STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365611	A. BUILDING _____ B. WING _____	08/20/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEARTLAND OF WESTERVILLE	**1060 EASTWIND DRIVE WESTERVILLE, OH 43081**

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], Nursing Home Guidance from the Centers for Disease Control (CDC), review of the facility's policy and procedure, review of the facility's Coronavirus (COVID-19) timeline, review of daily resident census reports, record review, and staff interview, the facility failed to perform adequate contact tracing to properly identify, quarantine, and appropriately test residents with exposure to staff members who had tested positive for COVID-19. The facility failed to implement effective and recommended infection control practices, including appropriate use of a designated COVID unit, implement appropriate quarantine procedures, and ensure staff used appropriate personal protective equipment (PPE) to prevent the spread of COVID-19 within the facility. This resulted in Immediate Jeopardy on [DATE] when the facility dismantled the dedicated COVID-19 unit while there were still two positive COVID-19 residents residing on the unit. Residents #9 and #10 were moved to the end of the hall and the facility no longer had dedicated staff providing care for those residents that were COVID-19 positive. In addition, the facility failed to provide contact tracing after five employees tested COVID-19 positive on [DATE], [DATE], [DATE], [DATE], and [DATE]. This affected 23 residents (Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #23, #50, #54, #55, #61, #62, #71, and #79). The lack of effective infection control practices placed all residents at the facility at risk for serious life-threatening harm, complications and/or death related to the facilities failure to control the spread of Covid-19. The facility census was 87. On [DATE] at 10:02 A.M. the Administrator was notified Immediate Jeopardy began on [DATE] when the facility dismantled the dedicated COVID-19 unit while there were still two positive COVID-19 residents (Residents #9 and #10) residing on the unit. Observations on [DATE] also revealed PPE gowns were not being used for the residents under droplet, airborne precautions (quarantine status) on the 200 unit. Additional observations also revealed Resident #1 and #2 were under droplet, airborne precautions after the ordered time had expired; and, Resident #5, #6, and #7 did not have any signage on their doors indicating they were under droplet, airborne precautions. Review of medical records revealed Residents #12 and #14 were not tested during the whole house COVID-19 testing but continued to share rooms with a roommate (Residents #13, #15) resulting in these residents testing positive for COVID-19. The facility also failed to provide contact tracing after five employees tested positive on [DATE], [DATE], [DATE], [DATE], and [DATE]. The Immediate Jeopardy was removed on [DATE] when the facility implemented the following correction actions: On [DATE] the COVID 19 Isolation Unit was re-opened. On this date, Residents #14, #23, #50, #54, #55, #61, #62, and #71 were moved to the isolation unit. On [DATE] the Central Supply Clerk ensured isolation carts were placed and stocked with PPE, including gowns and gloves, in the hallway of resident rooms that required quarantine. On [DATE] the facility took immediate action through Quality Assessment Performance Improvement upon identification of the issue and notified the medical director. On [DATE] four facility staff that have tested positive and are currently on quarantine were contacted for contact tracing information by the Staffing Coordinator. Contact tracing was completed by the Staffing Coordinator. On [DATE] the facility COVID-19 Focused Rounds Tool was completed by the Quality Assurance Coordinator to ensure compliance with infection control practices. This tool is completed daily during COVID-19 outbreak and includes observations made to determine if the facility COVID-19 Prevention Plan is in place and if general standard precautions are being implemented. When the facility is not experiencing an outbreak, this tool is completed weekly. On [DATE] specified areas (quarantine area) for newly admitted residents and readmission of residents has been identified and placed on a floor map for education. The quarantine unit is located at the terminal end of the 200 hallway. Dedicated staff members will be assigned to specific areas of the facility. Staff members that work the COVID-19 positive area will only work that unit for that day. Once the staff member works the COVID-19 positive area that day, they will not be allowed to work any other unit that day. This will be completed by the facility Administrator. Beginning [DATE] placement of residents who require isolation precautions will be reviewed by the Director of Nursing or Quality Assurance Consultant. On [DATE] dedicated staffing for residents requiring isolation (COVID unit and quarantine unit) to be implemented with appropriate PPE available. Staffing will be reviewed by the Administrator, Director of Nursing or Infection Preventionist during the daily staffing meeting. Beginning [DATE] immediate education of 100% of facility staff on COVID 19 infection control practices in specified isolation areas will begin by the Quality Assurance Consultant, Director of Nursing and/or Infection Preventionist. Education will be completed by [DATE] at 5:00PM. Education will include, but not limited to appropriate use of PPE, identification of areas of the facility with specific isolation practices, and facility staff members will not be allowed to work until the education is completed. As of [DATE] at 4:00 P.M., 101 of 128 employees have received in-service education. Per Administrator, no staff will be permitted to work until they have received the in-service education. On [DATE] the Administrator will be educated on the contact tracing process for positive employees by the Quality Assurance Consultant. If needed, identified residents will be tested for COVID-19. There were no identified residents that required contact tracing based on the facility investigation. On [DATE] the Administrator and DON will be educated on the dedicated unit for COVID-19 positive residents and a dedicated space for quarantined residents by the Quality Assurance Consultant. On [DATE] the Infection Preventionist and DON will be educated on ensuring the facility COVID-19 tracking tool is filled out accurately and completely to monitor progression of COVID-19 positive residents by the Quality Assurance Consultant. This tool is used to track the following: resident's name, room number, admitted with lab confirmation and diagnosis, date of onset of symptoms, date of test, in house acquired or community acquired, isolation off unit, symptomatic, asymptomatic, discharge and location of discharge, expired, projected recovery date, and recovery date. On [DATE] residents requiring quarantine will be placed in the appropriate area as identified on the floor map per isolation needs. This will be completed by facility managers. On [DATE] therapy employee (Therapist #201) observed without appropriate PPE was removed from care and educated on PPE use by the Quality Assurance Coordinator. Moving forward employees will not be permitted to provide care without receiving PPE education. Beginning [DATE] random observations of staff will occur utilizing the competency: PPE (Donning and Doffing) audit tool. These observations continue to be completed by the Director of Nursing, Infection Preventionist, Unit Manager or Quality Assurance Consultant. Beginning [DATE] employees who work on the COVID Airborne Isolation Unit (CA I U) will be educated by the Quality Assurance Consultant, Director of Nursing or Unit Manager as it relates to entering and exiting the CAI U. This education was initiated on [DATE] by the Quality Assurance Consultant and will be completed on [DATE]. Employees will not be permitted to work on the CAIU unit until this education is completed. Beginning [DATE] random weekly audits will be conducted using the COVID-19 FOCUSED ROUNDS TOOL to ensure compliance as it relates to: COVID-19 Prevention Plan, General Standard Precautions, Transmission Based Precautions, Infection Surveillance and Staff Screening and Monitoring. These audits will be completed by the Director of Nursing, Infection Preventionist or Quality Assurance Consultant. Beginning [DATE] facility staffing meeting minutes will be reviewed daily to ensure dedicated nursing, therapy, and housekeeping staff are scheduled on the COVID-19 unit and for quarantined residents. On [DATE], [DATE], [DATE], and [DATE] the facility QAPI committee met through Ad Hoc or full QAPI and shall monitor weekly (beginning [DATE])

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

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 1) for 4 weeks to review any trends and findings, issues or concerns and develop plan of action for follow up and resolution. On [DATE] onsite observations of the facility revealed staff were appropriately wearing and removing PPE, hand hygiene was in place, and residents requiring quarantine were residing on the appropriate unit. On [DATE] from 4:47 P.M. to 5:01 P.M., three staff members (an STNA, a nurse supervisor LPN, and a dietary aide) were interviewed and found to be knowledgeable of the facility's COVID -19 practices and general infection control practices. The staff confirmed they received recent education at the facility that included: appropriate use of PPE, admission and readmission policy and procedures, areas of the facility where isolation and quarantined residents would be placed, and hand hygiene. 