [DATE], with [DIAGNOSES REDACTED]. R17's room was in the upper section of the 59A - 63B Hallway, close to the RCM office. The medical record lacked documented evidence R17 was quarantined in another area in the facility after a possible exposure to COVID-19, when R17's roommate had tested positive for [MEDICAL CONDITION] on [DATE]. R17 remained on isolation in the same room, in the same unit with other residents not known to have been exposed to the COVIE-19 virus. No dedicated staff were assigned to this area. Resident #14 (R14) R14 was admitted on [DATE] and readmitted on [DATE], with [DIAGNOSES REDACTED]. R14's room was in the upper section of the 48A - 52B Hallway. A Nurse's Progress Note dated [DATE], documented the nurse would continue to monitor the resident's temperature. Last noted temperature was 99.0 F. The medical record lacked documented evidence R14 was transferred to a dedicated quarantine area. A Nurse's Progress Note dated [DATE] at 6:27 PM, revealed R14's temperature was 100.6 F and the nurse practitioner ordered to send the resident to the acute hospital. A Physician order [REDACTED]. A Microbiology Results Report received [DATE], revealed COVID-19 was detected for R14. Resident #18 (R18) (Roommate of R14) R18 was admitted on [DATE], with [DIAGNOSES REDACTED]. R18's room was in the upper section of the 48A - 52B Hallway. A Nurse's Progress Note dated [DATE], documented R18 was on contact isolation. The medical record lacked documented evidence R18 was quarantined in another area of the facility after a possible exposure to COVID-19, when R18's roommate had shown signs and symptoms of [MEDICAL CONDITION] and was sent to the acute care hospital. R18 remained isolated in the same room, on the same unit with other residents not known to have been exposed to [MEDICAL CONDITION]. No dedicated staff were assigned to this area. On [DATE] at 11:00 AM, the Administrator, Director of Nursing (DON) and Infection Preventionist indicated the residents (R8, R10, R16, R17 and R18) who have had possible exposure to COVID-19 when their roommates tested positive for [MEDICAL CONDITION], did not need to be quarantined to another unit because these residents were isolated in their own room. The DON indicated there would be a greater risk of spreading [MEDICAL CONDITION] if these residents were transferred to one dedicated unit. Resident #12 (R12) R12 was admitted on [DATE], with [DIAGNOSES REDACTED]. R12's room was in the lower section of the 1A - 5B Hallway. A Physician Note dated [DATE], documented R12 had mild coughing and low-grade fever of 99.2 degrees F. Chest x-ray showed diffuse congestion right-sided infiltrate with no lobar consolidation. R12's oxygen saturation was 86%. The resident was started on intravenous fluids and antibiotics. A Physician order [REDACTED]. A Physician order [REDACTED]. The medical record lacked documented evidence R12 was transferred to a dedicated quarantine area. The resident had been wheeling self around the facility. A Nurse's Progress Note dated [DATE], documented R12 was transferred to the acute care hospital secondary to shortness of breath, labored breathing and oxygen saturation dropped to 60% while on five liters of Oxygen. A Physician Note dated [DATE], documented R12 was transferred to the Intensive Care Unit in the acute care hospital. A Microbiology Result Report dated [DATE], revealed COVID-19 was detected in R12. Resident #7 (R7) R7 was admitted on [DATE], with [DIAGNOSES REDACTED]. R7's room was in the middle of the 48A - 52B Hallway. A Nurse's Progress Note dated [DATE], documented R7 had a fever, temperature was 101.6 degrees F. Tylenol 650 milligrams was administered to R7. The medical record lacked documented evidence the resident's temperature level was rechecked after Tylenol was administered on [DATE] at 10:54 PM and the resident's temperature levels were monitored on [DATE] through [DATE]. The Vitals Report revealed on [DATE], R7's Oxygen saturation level was 91% on room air. The medical record lacked documented evidence the resident's Oxygen saturation level was checked on [DATE] through [DATE]. The medical record lacked documented evidence R7 was transferred to a dedicated quarantine area with dedicated staffing. A Nurse's Progress Note dated [DATE], documented R7 was transferred to the acute care hospital due to