STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065163	A. BUILDING _____ B. WING _____	06/25/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
EBEN EZER LUTHERAN CARE CENTER	122 HOSPITAL RD BRUSH, CO 80723

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** - Minimal harm or potential for actual harm **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, interviews and record review, the facility failed to establish and maintain an infection control program designed to provide a safe, sanitary environment and to help prevent the development and transmission of communicable diseases and infections such as Coronavirus disease (COVID-19). Specifically, the facility failed to follow Centers for Disease Control and Prevention (CDC) guidelines to: -Ensure two of three screening stations utilized as an access point by dietary, environmental, maintenance and transportation staff was manned and that the screening forms were audited to ascertain that staff did not answer a yes to any of the questions contained in the screening form (questionnaire); -Ensure staff consistently perform hand hygiene before and after contact with residents and potentially contaminated items; -Ensure residents were offered, encouraged and assisted to perform hand hygiene before eating their meals; and, -Ensure staff wore medically approved face masks while in resident care areas. Findings include: On 6/24/2020 at approximately 4:45 p.m., the nursing home administrator (NHA) said throughout the past three months, the facility had experienced in excess of 20 cases of positive COVID-19. She said the infection control policy had been updated numerous times and the facility was constantly educating staff on infection control. She said the facility had been COVID free for the past 28 days. Although the facility was COVID-19 free, the facility continued to experience breaks in infection control. I. Failed to ensure active screeing at all stations were monitored A. Professional reference According to the Centers for Disease Control and Prevention (CDC) updated 4/15/2020, retrieved from https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html, included the following recommendations: -Actively screen everyone for fever and symptoms of COVID-19 before they enter the healthcare facility. B. Observation On 6/24/2020 at 4:39 p.m. and on 6/25/2020 at 11:15 p.m., the dining services building was observed, the building had two screening stations. One of the stations was designated for vendors who brought food supplies and other necessities to the facility while the other screening station was designated for the dietary staff. The dietary staff were however observed utilizing both screening stations to enter and exit the building. Whilst the vendor screening entrance was manned with a staff who screened the vendors by asking pertinent questions related to COVID 19. Specifically, the screening questionnaire included a COVID-19 specific screening questions which asked about whether or not the individual completing the questionnaire had travelled to counties, states and international countries where COVID-19 had been reported. It also asked the question of any symptom consistent with COVID-19 which included fever, chills, cough, sore throats, difficulty breathing etc. The dietary staff screening entrance was not manned, although it had the same questionnaire in place, alongside a thermometer and an alcohol based hand rub (ABHR). The Dietary staff screening station also had piles of screening forms which dated back to May 2020. C. Interview On 6/25/2020 at12:45 p.m., dietary aide (DA) #1 was interviewed. She said she came into the facility through the service building. She said when she arrived at the facility, she answered no to the questions asked in the screening form. She said she took her temperature by herself. She said she was supposed to have another co-worker verify her temperature, she however verified that she does not get to do that. Specifically, DA #1 said It's a waste of time to be waiting on another employee to verify my temperature, I just want to get to work straight away. She also reported that there was no section of the screening form that recorded temperatures. DA #2 was interviewed on 6/25/2020 at 12:52 p.m. She said the service building was recently built and had its own primary access that was not the facility's main entry. She said when she arrived at the beginning of her shift, she was required to screen herself into the service building. She said she was required to fill out the screening questionnaire and to also take her temperature. She verified that the questionnaire did not have a section to document temperatures. In addition, DA #2 said when she was last to arrive at the service building, she was unable to have a co-worker verify her temperature. She said she would take her temperature and resumed her duties. She said she did not know the temperature threshold that would raise a red flag (hinder her from resuming work). On 6/25/2020 at 12:15 p.m., the executive assistant (EA) was interviewed. She said the facility was not allowing visitors which included staff and resident