STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065246	A. BUILDING _____ B. WING _____	06/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAUREL MANOR CARE CENTER, INC	920 S CHELTON RD COLORADO SPRINGS, CO 80910

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 0865 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Have a plan that describes the process for conducting QAPI and QAA activities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations and interviews, the facility failed to ensure an effective quality assurance program to identify and address facility compliance concerns was implemented, in order to facilitate improvement in the lives of nursing home residents, through continuous attention to quality of care, quality of life, and resident safety. Specifically, the quality assurance performance improvement (QAPI) program committee failed to identify and address concerns related to systemic failures and the root cause related to the COVID-19 outbreak, which resulted in immediate jeopardy. Cross-referenced to F880-Infection Prevention and Control. Findings include: I. Facility policy The Quality Assessment and Assurance/Quality Assurance Performance Improvement (QA&A/QAPI) Committee policy was provided by the director of nursing (DON) via email on 6/23/2020. It read in pertinent part, The QA&A/QAPI is highly organized and structured to find system failures. It is a systematic approach to fully understand the problem, its causes, and implications of a change. The utilization of policies and procedures on Root Cause Analysis (RCA) assists the PIP teams to identify the root cause and/or causal factors of a system failure. The learnings help prevent future events. When the root cause and/or causal factors are identified, PIP's can determine what improvement in process will prevent repeat events, lessen the prevalence of events, and build in a sustainability plan for the new process. This creates continual learning and a continuous improvement. II. Status of COVID-19 in the facility The first positive test results for COVID-19 at the facility were from a resident and a staff member on 3/17/2020 according to the director of nursing (DON) via email on 6/10/2020. She wrote that the facility was monitoring a total of eight residents and staff for COVID-19. Three residents tested positive for COVID-19 residing on wing 2, three residents and two staff members were under investigation for COVID-19. There were no pending test results as of 6/10/2020. The DON, in an interview on 6/9/2020 at 1:40 p.m., said that since the outbreak, the facility had 23 resident deaths but 15 of those deaths were presumptive for COVID-19; only eight of the deaths were confirmed positive for [MEDICAL CONDITION] through testing. The facility failed to implement expected and recommended infection control measures and active cases of COVID-19 had continued with serious adverse outcomes. The DON said that the outbreak was identified on 3/17/2020 on the memory care wing, which eventually spread to the other wings in the facility. She said the facility had designated wing 3 as the wing that would receive residents that tested positive for COVID-19 or were under suspicion, however, the County Health Department (CHD) told them not to move residents from wing to wing and instead to cohort on each wing. III. Immediate Jeopardy findings Observations and interviews revealed multiple failures in infection control which placed all residents as well as staff at continued risk for COVID-19. Observations revealed staff misused personal protective equipment (PPE), failed to follow proper hand hygiene practices, and improperly disinfected common use articles. In addition, the facility lacked an active screening process for staff. Furthermore, the facility failed to ensure the appropriate need for aerosolized treatment with Resident #1 who had active respiratory illness and/or ensured appropriate PPE and training to staff providing care during the aerosolized activity. These multiple failures created the likelihood that active cases of COVID-19 would continue in the facility, placing residents and staff at risk for serious adverse outcomes. IV. Staff interviews The nursing home administrator (NHA) and director of nursing (DON) were interviewed on 6/9/2020 at 1:40 p.m. The DON said that she did not feel she could stop the outbreak because it was like influenza (flu) and the flu could not be stopped from entering the building. She said she could not identify the ports of entry since she felt they were doing everything they could to contain it. She said when the audits were conducted throughout the building pertaining to hand hygiene, donning and doffing of PPE, no root cause of the continued outbreak was identified. She said if there was a break in infection control practices then education was provided at that time so the behavior was not continued. She said she did not have audits of increased monitoring during