STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155664	A. BUILDING _____ B. WING _____	**10/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
EAGLE CREEK HEALTHCARE CENTER	**4102 SHORE DR INDIANAPOLIS, IN 46254**

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 -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interview, the facility failed to ensure infection control practices for COVID-19 were followed for residents with symptoms of COVID-19 and/or exposure to positive COVID-19 residents related to implementing transmission based precautions, screening for symptoms, and social distancing for 6 of 6 residents reviewed for infection control (Residents 1, 2, 3, 4, 5, and 6) and for 28 residents who smoke, who were potentially exposed to the facility's 3 confirmed COVID-19 positive residents, who also smoked in the facility's designated smoking area. The Immediate Jeopardy began on 9/1/20 when Resident 3 had a fever of 100.6 on 9/1/20. Resident 2 had fevers greater than 100.2 starting on 9/15/20. The physician was not notified and isolation precautions were not implemented for either resident. Residents 3 and 2 were positive for COVID on 9/23/20. Resident 4 had symptoms of COVID-19 on 9/23/20 and was not placed on isolation. Resident 5, was moved into Resident 4's room, without isolation precautions on 9/25/20. Residents 4 and 5 were observed on 9/28/20 without isolation precautions, and the staff caring for the residents were not aware the residents needed isolation. Smoking residents who have had potential exposure to COVID-19 positive residents, walk through the building to utilize the shared smoking area. Residents were observed smoking without social distancing. A serious adverse outcome was likely as this created the potential for further spread of [MEDICAL CONDITION] to other residents. The Administrator and the Corporate Registered Nurse (RN) 5 were notified of the Immediate Jeopardy at 1:55 p.m., on 9/29/20. The immediate jeopardy was removed on 10/1/20, but noncompliance remained at a lower scope and severity of pattern, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: On 9/25/20 at 10:00 a.m., the Administrator provided the facility floor plan with the 200 unit and one room on the 100 unit highlighted as yellow (precautionary) isolation rooms for a total of 35 rooms. There was one red (COVID-19 positive) isolation room on the 200 unit with a confirmed positive COVID-19 resident (Resident 3). On 9/25/20 at 10:08 a.m., during an initial tour of the facility, there were only 4 rooms on the 200 unit yellow area observed with isolation signs on the doors. There were an additional 3 rooms on the 100 unit with isolation signs on the doors but not highlighted on the facility floor plan provided by the Administrator. 1. Resident 3's record was reviewed on 9/25/20 at 2:30 p.m. Resident 3 was tested positive for COVID-19 on 9/23/20. A physician's orders [REDACTED]. A care plan, initiated 7/17/20, indicated the resident was at risk for COVID exposure due to new guidelines for visitations, but the medical record lacked care plan documentation of a COVID-19 [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. Review of the September 2020 vital signs records for Resident 3 indicated Resident 3 was not assessed every shift for temperature and O2 SATS: a. 9/1/20 at 10:07 a.m. elevated temperature of 100.6 b. 9/2/20 not assessed two times for temperature and two times for O2 SATS c. 9/3/20 not assessed two times for temperature and two times for O2 SATS d. 9/5/20 no documented temperature nor O2 SATS for the day e. 9/6/20 not assessed two times for temperature and two times for O2 SATS f. 9/7/20 not assessed one time for temperature and two times for O2 SATS g. 9/10/20 not assessed one time temperature and one time for O2 SATS h. 9/11/20 not assessed two times for temperature and two times for O2 SATS. Elevated temperature of 99.1 recorded at 7:56 a.m. i. 9/12/20 not assessed one time for temperature and one time for O2 SATS j. 9/13/20 not assessed two times for temperature and two times for O2 SATS. Elevated temperature of 100 recorded at 7:24 a.m. k. 9/14/20 not assessed two times for temperature and two times for O2 SATS. Elevated temperature of 99.3 recorded at 12:22 