family into the facility. She said few essential vendors were allowed into the facility. She said dietary staff were not screened through the main entrance. Specifically, the EA said the kitchen was located in the service building which had its own screening station and it was where dietary, environmental, maintenance and transportation staff got screened. She said the screening station was not manned and that she does not know who reviewed the screening forms to identify when a dietary staff answered a yes to any of the questions within the screening form. On 6/25/2020 at 1:22 p.m. the nursing home administrator (NHA) and the director of nursing (DON) were interviewed. The DON said there was three different screening points across the facility. She clarified that of the three screening points, only the main entry screening point was manned. She said staff had been trained to screen themselves. The DON said four members of the administration reviewed the screening forms to ensure no staff had answered a yes to any of the pertinent screening questions. She listed herself (DON), the NHA, the chief executive officer (CEO) and maintenance director (MD) as the individuals who reviewed the screening forms. The DON and NHA however verified that they only reviewed the screening forms from the main entry. Specifically, the DON and the NHA said none of the administrative members listed above reviewed the screening forms from other entry points. They also verified that dietary staff went across the facility and were not restricted to the service building alone. On 6/25/2020 at 1:39 p.m., the CEO was interviewed. She verified that she only reviewed the screening forms from the main entry. On 6/25/2020 at 1:51 p.m. The dining director (DD) was interviewed. The DD said she does not know what to do with the screening forms. She said she guesses she would be reviewing them going forward. On 6/25/2020 at 1:57 p.m. The maintenance director (MD) was interviewed. He said he was just made aware (on survey day) that he would be auditing the screening forms. He said going forward, the backlogs of the screening forms in the service building would be taken to the main entry where they would be audited alongside the screening forms across the building. II. Improper hand hygiene during meals A. Facility policy and procedure The Novel Coronavirus Prevention and Response policy dated 3/13/2020, was provided by the nursing home administrator (NHA) on 6/25/2020 at 10:43 a.m., it read in pertinent part: The facility will follow any recommendations from the CDC. Frequent hand washing or use of alcohol based hand sanitizer after resident contact. The Infection Control, Standard Precautions policy was provided by the NHA on 6/25/2020 at 10:43 a.m., it read in pertinent part: Handwashing: -Wash hands after touching blood, body fluids, secretions, excretions, and contaminated items, whether or not gloves are worn. -Wash hands immediately .between resident contacts, and when otherwise indicated to avoid transfer of microorganisms to other residents or environments. -Wash hands between tasks and procedures on the same resident to prevent cross-contamination of different body sites. The Nursing Infection Control policy was provided by the NHA on 6/25/2020 at 10:43 a.m., it read in pertinent part: Hands shall be washed thoroughly before and after caring for each resident, before serving meals .after handling a patient's articles or supplies . - Handwashing is the single most important procedure for the prevention of infection. Indications for handwashing: Before preparing or serving food, passing fresh water, giving medications, and before eating. Before and after .assisting residents .even when gloves are used. -To be effective, alcohol based hand rub (ABHR) must cover the entire surface of the hands and then be allowed to evaporate from the skin. None of the policies provided by the facility contained guidance for

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** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) resident hand hygiene. B. Professional standard According to the CDC, Hand Hygiene Guidance, last updated 1/30/2020: Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following: -Immediately before touching a patient, -Before moving from work on a soiled body site to a clean body site on the same patient, -After touching a patient or the patient's immediate environment, -After contact with blood, body fluids, or contaminated surfaces, -Immediately after glove removal. -Healthcare facilities should: Require healthcare personnel to perform hand hygiene in accordance with CDC recommendations. Retrieved 6/26/2020 from https://www.cdc.gov/handhygiene/providers/guideline.html. According to the CDC Hand Hygiene in Healthcare Settings: Patients guidance, last updated 3/15/16: Clean Hands Count for Patients. Patients should clean their hands: Before preparing or eating food. Before touching eyes, nose, or mouth. After using the restroom. After blowing their nose, coughing, or sneezing. After touching facility surfaces. Retrieved 6/26/2020 from: https://www.cdc.gov/handhygiene/patients/index.html