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. Findings include: Review of the Department of Health and Human Services, Centers for Medicare and Medicaid (CMS) Memo QSO ,[DATE]-ALL dated [DATE] revealed CMS is committed to taking critical steps to ensure America's healthcare 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 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 diseases or infections should be reported (42 CFR 483.80 (a) (2) (i) and (ii). 1. A tour of the facility on [DATE] from 2:05 P.M. to 3:00 P.M. revealed there were no personal protective equipment (PPE) carts on the 200 hall. Personal Protective Equipment (PPE) is specialized clothing or equipment worn by an employee that provides protection against infectious materials. An observation on the 200-hall revealed Residents #1, #2, #3, and #4 had a STOP sign on their doors. The sign on the door had STOP, N95 mask, gloves, and face shield. No staff were observed wearing gowns on the 200-hall. STOP signs were posted on the doors of those residents that had been admitted within the last 14 days and were under droplet, airborne precautions/quarantine status. Interview on [DATE] at 2:15 P.M. with the Administrator verified there were no PPE carts outside of the rooms on the 200-hall. The Administrator stated the STOP signs on the door stated a N95 mask, gloves, and face shield were required. The Administrator verified that gowns were not listed as required PPE. The Administrator verified no gowns were worn for residents under droplet, airborne precautions. The Administrator stated, if a resident was under investigation (exposed or showing symptoms of COVID-19), the staff would wear a gown in addition to the N95 mask and face shield or goggles. Interview on [DATE] at 2:25 P.M. with State tested Nursing Assistant (STNA) #105 revealed the STOP signs on the door showed what PPE was required. STNA #105 verified gowns were not on the list of required PPE. The STNA stated a N95 mask and face shield or googles were worn all day. Gloves were changed between residents, but gowns were not worn for residents under droplet, airborne precautions. STNA #105 verified the same PPE was required for those under droplet, airborne precautions and those that were not. On [DATE] at 3:59 P.M. an email response from Registered Nurse (RN) #200 from the local health department (LHD) revealed there was frequent communication with the Administrator regarding new cases. RN #200 wrote she was told residents who were under droplet, airborne precautions were being placed on the appropriate transmission-based precautions and staff were wearing masks, gowns, gloves, and face protection while caring for those residents. 2. a. Observations on [DATE] from 2:10 P.M. through 2:50 P.M. revealed Resident #1 had a STOP sign on the door which indicated the resident was under droplet, airborne precautions. Review of Resident #1's medical record revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of physician order dated [DATE] revealed Resident #1 was to be on airborne isolation for 14 days with an end date of [DATE]. b. Observations on [DATE] at 2:10 P.M. through 2:50 P.M. revealed Resident #2 had a STOP sign on the door which indicated the resident was under droplet, airborne precautions. Review of Resident #2's medical record revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. A physician order dated [DATE] revealed Resident #2 was to be in airborne isolation for 14 days with an end date of [DATE]. c. Observations on [DATE] at 2:10 P.M. through 2:50 P.M. revealed Resident #5 did not have a STOP sign on the door to indicate the resident was under droplet, airborne precautions. Review of Resident #5's medical record revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of progress note dated [DATE] at 10:56 A.M. revealed Resident #5 was on airborne isolation. A physician order dated [DATE] revealed Resident #5 was to be in airborne isolation for 14 days with an end date of [DATE]. d. Observations on [DATE] at 2:10 P.M. through 2:50 P.M. revealed Resident #6 did not have a STOP sign on the door to indicate the resident was under droplet, airborne precautions. Review of Resident #6's medical record revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of progress note dated [DATE] at 11:27 A.M. revealed Resident #6 was on airborne isolation. A physician order dated [DATE] revealed Resident #6 was to be in airborne isolation for 14 days with an end date of [DATE]. e. Observations on [DATE] at 2:10 P.M. through 2:50 P.M. revealed Resident #7 did not have a STOP sign on the door to indicate the resident was under droplet, airborne precautions. Review of Resident #7's medical record revealed an admitted on [DATE] with [DIAGNOSES REDACTED]. A physician order dated [DATE] revealed Resident #7 was to be in airborne isolation for 14 days with an end date of [DATE]. Interview on [DATE] at 11:41 A.M. with the Administrator verified Residents #1 and #2 still had STOP signs on their doors on [DATE] and they should not have. The Administrator also verified Residents #5, #6, and #7 did not have STOP signs on their doors on [DATE] and they should have. The Administrator stated an audit had been completed of the facility since [DATE] to ensure STOP signs were located on the doors of those residents that were under droplet, airborne precautions and STOP signs were removed from any residents' doors who were no longer under droplet, airborne precautions. f. Observation on [DATE] at 8:35 A.M. revealed Therapist #201 entered Resident #5's room. A STOP sign was on the door which indicated the resident was on droplet, airborne precautions and another sign was posted next to it that indicated the appropriate PPE to be used, including gown and gloves. Therapist #201 was observed looking at the resident's door and then entered the room without putting on a gown or gloves. The therapist was wearing an N95 mask, goggles, and face shield. Therapist #201 walked over to the resident's bedside and touched the resident's arm. The interim Director of Nursing (DON), also observed Therapist #201 in Resident #5's room without appropriate PPE on. The DON knocked on the door and informed Therapist #201 that she needed to put on a gown and gloves before entering the resident's room. Therapist #201 came out of the resident's room and put on a gown and gloves. Therapist #201 did not use any hand hygiene prior to putting on the clean gloves. Therapist #201 re-entered the room. Interview with the interim DON on [DATE] at 8:40 A.M. confirmed the therapist entered a room without appropriate PPE on and did not use any hand hygiene before putting on clean gloves. The DON confirmed Resident #5 was under droplet, airborne precautions. 3.a. Review of Resident #12's medical record revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. The resident's census report revealed the resident had resided on Unit 4, in room [ROOM NUMBER]-B from [DATE] through [DATE]. Review of Resident #12's progress notes revealed the resident was not tested for COVID-19 on [DATE] due to being at [MEDICAL TREATMENT]. The facility had completed 400 hall (the hall the resident resided on) COVID-19 testing on [DATE]. The resident continued to share a room with Resident #13. Resident #12 was tested later, on [DATE] and received a COVID-19 positive result on [DATE]. There was no evidence the facility increased monitoring of Resident #12, placed the resident in quarantine, or notified the physician regarding the resident's refusal to be tested . Review of Resident #13's medical record revealed an admitted on [DATE] with [DIAGNOSES REDACTED]. The resident's census report revealed the resident resided on Unit 4, in room [ROOM NUMBER]-A from [DATE] through [DATE]. Review of Resident #13's progress notes revealed the resident was tested for COVID-19 on [DATE] and received a negative result. On [DATE] at 10:41 A.M., a nurse practitioner (NP) progress note revealed Resident #13 was evaluated for any signs or symptoms associated with COVID-19 due to exposure to his roommate (Resident #12) who had tested positive for COVID-19. Review of the laboratory results dated [DATE] revealed Resident #13 tested positive for COVID-19. Review of an email from the Administrator on [DATE] at 9:44 A.M. revealed the facility did not do anything different for those residents who refused COVID-19 testing. The facility continued respiratory assessments and encouraged residents to stay in their rooms. Interview on [DATE] at 11:41 A.M. with the Administrator revealed Resident #12 was at [MEDICAL TREATMENT] when the facility testing for COVID-19 on the 400-hall was completed on [DATE]. The Administrator verified Resident #12 and #13 continued to share a room until Resident #12 tested positive for COVID-19 on [DATE]. The Administrator confirmed the residents were not separated, neither resident

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 2) was placed under droplet, airborne precautions or had increased monitoring when Resident #12 was not tested on [DATE]. The Administrator also verified Resident #13 tested positive for COVID-19 on [DATE]. 4. Review of Resident #14's medical record revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. The resident's census report revealed the resident resided on Unit 3, in room [ROOM NUMBER]-B, from [DATE] through [DATE]. Review of the resident's progress notes revealed Resident #14 refused to be tested for COVID-19 on [DATE]. The resident later agreed to be tested on [DATE]. The resident continued to share a room with Resident #15. Review of the laboratory results dated [DATE] confirmed Resident #14 tested positive for COVID-19. Review of Resident #15's medical record revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. The resident's census report revealed the resident resided on Unit 3, in room [ROOM NUMBER]-A, from [DATE] through [DATE]. Resident #15 was tested for COVID-19 on [DATE] and received a negative result. Resident #15 continued to share a room with Resident #14 until [DATE]. The