p.m. l. 9/15/20 not assessed one time for temperature and one time for O2 SATS. Elevated temperature of 99.1 recorded at 9:01 a.m. m. 9/16/20 at 12:03 a.m. elevated temperature of 99.3 n. 9/17/20 at 8:36 a.m. elevated temperature of 101.1 and at 10:45 a.m. elevated temperature of 99.1 and only assessed two times for temperature and two times for O2 SATS o. 9/18/20 not assessed one time for temperature and one time for O2 SATS p. 9/19/20 not assessed one time for temperature and one time for O2 SATS q. 9/20/20 not assessed one time for temperature and one time for O2 SATS r. 9/21/20 at 11:57 p.m. elevated temperature of 99.1 s. 9/22/20 no documented temperature nor O2 SATS for the day t. 9/23/20 not assessed one time for temperature and one time for O2 SATS u. 9/24/20 not assessed one time for temperature and one time for O2 SATS v. 9/25/20 not assessed two times for temperature and two times for O2 SATS w. 9/26/20 no documented temperature nor O2 SATS for the day x. 9/27/20 not assessed one time for temperature and one time for O2 SATS Resident 3's record lacked documentation of physician notification of the elevated temperatures on 9/1/20 and from 9/14 through 9/17/20 and physician orders [REDACTED]. During an interview, on 9/25/20 at 5:10 p.m., the Administrator indicated Resident 3 resided on the 200 unit with 55 other residents. Residents 2 and 3 resided on the same unit, were friends, and went out to smoke together at the facility. Resident 3 tested positive for COVID-19, and was in droplet isolation. 2. Resident 2's record was reviewed on 9/25/20 at 2:17 p.m. Resident 2 was admitted to the hospital, on 9/22/20, with [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. Review of the September 2020 vital signs records for Resident 2 indicated Resident 2 was not assessed every shift for temperature and O2 SATS: a. 9/1/20 not assessed one time for temperature and one time for O2 SATS b. 9/4/20 not assessed two times for temperature and two times for O2 SATS c. 9/5/20 not assessed one time temperature and two times for O2 SATS d. 9/6/20 not assessed one time for temperature and one time for O2 SATS e. 9/7/20 not assessed two times for temperature and two times for O2 SATS f. 9/8/20 not assessed two times for temperature and two times for O2 SATS g. 9/10/20 not assessed two times for temperature and two times for O2 SATS h. 9/13/20 not assessed one time for temperature and one time for O2 SATS i. 9/15/20 at 10:39 a.m. elevated temperature of 100.4 recorded j. 9/16/20 at 9:59 a.m. elevated temperature of 100.2 recorded and only two temperatures were taken for the day k. 9/17/20 not assessed two times for temperature and two times for O2 SATS l. 9/18/20 not assessed one time for temperature and one time for O2 SATS m. 9/19/20 not assessed two times for temperature and two times for O2 SATS n. 9/20/20 no documented temperatures or O2 SATS for the day o. 9/21/20 not assessed one time for temperature and one time for O2 SATS p. 9/22/20 no documented temperatures or O2 SATS for the day q. 9/24/20 Temperatures and O2 SATS were recorded for two of three shifts, even though the resident was not in the facility, but at the hospital as of 9/22/20. Resident 2's record lacked documentation of physician notification of the elevated temperatures on 9/15 and 9/16/20 and physician orders [REDACTED]. During an interview, on 9/25/20 at 5:10 p.m., the Administrator indicated Resident 2 was admitted to the hospital, on 9/22/20, and was diagnosed with [REDACTED]. Her roommate was immediately placed into droplet isolation due to direct exposure and will remain in isolation for 14 days. They had completed contact tracing. Resident 3 was the only additional resident to test positive, and was in droplet isolation. Residents 2 and 3 resided on the same unit, were friends, and went out to smoke together at the facility. On 9/28/20 at 5:27 p.m., DON indicated staff had reported, on 9/25/20, Resident 2, who had tested positive for COVID-19 had visited and talked to Resident 4 in his room, prior to her transfer to the hospital. On 9/29/20 at 9:12 a.m., Nurse Practitioner (NP) 6 indicated, on 9/22/20, she had examined Resident 2 and had noted Resident 2 was congested bilaterally in the upper and lower lung lobes and transferred Resident 2 to the hospital, where she was tested positive for COVID-19. 3. On 9/25/20 at 10:55 a.m., during the initial tour of the facility, Resident 5's and Resident 6's shared room on the 200 hall was observed without an isolation sign on the door with the door closed. On 9/25/20 at 11:11 a.m., the 200 hall Unit Manager 9 indicated Resident 3 (confirmed positive COVID-19 resident) had droplet isolation precautions for her room. Resident 4, Resident 5, and Resident 6 did not have isolation