identified breaks in infection control practices other than the on the spot training that was conducted. The NHA said there was no way to keep COVID-19 out of the building because the outside community was highly affected. He said that he could not identify how to contain the outbreak any faster than how it was being done. The infection prevention and control nurse (IPCN) was interviewed on 6/11/2020 at 12:48 p.m. She said she discussed the infection control monitoring/surveillance and tracking information including identified trends to the QAPI meetings. She said she would provide the training on the spot if identified breaks in infection control practices were identified then increase the monitoring and continue tracking the identified break in practice. She said the interdisciplinary team (IDT) would do the root cause analysis to determine if it was an isolated incident or was it an ongoing issue then provide the training. She said they strove towards implementing long standing corrections. The infection prevention and control nurse (IPCN), the assistant director of nursing (ADON), the DON, the nursing home administrator (NHA) in-person and the medical director over the phone were interviewed on 6/10/2020 at 1:12 p.m. The medical director (MD) said that he spoke to the DON, ADON and NHA on a frequent basis. He felt the facility's team was doing well and practiced protocols and policies by the recommendations of the CHD, corporate and local teams. He said he worked with the IPCN and felt that she scrutinized practices and ensured protocols were being followed. He said he did a lot of work with policy and carrying it out. He said the facility was making sure what was being educated on was being demonstrated by the staff. He said there was ongoing education provided to staff and residents about hand hygiene and the use of ABHR. He said that the facility had not struggled during the outbreak and that the facility contained it as fast as they could. He said there was no way for the facility to contain [MEDICAL CONDITION] any faster than had been done. He said he attended the QAPI meetings monthly and had been in almost daily contact with the facility during the outbreak.
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 observations, record review and interviews, the facility failed to ensure infection control practices were established and maintained to provide a safe, sanitary and comfortable environment to help prevent the possible development and transmission of Coronavirus (COVID-19) and other communicable diseases and infections. The failure to properly use personal protective equipment (PPE), follow proper hand hygiene practices, follow an active screening process for staff, and follow proper disinfection processes created the likelihood of serious harm if not corrected, potentially affecting all residents in the facility. Cross-referenced to F865 (QAPI Program/Plan, Disclosure/Good Faith Attempt). Findings include: I. Status of COVID-19 in the facility The first positive test results for COVID-19 at the facility were from a resident and a staff member on 3/17/2020 according to the director of nursing (DON) via email on 6/10/2020. She wrote that the facility was monitoring a total of eight residents and staff for COVID-19; three residents tested positive for COVID-19 residing on wing 2, three residents (two residents resided on wing 4 and one on wing 2) and two staff members were under investigation for COVID-19. There were no pending test results as of 6/10/2020. The DON, in an interview on 6/9/2020 at 1:40 p.m., said that since the outbreak, the facility had 23 resident deaths but 15 of those deaths were presumptive for COVID-19; only eight of the deaths were confirmed positive for [MEDICAL CONDITION] through testing. The facility failed to implement expected and recommended infection control measures and active cases of COVID-19 have continued with serious adverse outcomes. The DON said that the outbreak was identified on 3/17/2020 on the Memory Care wing, which eventually

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) spread to the other wings in the facility. She said the facility had designated wing 3 as the wing that would receive residents that tested positive for COVID-19 or were under suspicion, however, the County Health Department (CHD) told them not to move residents from wing to wing and instead to cohort on each wing. II. Immediate Jeopardy A. Findings Observations and interviews revealed multiple failures in infection control which placed all residents as well as staff at continued risk for COVID-19. Observations revealed staff misused personal protective equipment (PPE), failed to follow proper hand hygiene practices, and improperly disinfected common use articles. In addition, the facility lacked an active screening process for staff. Furthermore, the facility failed to ensure the appropriate need for aerosolized treatment with Resident #1 who had active