resident's progress notes revealed the resident was tested again on [DATE] and received a COVID-19 positive result on [DATE]. Review of an email from the Administrator on [DATE] at 9:44 A.M. revealed the facility did not do anything different for those residents who refused COVID-19 testing. The facility continued respiratory assessments and encouraged residents to stay in their rooms. Interview on [DATE] at 11:41 A.M. with the Administrator confirmed Resident #14 refused to be tested on [DATE] but later agreed to be tested on [DATE]. The Administrator confirmed Resident #15 tested negative for COVID-19 on [DATE]. The Administrator confirmed Resident #14 and Resident #15 continued to share a room after Resident #14 refused to be tested . The residents were not separated, neither resident was placed under droplet, airborne precautions or had increased monitoring after Resident #14 refused to be tested on [DATE]. Resident #14 was confirmed to be COVID-19 positive on [DATE]. Resident #15 was confirmed to be COVID-19 positive on [DATE]. 5. Review of the facility Employee Log and COVID-19 timeline revealed the following: a. STNA #108 worked with residents on [DATE] and tested positive for COVID-19 on [DATE]. b. LPN #106 worked with residents on [DATE] and tested positive for COVID-19 on [DATE]. c. LPN #107 worked with residents on [DATE] and tested positive for COVID-19 on [DATE]. d. Housekeeping Supervisor #109 worked at the facility and was in contact with residents on [DATE] and tested positive for COVID-19 on [DATE]. e. STNA #111 worked with residents on [DATE], [DATE], [DATE], and [DATE]. STNA #111 tested positive for COVID-19 on [DATE]. Review of facility contact tracing documentation, dated [DATE], revealed the facility completed contact tracing of STNA #111 to include those residents this staff member had contact with when she worked on [DATE], [DATE], [DATE], and [DATE]. These residents were monitored for signs and symptoms of COVID-19 but were not tested . The contact tracing and monitoring of residents was not completed until nine (9) days after STNA #111 tested positive for COVID-19. Review of CDC guidance revealed the facility should have performed expanded [MEDICAL CONDITION] testing of all residents in the nursing home if there is an outbreak in the facility. A single case of COVID-19 infection in any health care provider (HCP) or a nursing home onset infection of a resident should be considered an outbreak. Performing [MEDICAL CONDITION] testing of all residents as soon as there is a new confirmed case in the facility will identify infected residents quickly, in order to assist in their clinical management and allow rapid implementation of IPC interventions such as isolation, cohorting, and use of PPE to prevent infection transmission. There was no evidence the facility completed these actions. Interview on [DATE] at 2:05 P.M. with the Administrator revealed she was not sure if any contact tracing had been completed by the local health department. The Administrator verified the facility had not completed any contact tracing after staff, who had worked with residents, tested positive for COVID-19. Review of an email response from the Administrator on [DATE] at 12:12 P.M. stated, Contact tracing was not necessary due to the fact we (facility) tested 100% of the population of the residents (minus the 3 patient refusals that were asymptomatic) and our employees wear appropriate PPE in a clinical setting. Review of an email response from the Administrator on [DATE] at 4:14 P.M. verified the facility had concluded no residents needed to be tested after exposure to STNA #111 who tested positive for COVID-19. The conclusion was based on no signs and symptoms. 6. Review of the medical record revealed Resident #9 was admitted as COVID-19 positive on [DATE] with additional [DIAGNOSES REDACTED]. A physician order dated [DATE] revealed Resident #9 was to be on airborne isolation. Review of a Nurse Practitioner (NP) note dated [DATE] at 11:48 A.M. revealed Resident #9 was an [AGE] year-old male recently hospitalized as COVID-19 positive with bilateral pneumonitis. Due to COVID-19 infection, Resident #9 remained on the respiratory care unit. Review of the medical record revealed Resident #10 was admitted as COVID-19 positive on [DATE] and discharged on [DATE]. Resident #10 had additional [DIAGNOSES REDACTED]. A physician order dated [DATE] revealed Resident #10 was to be on airborne isolation. Review of a NP note dated [DATE] at 2:28 P.M. revealed Resident #10 was a [AGE] year-old female who was admitted to the hospital with [REDACTED]. Due to COVID-19 infection, Resident #10 remained on the respiratory care unit. Review of the facility COVID-19 timeline sent by the Administrator on [DATE] at 2:35 P.M. revealed the COVID Airborne Isolation Unit (CAIU) was reinitiated on [DATE] but was later confirmed to be reinitiated on [DATE]. Interview on [DATE] at 2:05 A.M. with the Administrator