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) precaution orders despite being highlighted yellow on the facility floor plan. Unit Manager 9 indicated the Staff Development Coordinator had the complete list of the facility's isolation residents, but the unit managers did not have the isolation residents list. On 9/25/20 at 3:15 p.m., the Staff Development Coordinator provided a document titled, Monthly Isolation Log September 2020, and Resident 4, Resident 5, and Resident 6 were not listed on the isolation log. On 9/25/20 at 5:10 p.m., the Corporate Registered Nurse (RN) 5, indicated she had updated the facility's floor plan with the correct droplet isolation residents' rooms. Resident 1's, Resident 3's, Resident 5's, and Resident 6's rooms were highlighted on the floor plan, but Resident 4's room was not highlighted on the list of isolation rooms. Resident 6's record was reviewed on 9/29/20 at 10:40 a.m. Resident 6 was readmitted to the facility from the hospital on [DATE]. [DIAGNOSES REDACTED]. The record lacked documentation of a physician's orders [REDACTED]. A physician's orders [REDACTED]. A review of the September vital signs records indicated Resident 6's temperature was recorded as 91.4 degrees Fahrenheit on 9/25/20 at 8:47 a.m. Resident 6's record lack documentation of additional temperatures from 9/23/20 to 9/25/20. The record indicated his temperature was not taken daily in September. A Social Services Director (SSD) progress note, dated 9/26/20 at 5:49 p.m., indicated SSD arrived to resident's room and the resident requested to be sent to the emergency room (ER). On 9/28/20 at 9:10 a.m., the Administrator indicated Resident 6 sent himself to the hospital in an ambulance, on 9/26/20, and had a positive result COVID-19 test at the hospital. The Administrator indicated Resident 6 was asymptomatic at the time he went to the hospital. On 9/28/20 at 3:45 p.m. Unit Manager 9 indicated, on the evening of 9/25/20, the Nurse Practitioner (NP) 6 had examined Resident 6 and requested staff to place Resident 6 in droplet isolation precautions and his roommate, Resident 5, was transferred to another room, because Resident 6 was not feeling well. On 9/29/20 at 9:12 a.m., Nurse Practitioner (NP) 6 indicated, on 9/25/20, the nurse had noted Resident 6 had a fever and was not feeling well. When NP 6 examined Resident 6, on the evening of 9/25/20, he appeared sick with [MEDICAL CONDITION], lying in bed, not wanting to talk, but did not have any congestion in his lungs. She had concluded Resident 6 had [MEDICAL CONDITION] and a fever. NP 6 suggested to staff at the nurses' desk to isolate Resident 6 and transfer Resident 5 (Resident 6's roommate) to another room. 4. On 9/25/20 at 10:53 a.m., during the initial tour of the facility, Resident 4's room on the 200 hall was observed without an isolation sign on the door and the door open. On 9/28/20 at 10:29 a.m., Resident 4's room was observed without an isolation sign or PPE, and the door was open with the curtain drawn. Resident 5 and Resident 6's shared room was observed with their names on the door and a sign on the closed door that indicated to see the nurse. On 9/28/20 at 3:45 p.m. Unit Manager 9 indicated, on the evening of 9/25/20, the Nurse Practitioner (NP) 6 had examined Resident 6 and requested staff to place Resident 6 in droplet isolation precautions and his roommate, Resident 5, was transferred to another room, because Resident 6 was not feeling well. Resident 5 was immediately transferred to Resident 4's room. On 9/28/20 at 4:01 p.m., the Administrator indicated staff had not notified her nor the Director of Nursing (DON) that Resident 5 had been transferred to Resident 4's room, on the evening of 9/25/20. She had just been