C. Observations and interviews during meal service of improper hand hygiene Observations on the Bethany and Immanuel neighborhoods were conducted on 6/24/20 between 4:30 and 4:45 p.m. Observations did not reveal resident hand hygiene was performed before meal service. -At 4:45 p.m., four residents were assisted out of their rooms and into the assisted dining room. Residents were not offered hand hygiene as they entered the dining room. -Between 4:52 p.m. and 5:00 p.m., the residents in the assisted dining room were served their meal. Hand hygiene was not provided to the resident's before they ate their meal. On 6/24/2020 at 4:42 p.m., certified nurse aide (CNA) #1 was observed, in the common area of the secured unit, bringing a male resident, his walker and a cloth facemask. After assisting the male resident put on his cloth facemask, she approached a female resident who had called the CNA over to ask a question. CNA #1 touched the female resident hand and shoulder while consoling the female resident. Immediately following CNA #1 touched the shoulder of a second female resident as she passed by. CNA #1 then stopped to talk to the third female resident and assist the female resident who was in a wheelchair to the bathroom. The CNA did not perform any hand hygiene between contacts with any of the four residents that she provided physical hand on assistance too. On 6/24/2020 between 4:42 p.m. and 5:03 p.m., there were several more observations of CNA #1 touching potentially contaminated surfaces (tables in the common area, resident wheelchairs and walkers, rolling tray tables, the counter at the nurses station, resident hands/bodies and resident masks without performing hand hygiene in between contact with those surfaces and residents. On 6/24/2020 from 4:42 p.m. to 5:04 p.m., residents were observed waiting in the common area for their dinner. The residents were socializing with each other, touching potentially contaminated surfaces in the common area, touching their faces and facemasks, wandering the hall touching the handrails, coloring with shared [MEDICATION NAME] and watching television. No hand hygiene was provided. The dinner trays arrived in the common area at 5:04 p.m. None of the residents eating in the common area of the secured unit were offered, encouraged or assisted to perform hand hygiene before they were served and started to eat their dinner. CNA #1 and #2 were observed physically assisting residents to the common area dining tables to eat. The CNAs assisted some residents to the table in their wheelchair, assisted one resident to transfer from her wheelchair to a dining chair and physically guided others to sit safely in dining chairs. The CNA served dinner trays, removed plastic wrap and lids from the cups and plates, unwrapped eating utensils, handed the residents napkins and cut up food. Neither CNA #1 or #2 performed hand hygiene on themselves before or after each resident contact during the dinner services. On 6/24/2020 at 5:07 p.m., two female residents were observed waiting in the common area of the secured unit for their meal. CNA #1 assisted the residents from the common room and the back dining room to eat dinner. Neither resident was offered, encouraged or assisted to perform hand hygiene before they were served and started to eat their dinner. CNA #2 was interviewed on 6/25/2020 at 5:20 p.m. CNA #2 said most residents use the bathroom before meal time and washed their hands then. There was no sink in the common room or in the dining room for residents to wash their hands. Observations were conducted during the dinner meal on 6/24/20 between 5:25 p.m. and 5:39 p.m. CNA #8 fed two residents at the same table in the dependent dining room. The CNA alternated between feeding the two residents. During the observation, CNA #8 touched multiple potentially contaminated items such as the bottom of the stool he sat on, and both residents ' utensils, bowls and cups. He did not perform hand hygiene between feeding each resident or after he touched the stool. On 6/26/2020 at 12:35 p.m. lunch service on the secured unit was observed. CNA #3 was delivering resident meals in the common area. The CNA delivered lunch to a male resident who had been sitting in the common area of the unit. The CNA did not offer, encourage or assist the resident to perform any type of hand hygiene before serving his meal or before he started to eat. The CNA did not perform hand hygiene on herself before or after serving and setting up the meal for the resident. The CNA served another resident without performing hand hygiene. She handled a rolling table tray; positioned it in front of the resident; removed plastic wrap from the plates and cups and poured drinks; then continued to serve four other residents without offering the residents ' hand hygiene or performing hand hygiene on herself between resident contacts. CNA #3 was observed physically assisting residents into alternative seating, brushed the hair out of one resident's face with her hand, and cut up the residents food items without any hand hygiene in-between residents' contact. CNA #4 was interviewed on 6/25/2020 at 12:04 