verified the COVID-19 unit was reinitiated on [DATE] after there were seven residents who tested positive for COVID-19 on the 300-hall. Review of an email from the Administrator on [DATE] at 4:49 P.M. confirmed the CAIU was first set up on [DATE], taken down on [DATE], and then put back up on [DATE]. Interview on [DATE] at 11:41 A.M. with the Administrator revealed Resident #9 and #10 (residents were COVID-19 positive) were moved to the end of the COVID-19 hall and the barrier was removed. The Administrator verified there was not dedicated staff to provide care for Residents #9 and #10. The staff changed their PPE in the shower room between Resident #9 and #10, and those at the other end of the hall. 7. Interviews on [DATE] at 8:55 A.M. and 9:10 A.M. with Registered Nurse (RN) #202 and STNA #203, on the CAIU, revealed the process changed over the weekend on how the staff exited the CAIU at the end of a shift. RN #202 and STNA #202 stated instead of exiting the facility at the end of the hallway, taking off their PPE, placing it in a covered trashcan outside, and then going directly to their cars, the staff were now taking off their dirty PPE in the same room that had been converted into a nurse's station and breakroom. The staff use the room to chart, eat, and store personal belongings. RN #202 and STNA #203 confirmed there was no covered trash can or bio-hazard bags to place dirty PPE in. The nurse stated they use a small, uncovered office trash can with a regular trash bag in it. Staff used the bathroom in the room to wash their hands after taking off their PPE. Goggles or face shields were wiped down with bleach wipes, allowed to air dry, and then placed in paper bags to reuse. Interview on [DATE] at 9:10 A.M. with STNA #203 revealed the aide did not feel comfortable and did not feel it was appropriate to take off dirty PPE in the same room where the staff ate, charted, and stored personal belongings. Interview on [DATE] at 3:56 P.M. with the interim DON confirmed staff had been using the room that was converted into a nurse's station and breakroom to take off dirty PPE. The DON stated the staff were not supposed to be using that room as the dirty room and should have been using the room across the hallway as the dirty room. The nurse's station/breakroom room should be a clean room and should be used to put on clean PPE before going on to the COVID unit. The DON confirmed there was not a covered trash can or any biohazard bags being used for dirty PPE. The DON stated a large covered trash can with trash bag had been placed on the unit now. Review of the facility policy, Hand Hygiene updated ,[DATE], stated, When to wash hands or use an alcohol-based hand rub: before applying and after removing gloves and after having direct contact with patient's intact skin (e.g., when taking pulse or blood pressure and turning a patient) if hands are not visibly contaminated. Review of the facility Practice Guidelines: Transmission-Based Precautions dated ,[DATE] revealed standard precautions required a gown to be worn that was appropriate to the task, to protect skin and prevent soiling or contamination of clothing during procedures and resident care activities when contact with blood, body fluids, secretions or excretions was anticipated. The soiled gown was to be removed promptly before leaving the residents room. Droplet precautions included standard precautions and gloves, mask, and goggles if there was a likelihood of exposure during care. Review of Preparing for COVID-19 in Nursing Homes dated [DATE] from https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html revealed a plan needed created for managing new admissions and readmissions whose COVID-19 status was unknown. Healthcare personnel should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a face shield that covers the front and sides of the face), gloves, and gown when caring for these residents. Review of Key Strategies for Long-term Care Facilities provide by the LHD revealed COVID-19 Prevention & Control Measures for Long-Term Care Facilities (named county) Public Health from https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care-strategies.html if COVID-19 was identified in the facility, all residents should be restricted to their rooms and health care providers should wear all recommended PPE for care of all residents (regardless of symptoms) on the affected unit (or facility-wide depending on the situation). This included: an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection, gloves, and gown. This approach is recommended because of the high risk of unrecognized infection among residents. Recent experience suggests that a substantial proportion of residents could have COVID-19 without reporting symptoms or before symptoms develop. Review of guidance from the Center of Disease Control (CDC) states, Perform expanded [MEDICAL CONDITION]

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