notified, minutes ago, that Resident 4 and Resident 5 were now roommates. The Administrator further indicated, during the morning's meeting, on 9/28/20, Resident 5's room transfer was not mentioned, but should have been discussed. On 9/28/20 at 4:30 p.m. the DON provided an updated droplet isolation facility floor plan that she had personally created with Resident 4's and Resident 5's room highlighted with droplet isolation precautions. On 9/28/20 at 4:54 p.m., the Staff Development Coordinator indicated Resident 4 and Resident 5 were placed into droplet isolation precautions today, 9/28/20, because Resident 4 was exposed to COVID-19 positive Resident 2, and Resident 5 was exposed to his previous roommate, Resident 6, before he was moved into Resident 4's room on 9/25/20. Resident 4 was in a green zone room, when Resident 5 was moved into the room with him on 9/25/20. Resident 5's record was reviewed on 9/29/20 at 10:25 a.m. [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. Review of the September 2020 vital signs records for Resident 5 indicated Resident 5 was not assessed every shift (three times a day) for temperature and O2 SATS: a. 9/5/20 not assessed two times for temperature and two times for O2 SATS b. 9/6/20 not assessed two times for temperature and two times for O2 SATS c. 9/7/20 not assessed two times for temperature and two times for O2 SATS d. 9/20/20 not assessed one time for temperature and one time for O2 SATS e. 9/22/20 not assessed two times for temperature and two times for O2 SATS A physician's orders [REDACTED]. Continue to monitor O2 SAT, temperature, and symptoms. On 9/25/20 at 10:55 a.m., during the initial tour of the facility, Resident 5's and Resident 6's shared room on the 200 hall was observed without an isolation sign on the door with the door closed. On 9/25/20 at 11:11 a.m., 200 hall Unit Manager 9 indicated Resident 5 and Resident 6 did not have isolation precaution orders despite being highlighted yellow on the facility floor plan. On 9/25/20 at 3:15 p.m., the Staff Development Coordinator provided a document titled, Monthly Isolation Log September 2020. Resident 5 and Resident 6 were not listed on the isolation log. On 9/28/20 at 3:45 p.m. Unit Manager 9 indicated, on the evening of 9/25/20, the Nurse Practitioner (NP) 6 requested staff to transfer Resident 5 to another room, because Resident 6 (Resident 5's roommate) was not feeling well. Resident 5 was immediately transferred to Resident 4's room. On 9/29/20 at 9:12 a.m., Nurse Practitioner (NP) 6 indicated, on 9/25/20, she had concluded Resident 6 (Resident 5's roommate) had [MEDICAL CONDITION] and a fever. NP 6 suggested to staff at the nurses' desk to transfer Resident 5 to another room. Since there were no empty rooms available at the facility, NP 6 suggested to staff to transfer Resident 5 into Resident 4's room. 5. Resident 4's record was reviewed on 9/29/20 at 10:15 a.m. [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. A Social Services Director (SSD) progress note, dated 9/23/20 at 5:50 p.m., indicated Resident alert and orientated to self. Resident quiet and calm most of the day. Resident refused OT (occupation therapy). SSD while visiting resident witnessed resident have projectile vomiting. Resident stated '(name of former roommate) is killing me.' Resident felt previous roommate that passed on 9/21/20 at midnight was responsible for resident being sick. SSD reassured resident and resident remained calm. A physician's orders [REDACTED]. Review of the September 2020 vital signs records for Resident 4 indicated Resident 4 was not assessed every shift (three times a day) for temperature and O2 SATS: a. 9/5/20 not assessed two times for temperature and two times for O2 SATS b. 9/6/20 not assessed two times for temperature and two times for O2 SATS c. 9/7/20 not assessed two times for temperature and two times for O2 SATS d. 9/15/20 not assessed two times for temperature and two times for O2 SATS. Elevated temperature of 99.1 was recorded at 11:40 p.m. e. 9/20/20 not assessed one time for temperature and one time for O2 SATS f. 9/22/20 not assessed one time for temperature and one time for O2 SATS On 9/25/20 at 10:53 a.m., during the initial tour of the facility, Resident 4's room on the 200 