respiratory illness and/or ensure appropriate PPE and training to staff providing care during the aerosolized activity. These multiple failures made the likelihood that active cases of COVID-19 would continue in the facility, placing residents and staff at risk for serious adverse outcomes. On 6/10/2020 at 2:13 p.m., the nursing home administrator (NHA), director of nursing (DON), infection prevention and control nurse (IPCN) in-person, and the medical director of the facility over the phone notified of the immediate jeopardy under F880, infection prevention and control. B. Plan to remove immediate jeopardy On 6/11/2020 at 12:27 p.m., the director of nursing (DON) provided a plan to lift the immediate jeopardy. The plan read: Summary of Incident A federal COVID-19 focused survey was conducted at the facility in which observation of facility practice was completed. Observation of proper personal protective equipment (PPE) use, hand hygiene, universal face mask use by staff, staff screening, and disinfection processes was completed. Breaks in practice were identified. Proposed Removal Plan Resident(s) Identified The nurses responsible for Resident #1's care were re-educated on appropriate PPE use during aerosolized medication delivery. Other Residents with Potential to be Affected by the Immediate Jeopardy Incident - Upon notification of the immediate jeopardy, education was initiated immediately on June 10, 2020 for all staff as indicated above. All staff are required to complete the education outlined prior to their next shift. - All nurses have been re-educated on appropriate PPE use during aerosolized medication delivery according to the CDC guidelines. Education initiated June 10, 2020 evening shift and each nurse to receive the education prior to beginning their shift. Education included for staff to wear a face shield with nebulizer treatments and disinfect immediately after treatment. Medical Director gave guidance to FNP/MD to get nebulizer treatment changed to MDI (multi-dose inhaler). RN Supervisor received orders and changed Nebulizer treatment to an MDI. - All employees including activity employees have been re-educated in disposal of paper products after one-time resident use. Education initiated on June 10, 2020 evening shift and continue with education to employees prior to next shift. Education included paper products or non-cleanable items are to either remain in the resident's room or be discarded in the trash in resident's room. Non-reusable paper bingo cards and markers to remain in resident room provided to residents for bingo. Puzzles left in resident rooms. - All staff have been re-educated on laundry pick-up and delivery procedures and for donning and doffing PPE between resident units. Education initiated June 10, 2020 evening shift and continued with education to employees prior to the next shift. Education included no breaching of plastic wall barrier on 200 hall, laundry staff to obtain dirty linen barrels outside of units, disinfecting with EPA approved disinfectant following manufacturer's guidelines. Then laundry personnel bring disinfected sealed barrels around outside of the building through the front door straight to the right side of 200 Hall door, maintaining to the right side of the plastic barrier down to the soiled laundry room. After emptying barrel, disinfecting barrel with EPA approved disinfectant following manufacturer's guidelines, the laundry personnel will return the barrel using the same route in reverse. - All staff have been re-educated to perform hand hygiene if touching outside of mask, eye protection or gowns per CDC guidelines. All staff have been re-educated in performing hand hygiene, and hand hygiene with donning and doffing of PPE per CDC guidelines. Education initiated June 10, 2020 evening shift and continue with education to employees prior to next shift. Education included face shields, masks required in all areas. Gowns are required on 200 hall. Employees are to prevent breaking PPE barrier to reach for personal items in pockets, hand hygiene to be completed if PPE barrier breached. Masks to be worn per CDC guidelines, over the nose, under the chin and loops over ears. If touching mask, perform hand hygiene immediately. Disinfecting with EPA approved product per manufacturing guidelines for face shields. PPE to be removed prior to entering break room or leaving the building, and hand hygiene to be completed immediately. Return demonstration of proper PPE use, donning, doffing, and hand hygiene initiated. Face shields provided to all staff immediately June 10, 2020 for recommended PPE protection. - All staff have been re-educated on facility policy for disinfecting with EPA approved product per manufacturing guidelines for face shields/eye protection after use and prior to placing in designated paper bag and storage in facility per CDC recommendations. No PPE items including gowns or face shields to be taken home. Education