p.m. CNA #4 said she was trained to clean her hand frequently, including after touching contaminated equipment and in-between each resident contact. She said she mostly used ABHR, but washed with soap and water after assisting residents in the bathroom. The NHA was interviewed on 6/25/2020 at 1:22 p.m. The NHA said staff were to perform some type of hand hygiene after each resident contact, after touching potentially contaminated surfaces, and prior to and in-between serving the resident meals. Staff assist residents with hand hygiene first thing in the morning, at bedtime, after they used the bathroom and before they left their rooms for meals. They do not have a sink in the dining rooms so it would be challenging to wash the residents ' hands in the dining room and other residents would not understand how to use ABHR. The NHA acknowledges the facility could offer ABHR or hand wipes in the dining room and in common areas for residents who were not brought to the dining room from their rooms. Staff would have to assist those who did not understand how to use ABHR and wipes. The NHA said according to the management team, hand hygiene should have been performed between residents to prevent the potential spread of transmission [MEDICAL CONDITION] and infections. III. Improper use of alcohol based hand rub A. Manufacturer's instructions for use The Mystic Mountain hand sanitizer (ABHR) instructions for use, undated, was provided by the NHA on 6/29/20 via email. According to the instructions, the ABHR should cover all surfaces of the hands. The hands should be rubbed together until dry. B. Observations On 6/25/20 at 11:44 a.m., AC #1 placed a clothing protector on a resident in the assisted dining room in the Bethany neighborhood. AC #1 touched his neck and back of his shirt as she placed the clothing protector on the resident. She retrieved a bottle of alcohol based hand rub (ABHR) from her pocket and sprayed it on the palms of her hands. She did not spray the ABHR to cover all surfaces of her hands. The AC quickly rubbed together the palms of her hands for two to three seconds and exited the dining room. -At 11:55 a.m., AC #2 removed a meal tray from the meal cart outside of the assisted dining room in the Bethany neighborhood. The AC placed the meal in front of the resident. She uncovered the plate, drinking cup and bowls. She touched his utensils as she cut up his meal in bit sized pieces. AC #2 sprayed a ABHR on the back side and palms of her hands and waved her hands in the air to dry. She did not rub the ABHR over the surfaces on her hands till they were dry. C. Staff interview CNA #7 was interviewed on 6/25/20 at 1:10 p.m. According to the CNA, most staff used the Mystic Mountain hand sanitizer. She said the ABHR sanitizer needed to cover the hands and be rubbed together till dry for proper use. The nursing home administrator (NHA) was interviewed with the director of nursing (DON) and was interviewed on 6/22/20 at 1:22 p.m. According to the DON, ABHR should have been applied to all surfaces of the hands and the rubbed together to dry for effective use. IV. Improper hand hygiene when donning and doffing gloves A. Professional standards The Centers for Disease Control and Prevention (CDC) Using PPE, last updated 4/3/2020, retrieved from https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html. According to CDC recommendations for how to put on (don) PPE gear included identifying and gathering the proper PPE to don and perform hand hygiene before putting on gloves. B. Facility policy and procedure The Infection Control Standards Precautions policy, undated, was provided by the facility on 6/25/20. The policy read in pertinent part: Wash hands immediately after gloves are removed, between resident contacts, and otherwise indicated to avoid transfer of microorganisms to other residents and environments Wear gloves (clean, non sterile) when touching blood, body fluids, secretions, excretions, and contaminated items Change gloves between tasks and procedures on the same resident after contact with material that may contain a high concentration of microorganisms. Remove gloves promptly after use, before touching non contaminated items and environmental surfaces, and before going to another resident. Wash hands immediately to avoid transfer of microorganisms to other residents and environments. C. Observations Housekeeper (HK) #1 was observed on 6/25/20 at 10:25 a.m. cleaning room [ROOM NUMBER]. The HK donned a pair of gloves from her pocket. She did not perform hand hygiene before donning the gloves. HK #1 entered the resident room and removed a bag of trash from the waste bin next to the resident's bed. She set the trash bag off the floor and placed a new bag inside the waste bin. The HK spoke to the resident laying in bed as HK #1 touched the