hall was observed without an isolation sign on the door and the door open. On 9/25/20 at 11:11 a.m., 200 hall Unit Manager 9 indicated Resident 4 did not have isolation precaution orders despite being highlighted yellow on the facility floor plan. On 9/25/20 at 3:15 p.m., the Staff Development Coordinator provided a document titled, Monthly Isolation Log September 2020, and Resident 4 was not listed on the isolation log. On 9/25/20 at 5:10 p.m., the Corporate Registered Nurse (RN) 5, indicated she had updated the facility's floor plan with the correct droplet isolation residents' rooms. Resident 4's room was not highlighted on the list of isolation rooms. On 9/28/20 at 10:29 a.m., Resident 4's room was observed without an isolation sign or PPE. On 9/28/20 at 4:54 p.m., the Staff Development Coordinator indicated Resident 4 and Resident 5 were placed into droplet isolation precautions today, because Resident 4 was exposed to COVID-19 positive Resident 2, and Resident 5 was exposed to his previous roommate, Resident 6, before he was moved into Resident 4's room on 9/25/20. Resident 4 was in a green zone room, when Resident 5 was moved into the room with him on 9/25/20. On 9/28/20 at 5:27 p.m., DON indicated staff had reported, on 9/25/20, Resident 2, who had tested positive for COVID-19 had visited and talked to Resident 4 in his room, prior to her transfer to the hospital (on 9/22/20). Resident 4 was placed into droplet isolation precautions, because he was exposed to COVID-19 through Resident 2. Staff moved Resident 5 into the room with Resident 4, since they were both exposed to COVID-19 and were both in droplet isolation precautions. On 9/29/20 at 9:12 a.m., Nurse Practitioner (NP) 6 indicated, Resident 4 had a fever earlier on 9/23/20. The NP indicated she had ordered droplet isolation precaution for Resident 4 on 9/23/20. On 9/29/20 at 9:23 a.m., RN 5 indicated Resident 4 had a fever earlier in the week. Resident 2, prior to her transfer to the hospital and positive for COVID-19, would go into Resident 4's room to visit. So Resident 4 was placed into droplet isolation precautions last week, on 9/23/20, by NP 6 on a physician's orders [REDACTED]. 6. On 9/25/20 at 10:08 a.m., during an initial tour of the facility, Resident 1's room on the 100 unit had a Personal Protective Equipment (PPE) caddy containing isolation gowns hanging on the closed door. No isolation sign was observed on the door to indicate isolation precautions for Resident 1. Resident 1's room was not highlighted on the facility floor plan provided by the Administrator on 9/25/20 at 10:00 a.m. On 9/25/20 at 10:22 a.m., 100 Unit Manager 10 indicated she thought Resident 1 was in droplet isolation precautions due to an upper respiratory infection and being a new admission to the facility, but was unsure. Unit Manager 10 reviewed Resident 1's electronic health records on the computer and indicated she could not find an isolation order for Resident 1. Unit Manager 10 indicated, the Staff Development Coordinator had the list of the facility's isolation residents, but the unit managers did not have that isolation list of residents. Resident 1's record was reviewed, on 9/25/20 at 2:00 p.m. Resident 1 was admitted to the

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) facility, on 9/17/20, with [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. A physician's orders [REDACTED]. Review of the September 2020 vital signs record for Resident 1 indicated Resident 1 was not assessed every shift for temperature and oxygen saturation percentage (O2 SATS): a. 9/18/20 not assessed one time for temperature and two times for O2 SATS b. 9/20/20 not assessed two times for temperature c. 9/22/20 not assessed two times for temperature and two times for O2 SATS d. 9/26/20 not assessed one time for temperature and one time for O2 SATS On 9/25/20 at 3:15 p.m., the Staff Development Coordinator indicated Resident 1 tested positive for COVID-19 at the hospital on [DATE]. He was admitted to the facility on [DATE] and should have been placed into droplet isolation precautions upon admission, because of his respiratory issues. Resident 1 continued to have respiratory issues and symptoms. Staff were assessing his vitals every shift, three times a day, for COVID-19 symptoms evaluation of temperature, oxygen saturation percentage (O2 SATS %) and respiratory signs or symptoms. At that time the Staff Development Coordinator provided the document titled, Monthly Isolation Log September 2020, which indicated Resident 1 was placed into droplet isolation precautions on 9/25/20. 