initiated June 10, 2020 evening shift and continue with education to employees prior to next shift. - All nursing staff have been re-educated to provide or assist residents with hand hygiene per CDC guidelines prior to meals. Education included staff to assist resident up to the sink, if able and use soap and water washing for 20 seconds, rinsing, and drying with washcloth. If unable to get resident to sink, staff to provide warm wet washcloths with soap, warm wet washcloth for rinsing, and one dry one to dry. Instant hand sanitizer wipes are approved for use when available. Education initiated June 10, 2020 evening shift and continue with education to employees prior to next shift. - All residents will be encouraged and offered face protection during cares per CDC recommendations. Education initiated June 10, 2020 evening shift and continue with education to employees prior to next shift. Masks immediately provided to all residents. - All staff have been re-educated that no cloth masks will be worn by facility staff in resident care areas while surgical masks are available. Education initiated June 10, 2020 evening shift and continue with education to employees prior to next shift. - All staff have been re-educated CDC guidelines for proper use of wearing masks (medical surgical or respirators) while providing resident care. Education initiated June 10, 2020 evening shift and continue with education to employees prior to next shift. Education included having mask placed over the nose and below the chin looped around the ears. - No resident medical care equipment will be removed from resident room without proper cleaning and disinfection with EPA approved disinfectant per manufacturer guidelines. Staff will be re-educated in this process. Education initiated June 10, 2020 evening shift and continue with education to employees prior to next shift. - The facility has implemented an active screening process in which an employee will screen staff and visitors immediately upon arrival at facility at identified entrance for fever and signs and symptoms of COVID-19 and an EPA disinfectant per manufacturer guidelines will be used to disinfect the thermometer after each use. The screening tool has been updated to reflect current CDC guidance. Screening table immediately adjusted to control the screening environment. Table placed at an angle, 3 designated wait areas 6 feet apart established to maintain control of social distancing environment while screening staff for entrance. Screener to actively complete the screening form asking questions and obtaining temperature of individual entering. Screener to notify Supervisor immediately of any questionable entries per instructions of screening form. A screener will be available 24 hours a day 7 days a week as CDC recommendations. Education initiated June 10, 2020 evening shift and continue with education to employees prior to next shift. Notification of the Allegation of Immediate Jeopardy Upon notification of an immediate jeopardy, the facility notified the Medical Director of survey outcomes. The Medical Director has been actively involved in the removal plan. Immediate Changes to Facility Systems The facility reviewed and revised the following policies and procedures: - Entering and exiting of the COVID-19 unit/Laundry Process - Screening Process - Staff Hand Hygiene Process - Resident Hand Hygiene Process - Resident covering nose and mouth during cares (mask or tissue) - Equipment Sanitation Process and Resident Personal Item Use/Storage - Appropriate PPE use - The facility immediately provided education as identified above starting June 10, 2020 and will continue prior to employees' next shift. - The facility immediately implemented targeted audits for Infection Control Compliance. These audits will include hand hygiene, environmental infection control, donning/doffing PPE and use to address the process changes listed above. Review of audits to continue until change in trends noted. One set of audits completed on June 11, 2020. Audits to be conducted each shift every day until changes in trends noted, then randomly daily for a month until changes in trends noted, then three times a week for three months. Audits will continue until changes in trends noted. - The facility interdisciplinary team will review infection control practices identified by audits mentioned above daily until changes in trends noted, then weekly until noted changes in trends. Education Plan Upon notification of the immediate jeopardy, education was initiated immediately on June 10, 2020 for all staff as indicated above. All staff are required to complete the education outlined prior to their next shift. Interdisciplinary Team Review The removal plan was developed by the interdisciplinary team. Systemic and systematic revisions were completed, and education was provided to all staff of the facility as indicated above. Monitor removal plan outcomes - Facility leadership will complete daily review of monitoring audits for trends and potential system changes or education needs as indicated. These audits will include hand hygiene, environmental infection control, donning/doffing PPE and use. Review of audits to continue until change in trends noted. - The results of monitoring of the corrective actions will be reported to