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She mopped behind the stand and replaced it against the wall. HK #1 exited the room, and returned the mop to the mop bucket. She did not perform hand hygiene. With her bare hands, she touched her housekeeping cart keys, opened the cart, removed clean cloths and a cleaning bottle caddy from the cart, and returned the keys to her pocket. HK #1 entered the room, placed the items in the bathroom and proceeded to wipe down the surface of the resident's bedside table without gloves. HK #1 paused, removed a pair of gloves from her pocket and donned a new pair of gloves before entering the bathroom. HK #1 cleaned the bathroom. After cleaning the bathroom, HK #1 exited the room with a balled pair of gloves in her right hand. She threw gloves away in the cart. She did not perform hand hygiene touching the balled gloves. HK #1 reentered the resident's room with a broom. She did not wear gloves as she touched the broom handle. She completed sweeping the room and bathroom. She exited the room without hand hygiene, emptied the contents of her dust pan, retrieved the mop from the bucket, touching the handle of the mop and entered the room. She did not perform hand hygiene when entering the room, she did not don gloves and she moped the rest of the room and bathroom. The HK mopped the corner of the room behind the resident's entrance door. As she cleaned behind the door, she touched the outer surface of the door frame with her hand. HK #1 exited the room without hand hygiene, placed the mob in the bucket and moved her cleaning cart the outside of the neighboring resident room [ROOM NUMBER]. HK #1 donned a pair of gloves without hand hygiene and entered room [ROOM NUMBER]. She collected the trash and proceeded to clean room [ROOM NUMBER]. On 6/24/20 at 4:50 p.m., a meal cart with plated and covered meals arrived outside the assisted dining room. Four residents sat in the assisted dining room, waiting for their meals. -At 4:52 p.m., CNA #5 removed a pair of gloves from her pocket. She donned the gloves over her hands. She did not perform hand hygiene before she donned the gloves. CNA #5 pulled the first tray from the meal cart and placed it in front of the first resident. CNA #5 removed the plastic wrap of the plate and cup. She removed the lids of the bowls and pulled the top of a prepackaged pat of butter and placed his utensils next to his plate. She doffed her gloves by using her right hand to pull the fingertips of the left glove away from her left hand. CNA #5 used her ungloved left hand to doff the right hand. When the CNA removed the glove, she touched the outer surface of the glove with her left hand when she quickly pulled the glove off from the wrist. She balled both gloves in her left and before disposing of them. CNA#5 did not perform hand hygiene after inappropriately doffing the gloves. CNA #5 returned to the meal cart and retrieved another set of gloves from her pocket. She donned the gloves without performing hand hygiene. CNA #5 proceeded to serve the three remaining residents. During each meal delivery, she continued to not perform hand hygiene before and after donning and doffing gloves. During each meal delivery she failed to appropriately doff gloves by touching the outer surface of each glove after she served and set up the resident's meals. D. Staff interview The maintenance director (MD) was interviewed on 6/25/20 at 12:32 p.m. The MD said he oversaw the housekeeping department. According to the MD housekeepers are trained during the new hire department orientation on appropriate housekeeping practices. He said all staff receive infection control during new hire orientation. The MD said that a couple of months ago, each staff member including the housekeeping staff, received one on one training on infection control. He said the training included hand hygiene and appropriate donning and doffing of personal protective equipment (PPE). He said he also personally performed routine observation audits of housekeeping practices pertaining to cleaning and infection control. The MD stated that he felt his staff was well trained and performed safe and effective cleaning to prevent the spread of infections [MEDICAL CONDITION]. HK #1 was interviewed on 6/25/20 at 12:55 p.m. According to HK #1 hand hygiene should be performed before donning and after doffing of gloves. She said she kept alcohol based hand rub (ABHR), inside her housekeeping cart. She said an ABHR pump was located next to the door inside each resident's room. The HK said she should have worn gloves when providing each task and change the gloves after each task was completed. The nursing home administrator (NHA) and the director of nursing (DON) was interviewed on 6/25/20 at 1:22 p.m. According to management, staff has received extensive training on appropriate use of personal protective equipment (PPE), to include how to don and doff PPE correctly and the importance of hand hygiene before and after donning and doffing of gloves. V. Staff hand hygiene after touching potentially contaminated surfaces A. Observations On 6/24/20 at 4:47 p.m. A resident in the assisted dining room removed his mask as he waited for his meal. CNA #6 encouraged the resident to put his face mask back on over his face. She picked up the mask from the table, touching the inside and outside of the mask as she adjusted it to cover his nose and mouth. CNA #6 did not perform hand hygiene after she replaced the mask on the