Oxygen saturation of 88% on room air, 90% on two liters of Oxygen per nasal cannula. A Microbiology Result received from the hospital on [DATE], revealed R7 tested positive for COVID-19 on [DATE]. Resident #1 (R1) R1 was admitted on [DATE], with [DIAGNOSES REDACTED]. R1 resided in room [ROOM NUMBER]-A. Vitals report documented the following vitals: [DATE] at 12:12 AM: Temperature (T)-100 degrees F, no O2 Saturation (Sat) documented. [DATE] at 12:24 PM: 98.9 F, no O2 Sat. The medical record lacked documented evidence R1 was transferred to a dedicated quarantine area with dedicated staff members. A nursing progress note dated [DATE] at 7:14 PM, revealed R1 was vomiting at 11:00 AM. The note indicated the resident did not complain of pain, shortness of breath or distress. Vitals signs documented temperature 98.1 degrees F. The note revealed the [MEDICAL TREATMENT] center was notified about the resident's conditions and the center requested to cancel the [MEDICAL TREATMENT]. A nursing progress note dated [DATE] at 3:21 PM, revealed the [MEDICAL TREATMENT] center called the facility to report R1 had temperature of 100.4 degrees F and was returned to the facility with recommendation from the nephrologist to send the resident to the Emergency Department. Resident #2 (R2) R2 was originally admitted on [DATE] and re-admitted on [DATE], with [DIAGNOSES REDACTED]. R2 resided in room [ROOM NUMBER]-B Vitals report documented the following vitals signs: [DATE] at 1:34 PM: T- 99.6 degrees F. Pulse rate not documented, no O2 Sat recorded. [DATE] at 10:03 PM: T- 100.1 degrees F. [DATE] at 11:28 PM: T- 99.8 degrees F. O2 Sat 95 %. [DATE] at 8:24 PM: T- 100.4 degrees F. O2 Sat 94 %. [DATE] at 11:28 PM: T- 99.8 degrees F. O2 Sat 95 %. [DATE] at 5:28 AM: T- 106.5 degrees F. [DATE] at 6:21 AM: T- 100.1 degrees F. O2 Sat 95 % [DATE] at 9:15 AM: T- 99.8 degrees F. O2 Sat 97 % A nursing progress note dated [DATE] at 7: 52 PM, indicated R2's temperature was 100.4 degrees Farenheit and Tylenol was given by the [MEDICAL TREATMENT] facility due to fever at [MEDICAL TREATMENT]. A nursing progress note dated [DATE] at 5:28 AM, documented R2 had temperature of 106.5 degrees Farenheit. A nursing progress note dated [DATE] at 2:10 PM, indicated a report was given to an acute care facility regarding the transfer of R2 for COVID-19 test. The medical record lacked documented evidence R2 was transferred to a dedicated quarantine area with dedicated staff members. Resident # 3 (R3) R3 was admitted on [DATE], with [DIAGNOSES REDACTED]. R3 resided in room [ROOM NUMBER]-A. Vitals report documented the following vital signs: [DATE] at 1:43 PM, T- 100.8 degrees F. [DATE] at 8:43 AM: T- 100 degrees Farenheit, O2 Saturation (Sat) 83 % with oxygen (O2) at 2 liters per minute (lpm). [DATE] at 1:56 PM, T- 100 degrees Farenheit, O2 Sat 94

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) % with O2 at 4 lpm. [DATE] at 4:30 PM, T- 101.2 F, O2 Sat 97 % with O2 at 2 lpm. [DATE] at 3:41 PM, T- 100 degrees Farenheit, O2 Sat 81 % with 02 at 3 lpm. [DATE] at 3:50 PM, O2 Sat 81 % with O2 at 3 lpm. A nursing progress note dated [DATE] at 7:25 AM, revealed R3 had complained of elevated temperature at 102.4 F. At 9 :45 AM, the temperature was re-checked at 101.9 F. The attending physician was made aware. A Chest X-ray was ordered and the resident was placed in droplet isolation. The record revealed R3 was placed on [MEDICATION NAME] and [MEDICATION NAME] but the cough and fever progressed. The resident was treated at the facility until [DATE], when R3 developed [MEDICAL CONDITION] and was transferred to an acute care facility. The medical record lacked documented evidence R3 was transferred to a dedicated quarantine area with dedicated staff members. Resident #4 (R4) R4 was admitted on [DATE], with [DIAGNOSES REDACTED]. R4 resided in room [ROOM NUMBER]-B. Review of the vitals report from [DATE] through [DATE], revealed R4 did not complain of fever or respiratory symptoms until [DATE], when a spike in the temperature occurred (100 degrees F). On [DATE] at 1:42 PM, the vitals report documented R4 had an oxygen saturation of 85 % while receiving oxygen at 3 liters per minute. A progress note dated [DATE] at 3:13 AM, documented R4 had a temperature spike to 100 degrees F. The note indicated the attending physician was notified