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) Performance Excellence/QAPI Committee monthly for three months. Upon this review, system revisions and/or staff education will be implemented if indicated. C. Removal of immediate jeopardy On 6/11/2020 at 12:27 p.m., the DON was notified the immediate jeopardy was lifted based on observations and interviews that showed implementation of the facility's plan above. However, deficient practice remained at an F level scope and severity. III. Infection Control policies and procedures and professional references A. Screening The CDC Infection Prevention and Control Assessment Tool for Nursing Homes Preparing for COVID-19, retrieved from https://www.cdc.gov/coronavirus/2019-ncov/downloads/hcp/assessment-tool-nursing-homes.pdf (updated 5/8/2020), read in part, All healthcare personnel (HCP) should self-monitor when they are not at work and be actively screened upon entering the facility. Ideally, this would occur at the entrance to the facility, before they begin their shift. Screening includes temperature, heart rate, blood pressure, respiratory rate, pulse oximetry, changes in mental status, and any symptoms (cough, shortness of breath, difficulty breathing, fever, chills, rigors, myalgia, headache, sore throat, new olfactory (smell) and taste disorder(s); consider also rhinorrhea, diarrhea, nausea or vomiting). B. Hand hygiene 1. Facility policy The Infection Prevention and Control Manual policy, dated 2017, was provided by the DON via email. The policy read in part, Assume that every person is potentially infected or colonized with an organism that could be transmitted in the healthcare setting and apply the following infection control practices during the delivery of health care. Hand hygiene continues to be the primary means of preventing the transmission of infection. The Infection Prevention and Control Manual Interim Policy for Suspected or Confirmed Coronavirus (COVID-19), which was not dated, was provided by the DON via email. The policy read in part, Hand Hygiene using Alcohol Based Hand Sanitizer before and after all patient contact, contact with infectious material and before and after removal of PPE, including gloves. 2. References The CDC Guidance for Healthcare Providers about Hand Hygiene and COVID-19, retrieved from https://www.cdc.gov/coronavirus/2019-ncov/hcp/hand-hygiene.html (updated 5/17/2020), read in part, Hand hygiene is an important part of the U.S. response to the international emergence of COVID-19. [MEDICATION NAME] hand hygiene, which includes the use of alcohol-based hand rub (ABHR) or handwashing, is a simple yet effective way to prevent the spread of pathogens and infections in healthcare settings. CDC recommendations reflect this important role. Hand washing mechanically removes pathogens, and laboratory data demonstrate that ABHR formulations in the range of alcohol concentrations recommended by CDC, inactivate [DIAGNOSES REDACTED]-CoV-2. ABHR effectively reduces the number of pathogens that may be present on the hands of healthcare providers after brief interactions with patients or the care environment. C. Personal protective equipment 1. Facility policy The Infection Prevention and Control Manual Interim Policy for Suspected or Confirmed Coronavirus (COVID-19), which was not dated, was provided by the DON via email. The policy read in part, It is the policy of this facility to minimize exposures to respiratory pathogens and promptly identify residents with Clinical Features and an Epidemiologic Risk for the COVID-19 and to adhere to Federal and State/Local recommendations. All healthcare personnel will be correctly trained and capable of implementing infection control procedures and adhere to requirements. Ongoing, frequent monitoring for potential symptoms of respiratory infection as needed throughout the day for signs for both residents and employees. Cohort residents identified with the same symptoms/COVID-19 confirmation. 