7. On 9/26/20 at 12:47 p.m., Resident 7 and an unidentified resident were observed outside in the smoking area, side by side, with no face masks, and not social distancing. No staff member was outside supervising them. On 9/28/20 at 9:28 a.m. the Administrator indicated there was a designated smoking zone, right outside the 100 hall unit. They tried to have the residents who smoked maintain social distancing of six feet apart. Unfortunately, some residents had a difficult time maintaining the social distance of six feet. They had assigned staff, smokers' aides, to monitor the smoking residents while they are outside. There were independent smokers that did not require monitoring by staff. Resident 7 was a staff-monitored smoker. The Administrator indicated the staff who monitored smoking residents was not out there at the time, but was probably on their way out to the smoking area to monitor the smoking residents. On 9/29/20 at 11:00 a.m., the Administrator indicated, during the contact tracing, a resident list of smokers was created and it was determined all smoking residents could have been exposed to COVID-19. The list indicated there were 31 smokers in the building, including the 3 confirmed COVID-19 positive residents. There were 14 smokers on the 100 hall and 17 smokers on the 200 hall. These potentially exposed residents were not placed in any transmission-based precautions. The Administrator indicated the facility had one designated smoking area, which was located by the 100 unit. All smokers must go through the 100 unit to get to the designated smoking area. Resident 2, Resident 3, and Resident 6, who all had tested positive for COVID-19, were independent smokers. Resident 7 was the only resident who required staff supervision when smoking On 9/29/20 at 11:57 a.m. RN 5 indicated the 100 and 200 units were not completely yellow isolation units. The whole building was considered green (no isolation) with yellow isolation rooms throughout the facility. Residents who smoked must go through the 100 unit to get to the designated smoking area. On 9/29/20 at 11:00 a.m., the Administrator provided and identified as a current facility policy, titled Resident/Patient Smoking, dated 3/25/2016, which indicated, .Supervised Smoker: a resident that is unable to demonstrate safe smoking habits including smoking materials management, lighting, controlling cigarette ash and extinguishing smoking materials and requires staff supervision when smoking . 8. On 9/26/20 at 12:55 p.m., Qualified Medication Aide (QMA) 8 was observed pushing a supply cart down the hall with her nose out of the face mask. On 9/26/20 at 1:12 p.m., the Medical Records Coordinator indicated the facility required all staff to wear a face mask while in the facility, and QMA 8 should have had her nose covered with her face mask. On 9/28/20 at 9:45 a.m. the Administrator indicated QMA 8 was observed, on 9/26/20, in the main hallway, with her mask not covering her nose. QMA 8 told the Administrator that she did not feel she had to have the face mask covering her nose, since she wasn't in a patient care area. The Administrator indicated all staff should wear their face mask with their mouth and nose covered, while in the building. On 9/28/20 at 12:30 p.m., the Administrator provided and identified as a current facility policy, titled PPE General Statement, dated 7/1/2017, which indicated, .Employees are required to use PPE's when indicated to reduce exposure risks On 9/29/20 at 10:50 a.m., RN 5 provided and identified as a current facility policy, titled Identification and response if resident in the facility is identified to potentially have COVID-19, updated 8/12/20, which indicated, .Be sure to follow your Divisional Directives regarding notification of potential COVID-19 Cases .The IP (Infection Preventionist) will remain aware of current CDC guidelines and of any occurrence of 2019-nCo V in their area .All staff have been educated on: a. Infection control techniques to include standard, contact, droplet, and respiratory precautions .b. Use of PPE equipment .Risk factors, Signs and Symptoms of COVID-19 may include but not limited to: a. Fever .b. Symptoms of lower respiratory illness (e.g., cough, shortness of breath) .c. Nausea, vomiting, diarrhea can also occur with respiratory symptoms .For suspected cases of 2019-nCo V, health care providers or any individual have knowledge, should: a. Residents with suspected symptoms of COVID-19 should be asked to wear a surgical mask as soon as they are identified and be evaluated in a private room with the door closed .b. Provide PPE outside room. Place dedicated trash can inside room .c. Immediately notify the infection control personnel at their health care facility .d. Infection control personnel will provide notification to facility administration .j. Continue with respiratory/droplet precautions until other instructions are provided by the health care provider and the health department .l. Provide instructions for care to all team members .m. Update the care plan to include isolation and illness .n. If the resident had a roommate prior to transferring to a private room, the roommate should be monitored for the next 14 days for potential infection and/or changes of condition. This should be documented daily The CDC guidance, updated 4/30/20, - Responding to Coronavirus (COVID-19) in Nursing Homes, Responding to COVID-19: Considerations for the Public Health Response to COVID-19 in Nursing Homes, indicated, .Increase monitoring of ill residents, including assessment of symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam, to at least 3 times daily to identify and quickly manage serious infections .Consider increasing monitoring of asymptomatic residents from daily to every shift to more rapidly detect any residents with new symptoms .Counsel all residents to restrict themselves to their room to the extent possible .HCP should use all recommended COVID-19 PPE for the care of all residents on affected units (or facility-wide if cases are widespread); this includes both symptomatic and asymptomatic residents .If testing is available, asymptomatic residents and HCP who were exposed to the resident with COVID-19 (e.g., on the same unit) should be considered for testing The CDC guidance - Preparing for COVID-19: Long-term Care Facilities, Nursing Homes, indicated, If COVID-19 is suspected, based on evaluation of the resident or prevalence of COVID-19 in the community, Residents with known or suspected COVID-19 do not need to be placed into an airborne infection isolation room (AIIR) but should ideally be placed in a private room with their own bathroom. Room sharing might be necessary if there are multiple residents with known or suspected COVID-19 in the facility. As roommates of symptomatic residents might already be exposed, it is generally not recommended to separate them in this scenario. Public health authorities can assist with decisions about resident placement .If a resident requires a higher level of care or the facility cannot fully implement all recommended precautions, the resident should be transferred to another facility that is capable of implementation. Transport personnel and the receiving facility should be notified about the suspected [DIAGNOSES REDACTED].g., kept in their room with the door closed). Appropriate PPE should be used by healthcare personnel when coming in contact with the resident The immediate jeopardy that began on 9/1/20 was removed on 10/1/20 when the facility assessed all residents for symptoms of COVID-19, symptomatic and/or exposed residents requiring isolation precautions were placed on isolation, residents and smoking areas were moved to prevent potential exposure of non-smokers, and procedures to monitor smoking were implemented. Nursing staff were in-serviced on COVID-19 symptoms and assessments, isolation precautions, personal protective equipment, and smoking protocols. The noncompliance remained at the lower scope and severity level of pattern, no actual harm with the potential for more than minimal harm that is not immediate jeopardy because of the facility's need for continued monitoring. 3.1-18(a)