and ordered a chest X-ray and laboratory works. A progress note dated [DATE] at 1:00 PM, indicated a COVID sample was obtained. A progress note dated [DATE] a 4:18 PM, revealed new orders were obtained and oxygen was increased to 4 liters per minute with no distress or shortness of breath noted afterwards. The medical record lacked documented evidence R4 was transferred to a dedicated quarantine area with dedicated staff members. A progress note dated [DATE] at 2:12 AM, documented R4 was transferred to an acute care facility secondary to chest X-ray findings and oxygen saturation of ,[DATE] %. Resident #5 (R5) R5 was originally admitted on [DATE] and re-admitted on [DATE], with [DIAGNOSES REDACTED]. R5 resided in room [ROOM NUMBER]-A. A progress note dated [DATE] at 7:03 PM, revealed R5 was in droplet isolation with temperature of 98.2 degrees F and oxygen saturation of 98 % on room air. No shortness of breath identified. A progress note dated [DATE] at 8:52 AM, indicated R5 complained of a spike in temperature (101.1 degrees F). Attending Physician was notified and laboratory work ordered. A progress note dated [DATE] at 6:47 PM, indicated R5 temperature was 100.1 and Tylenol was administered. A chest X-ray was ordered. The medical record lacked documented evidence R5 was transferred to a dedicated quarantine area with dedicated staff members. On [DATE] at 11:15 AM, the DON indicated moving residents who have had a possible exposure to COVID-19 to another section in the facility had not been done. These residents were located throughout the facility in isolation. The residents were being monitored for signs and symptoms. The DON indicated moving the residents from one area to another area within the facility would essentially leave the previous rooms still contaminated. The DON indicated not having the ability to move the residents. When asked about the Centers for Disease Control and Prevention (CDC) and Centers for Medicare and Medicaid Services (CMS) recommendations to move residents suspected to have COVID-19 from exposure to their roommates to a separate unit within the facility, the DON stated, I could review it. On [DATE] at 3:25 PM, the Infection Preventionist indicated the facility decided not to move the residents into a separate area because they were isolated in their rooms. Isolation precautions would be discontinued for the residents when their roommate tested negative for COVID-19. If the results were still pending, the residents would be kept in isolation. If the roommate tested positive for COVID-19, then the residents would remain in isolation for 14 days and monitored for signs and symptoms of COVID-19. The Infection Preventionist indicated the guidelines from CDC and CMS were changing so often and they had not received any clear guidance on what to follow. The Infection Preventionist indicated it was not possible to assign dedicated staff to an isolated/quarantine unit because the facility did not have enough staff. The Infection Preventionist explained a lot of nursing staff had tested positive for COVID-19 and were symptomatic. The staff were not allowed to work, and the facility could not assign designated staff to a quarantine/isolation unit because they did not have enough staff to cover just one unit. Safe- Sanitary Environment, not following policy/process: - On [DATE] at 1:30 PM, an Environmental Services (EVS) worker was cleaning room [ROOM NUMBER]. The room had a sign for contact isolation and a cart at the door of the room contained clean personal protective equipment (PPE). The EVS worker was wearing gloves, mask and gown. The EVS worker came out of the isolation room four times to get supplies from the cleaning cart located outside the room. The EVS worker did not remove the contaminated PPE and did not perform hand hygiene after coming out of the room and touching clean supplies in the cart with the contaminated gloves. After finishing the clean-up, the EVS worker removed the contaminated PPE and discarded it into the cleaning cart's trash can. During the observation, it was noted the EVS worker touched the facial mask with the contaminated glove four times. On [DATE] at 1:45 PM, the EVS worker explained deep cleaning had been performed since the resident in room [ROOM NUMBER] was in isolation. The EVS worker was not aware the PPE had to