2. Professional reference The Centers for Disease Control and Prevention (CDC) Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings, retrieved from https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html (updated 5/19/2020), read in part, If worn properly, a facemask helps block respiratory secretions produced by the wearer from contaminating other persons and surfaces. Patients should be wearing their own cloth face covering, which should be worn while they are in the facility (if tolerated). Patients may remove their cloth face covering when in their rooms but should put them back on when leaving their room or when others enter the room. Health care personnel (HCP) should wear a facemask at all times while they are in the healthcare facility. They should also be instructed that if they must touch or adjust their facemask or cloth face covering they should perform hand hygiene immediately before and after. HCP must receive training on and demonstrate an understanding of when to use PPE, what PPE is necessary, how to properly don, use, and doff PPE in a manner to prevent self-contamination, how to properly dispose of or disinfect and maintain PPE, and the limitations of PPE. Any reusable PPE must be properly cleaned, decontaminated, and maintained after and between uses. Facilities should have policies and procedures describing a recommended sequence for safely donning and doffing PPE. The PPE recommended when caring for a patient with known or suspected COVID-19 includes: respirator or facemask (cloth face coverings are not PPE and should not be worn for the care of patients with known or suspected COVID-19 or other situations where a respirator or facemask is warranted); eye protection (reusable eye protection must be cleaned and disinfected according to manufacturer's instructions prior to re-use); gloves (remove and discard gloves when leaving the patient room or care area, and immediately perform hand hygiene); gowns (disposable gowns should be discarded after each use; cloth gowns should be laundered after each use). D. Disinfecting equipment and other multi-use items 1. Facility policy The Infection Prevention and Control Manual Interim Policy for Suspected or Confirmed Coronavirus (COVID-19), which was not dated, was provided by the DON via email. The policy read in part, Dedicated or disposable patient-care equipment should be used. If equipment must be used for more than one resident, it will be cleaned and disinfected before use on another resident, according to manufacturer's recommendations using EPA-registered disinfectants against COVID-19. 2. Professional Reference The Colorado Department of Public Health and Environment (CDPHE) COVID-19 Preparation and Rapid Response: Checklist for Long-Term Care Facilities (LTCFs), retrieved from https://drive.google.com/file/d/1ej-1kbX20euOGJHkcgO5zJb1TTD1Lf87/view (updated 5/13/2020). It read in part, Ensure that all non-dedicated, non-disposable resident care equipment is cleaned and disinfected according to manufacturer's instructions after each use (e.g., thermometers, pulse ox, blood pressure cuffs, resident lifts) prior to use on additional residents. Use an environmental protection agency (EPA) registered hospital-grade disinfectant to frequently clean high-touch surfaces and shared resident care equipment in addition to routine environmental cleaning. Refer to the EPA website for a complete list of approved disinfectants with an emerging [MEDICAL CONDITION] pathogen claim: https://www.epa.gov/pesticide-registration/list- n-disinfectants-use-against-[DIAGNOSES REDACTED]-cov-2. Validate environmental services staff members processes: (1) Follow label instructions on the hospital grade disinfectant; (2) Validate disinfection policies and procedures (e.g., cleaning from clean to dirty, changing gloves and performing hand hygiene between rooms and between resident surfaces within the same room). E. Aerosol generating procedures Professional reference Centers for Disease Control and Prevention, 1. Recommended routine infection prevention and control (IPC) practices during the COVID-19 pandemic, (retrieved from website on 6/22/2020), last updated April 12, 2020, https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html. It reads in pertinent part, Aerosol Generating Procedures (AGPs): Some procedures performed on patients with suspected or confirmed [DIAGNOSES REDACTED]-CoV-2 infection could generate infectious aerosols. Procedures that pose such risk should be performed cautiously and avoided if possible. If performed, the following should occur: HCP (healthcare personnel) in the room should wear an N95 or equivalent or higher-level respirator, eye protection, gloves, and a gown. The number of HCP present during the procedure should be limited to only those essential for patient care and procedure support. Visitors should not be present for the procedure. AGPs should ideally take place in an AIIR (airborne infection isolation rooms). Clean and disinfect procedure room surfaces promptly as described in the section on environmental infection control below. IV. Failures in infection control - staff screening - potential to affect the entire facility Observations and interviews revealed, contrary to facility policies and professional references above, the facility's failure to follow an active screening process to screen staff for signs and symptoms related to COVID-19. This failure created the likelihood of serious harm affecting all residents in the facility if not immediately corrected. A. Record review Visitor and employee screening forms were provided for 6/8/2020 by the facility. Of the 50 screening forms provided, nine lacked either an employee name, documented temperature, and/or screener signature. Visitor and employee screening form were provided for 6/9/2020 by the facility. Of the 62 screening forms provided, 12 forms lacked a name, documented temperature, and/or screener signature. Visitor and employee screening for were provided for 6/10/2020 by the facility. Of the 46 screening forms provided, four lacked a name, temperature, and/or screener signature. B. Observations 1. 6/9/2020 At 1:40 p.m., the door to the facility was locked and signs posted read that the person visiting required screening and to push the doorbell for assistance. After pressing the doorbell, the screening person allowed the surveyor inside the building and indicated s/he was to stand next to the staff member being screened at the table, which would have placed the staff member and the surveyor within two feet of each other. The surveyor stood outside the door since there was nowhere to stand and maintain a distance of six feet. The screener sat behind the table doing the temperature readings with a laser thermometer. The maintenance services director (MSD) and a contract assistant entered the screening area by scanning the MSD's badge. They did not follow social distancing; the MSD sat in a chair behind the screener's table next to the wall and the assistant stood in the corner,

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 3) approximately four feet from the staff member being screened. Although the screener was present to perform screenings, staff being screened were observed filling out the screening questionnaire themselves. The screener neither asked the screening questions nor reviewed the staff's answers on the form. Review of screening form revealed it only asked questions about respiratory illness, and did not include any other possible symptoms of COVID-19. 2. 6/10/2020 At 4:40 a.m., upon the surveyors' arrival at the facility, registered nurse (RN) #1 answered the door and had the surveyors fill out the screening form. She took the surveyors' temperatures, putting the thermometer directly to the temple and running it across the forehead. She did not disinfect the thermometer between each use. At 4:50 a.m., laundry assistant (LA) #1 was observed self-screening at the entrance to the facility. She filled out a screening form, placed it in a box near the front of the screening table and entered the facility. No other staff member was present to screen her. LA #1 did not take her temperature at that time. At 5:09 a.m., Cook #1 arrived for work. She entered the building; she, too was not screened and her temperature was not taken. At 5:32 a.m., CNA #1 entered the facility and performed self-screening. She took her own temperature, filled out the screening form and then entered the facility. C. Interviews 1. The NHA and the DON were interviewed on 6/9/2020 at 2:18 p.m. The DON said the facility process was to screen everyone that entered the building. She said the screening person took staff members' temperatures and staff filled out the screening questionnaire. She said that everyone performed hand hygiene and wore a facemask before entering the facility. She said if staff had a cloth mask, they received a surgical mask before entering the building. The DON said that if anyone trying to enter the building was showing symptoms of COVID-19 or had any 'yes' answers to the screening questions, the screener was trained to contact a RN supervisor or the DON for further review, and the person would be denied access to the building. She said she thought the screening form had been updated to include symptoms beyond respiratory that had recently been identified as relating to possible COVID-19, such as gastrointestinal symptoms. The NHA said that the facility had been screening staff before it was mandated, based upon the recommendations of the corporate office. 2. LA #1 was interviewed on 6/10/2020 at 4:50 a.m. She said she was not screened by a staff member that morning (6/10/2020) when she came in around 3:00 a.m. (almost two hours prior to filling out the screening from), and said she usually screened herself when she arrived in the morning for her shifts. She said she would take her own temperature when she self- screened and said she had taken her temperature earlier when she arrived, but it was too dark so she came back to fill out the form when they turned the lights on in the front foyer. However, LA #1's wellness screening tool dated 6/10/2020 showed LA #1 filled out the tool at 5:00 a.m. There was no temperature documented on the form or signature from a screener. 