be removed and hand hygiene performed every time the worker came out of the room and prior to touching the cleaning cart. The EVS worker indicated the face mask was big and fell down and needed to be adjusted, reason why the mask was touched several times. The EVS worker was not aware the contaminated PPE had to be discarded into the biohazard container located inside the isolation room. - On [DATE] at 1:55 PM, a Certified Nursing Assistant (CNA) removed the biohazard trash receptacle and the Personal Protective Equipment (PPE) cart from room [ROOM NUMBER]. The CNA placed the biohazard receptacle filled with contaminated trash over the PPE cart and moved it to the biohazard room. The CNA acknowledged it was not appropriate to place the biohazard trash receptacle over the PPE cart. The CNA indicated the biohazard trash receptacle and the PPE cart were removed since the resident verbalized the infection was over and the isolation was not needed. Review of the medical record for the resident in isolation in room [ROOM NUMBER] (Resident #15) revealed a physician order [REDACTED]. The record lacked documented evidence of a physician order [REDACTED]. On [DATE] at 2:00 PM, a Licensed Practical Nurse (LPN) confirmed R15 was in isolation due to a MDRO urinary tract infection. The LPN could not explain why the CNA removed the biohazard trash receptacle and the PPE cart. - On [DATE] at 2:10 PM, a CNA entered room [ROOM NUMBER] with a vital signs machine and obtained vital signs (temperature, pulse and blood pressure) from a resident in A bed (near the door). The CNA then proceeded to obtain vitals signs in room [ROOM NUMBER] to a resident in A bed. The CNA did not disinfect the vital sign machine between use with resident #15. The State Surveyor stopped the procedure before being performed. The CNA acknowledged the machine was not disinfected after being used with the first resident and indicated the vital signs machine should be cleaned once daily. On [DATE] at 2:15 PM, a LPN explained the vital sign machine should have been cleaned before and after use with a resident. - On [DATE] at 2:30 PM, a CNA came out from isolation room [ROOM NUMBER] and removed the PPE outside the room, rolled the contaminated gown and walked in the hallway looking for a trash can. The CNA touched her clothes with the contaminated EPP. On [DATE] at 12:48 PM, the Infection Control Nurse explained staff should remove the PPE prior to exiting an isolation room, perform hand hygiene and dispose the contaminated PPE in the biohazard receptacle located in the room. - On [DATE] around 2:45 PM, three CNAs and 2 LPNs were asked about the N-95 respirator fit test and the training. The staff members affirmed they had not performed the fit test and had not received specific training for the use of the respirator. On [DATE] at 9:15 AM, seven staff members including three CNAs, an Administrative Clerk, one EVS worker and two LPNs were wearing N-95 masks in the quarantine and the isolation unit. One EVS worker entered the Quarantine Unit wearing a regular face mask. The DON confirmed the fit test for the use of the N-95 respirators had not been performed. The CDC Guidelines documented the facilities should consider implementing a respiratory protection program that is compliant with the OSHA respiratory protection standard for employees if not already in place. The program should include medical evaluations, training, and fit testing. - On [DATE] at 8:50 AM in the quarantine area, vital sign equipment owned by a staff member were found on a table in the hallway. The equipment consisted of a pulse oximeter, a blood pressure cuff and a digital thermometer. In addition to the vital sign devices, two coffee mugs were located on the same table. A CNA confirmed the ownership of the vital signs devices and one of the coffee mugs. The CNA indicated the vital sign devices were used to obtain vital signs of the residents in quarantine. - On [DATE] at 9:00 AM, a bottle of soda and a bag with snacks was on a table located in the hallway of the area designated as a Quarantine area. An LPN confirmed the ownership of the soda and snack. - On [DATE] at 9:12 AM, a red biohazard bag was attached to a bed side rail in isolation room [ROOM NUMBER]. A resident was in the bed at the time of the observation. On [DATE] at 9:20 AM, the Director