3. Certified nurse aide (CNA) #1 was interviewed on 6/10/2020 at 12:27 p.m. She said at the time she came in the morning (5:30 a.m.), It can be hit or miss if anyone is actually at the screening table and she usually screened herself, as there was nobody within seeing distance at the screening table. She said she was the screener for staff when COVID-19 infections started back in March 2020, and said she did that for two weeks before anyone trained her or told her what she was supposed to be doing. She said she placed her screening form up front when she screened herself, and she was unsure if anyone reviewed them. She said the charge nurse was supposed to review them and follow up with 'yes' responses to any of the screening questions or with an elevated temperature. V. Infection control - multiple failures on wing 2 where COVID-19 residents resided - potential to affect the entire facility Observations and interviews revealed, contrary to per facility policies and professional references above, staff failed to properly use personal protective equipment (PPE), follow proper hand hygiene practices, and follow proper disinfection processes. These failures created the likelihood of serious harm affecting all residents in the facility if not immediately corrected. A. Wing 2 layout and population 1. Layout An isolation cart, containing head coverings, gowns, gloves, alcohol based hand rub (ABHR), and biohazard bags was located in the main lobby of the facility, outside the double doors that led to wing 2. Signs on the doors to wing 2 read that upon entering wing 2 through the left side of the doorway, the person must don full PPE including mask, gown, gloves, and eye protection. Entering wing 2 through the double doors revealed a hallway divided in half with a plastic sheet. The left side of this temporary hallway contained resident rooms and wrapped around to the right side with two more resident rooms. The right side of the temporary hallway revealed doors that led to the kitchen, a closet, and the laundry room. The plastic sheeting hung from the ceiling to the floor, held in place on the ceiling with clips, and taped to the floor. There were zippered areas in the plastic sheeting that could be unzipped for access to the other side. The plastic sheeting reached to the end of the doors to the kitchen, closet and laundry room; it did not extend to all the resident rooms. Rather, plastic sheeting was taped around the edges of the doorway that led into the laundry room, the most distant doorway on the right side of the hallway. On the left side of the temporary hallway were three resident rooms with isolation carts outside. Staff wore the same head covering, surgical and N95 masks, goggles and/or face shields, a gown, and foot coverings as they entered and exited residents' rooms on the left side of the plastic sheeting. 2. Population and staff expectations The DON, interviewed on 6/9/2020 at 1:40 p.m., said the residents on wing 2 either had COVID-19 positive test results, had COVID-19-like symptoms, or were roommates with someone who was COVID-19 positive. She said there were 12 residents currently residing on wing 2; three residents tested positive, three residents were roommates with someone who was positive. The remainder of the residents were under suspicion for COVID-19. The DON said that once a staff member entered wing 2, they were not allowed to come back into other wings or units in the facility; the staff member had to leave for the day. She said staff, like the infection control and prevention nurse (ICPN), save their duties on wing 2 until last so they can leave for the day after completing their duties. She said the staff had to wear full PPE to enter wing 2 and stated full PPE includes head covering, surgical and N95 masks, gowns, gloves, foot coverings and eye protection. She said the facility treats all residents on wing 2 as though they have COVID-19, so the PPE was worn 'universally'. She said that meant the staff changed gloves and performed hand hygiene before and after care of residents but kept their head and foot coverings, masks, eye protection and gowns on when they entered and exited resident rooms and not changed unless soiled. B. Observations and interviews 6/9/2020 From 4:40 p.m. to 6:46 p.m. there were five staff working on wing 2 with 12 residents. 1. Licensed practical nurse (LPN) #1 prepared medications at the medication cart, including a nebulized respiratory treatment for [REDACTED]. She said the resident tested negative twice for COVID-19 but remained in a room with someone who did test positive for COVID-19. The LPN did not indicate any concern or need for extra precautions with administering a nebulized treatment, which can release unnecessary aerosols. LPN #1 wore a surgical mask over the N95 mask and a face shield. She adjusted her masks and face shield and/or gown multiple times without performing hand hygiene. She said that she performed hand hygiene before and after resident cares. She said she knew to do hand hygiene after touching her mask but did not feel she had touched her mask. 2. At 4:48 p.m., CNA #7 entered a COVID-19 positive room wearing head covering, surgical mask with N95 mask over it, gown, face shield, foot cover