resident. The CNA entered a resident room directly across from the dining room. She did not perform hand hygiene when entering the resident's room. CNA #6 spoke to the resident inside the room and touched the resident's bedside table with her un-sanitized hands. She closed the entrance door to the resident's room, touching the inside of the door. On 6/25/20 at 12:02 p.m., activity coordinator (AC) #1, was observed as she physically fed a dependent resident in the main dining room outside of the Bethany neighborhood/unit. A bottle of alcohol based hand rub (ABHR) was placed in the center of the table near the AC. -At 12:09 p.m., AC #1 scratched the top of her right shoulder with her left hand. AC #1 then placed her left palm over the resident's beverage cup, gripping the top edge of the cup with her fingers as she moved it towards the back side of the plate. AC #1 did not provide hand hygiene after scratching her shoulder and before she placed her palm and fingers directly over the resident's cup. The AC did not perform hand hygiene with the available ABHR before she proceeded to feed the resident after scratching her shoulder. On 6/25/20 at 12:13 p.m., Housekeeper (HK) #2 was observed feeding a resident in the assisted dining room in the Bethany neighborhood. She handled the resident's cup, plate, and utensils as she physically fed the resident. -At 12:15 p.m., HK #2 put her hand over her shoulder and under the backside of her uniform top. She scratched her shoulder blade and then proceeded to feed the resident. She did not use hand hygiene after she scratched her back and before she continued to feed the resident. B. Staff interview HK #2 was interviewed on 6/25/20 at 1:05 p.m. According to HK #2, she was a paid feeding assistant. She said she was provided a two day training class to learn how to feed residents. She said the infection control preventionist provided her the training. According to the HK, appropriate hand hygiene when feeding residents was part of the training to feed residents. AC #1 was interviewed on 6/25/20 at 1:18 p.m. AC #1 said she was a paid feeding assistant. According to the AC, she was trained to not touch the eating or drinking surface of resident cups, plates or utensils. She said placing her hand over the resident's cup, gripping it around the drinking surface of the cup, would not have been an appropriate infection control technique. She said she was also trained to perform hand hygiene anytime she touched a potentially contaminated surface, especially when feeding residents. VI. PPE use A. Facility policy and procedure The Mask Procedure, dated 6/5/2020, was provided by the NHA on 6/29/2020 at 12;12 p.m., it read in pertinent part: If the unit you are assigned to has no cases of COVID 19 ., you can wear a procedure mask or an KN95 mask as a procedure mask- it is your choice. Procedure masks will be made available at the desk where you sign in for the day. B. Professional standard According to the Centers for Disease Control and Prevention (CDC) Strategies for Optimizing the Supply of Facemasks, last updated 4/3/2020, retrieved from https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/face-masks.html#contingency-capacity: In settings where facemasks are not available, HCP (healthcare personal) might use homemade masks (e.g., bandana, scarf) for care of patients with COVID-19 as a last resort. However, homemade masks are not considered PPE, since their capability to protect HCP is unknown. Caution should be exercised when considering this option. Homemade masks should ideally be used in combination with a face shield that covers the entire front (that extends to the chin or below) and sides of the face. Retrieved 6/26/2020 C. Observations and interview On 6/25/20 at 12:14 p.m. the transportation coordinator (TC) wore a cloth mask as she entered the Bethany neighborhood (unit), a resident care area. She walked down the hall passing resident rooms with open doors. The TC entered the assisted dining room in the center of the unit. Still wearing her cloth mask she spoke to a resident eating in the dining room. On 6/26/2020 from 4:32 p.m. to 5:50 p.m., CNA #1 was observed wearing a homemade cloth face mask while working with residents on the secured unit. The CNA was not wearing any other type of medically grade FDA approved mask under the homemade cloth mask. The TC was interviewed on 6/25/20 at 12:19 p.m. According to the TC, she could wear a cloth mask in the facility as long as she was not providing patient care. She said she would wear a procedure face mask if she would have been providing care. The NHA was interviewed on 6/25/2020 at 1:22 p.m. The NHA said only medical records and administrative staff were permitted to wear a cloth mask, because they do not work in residents' care areas. All other staff were trained that they needed to wear a surgical mask when in the resident care areas or when they were

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 3) with residents. The facility has N95 masks available for staff if they choose to wear the N95 mask in place of a surgical mask by their choice or when working with resident's on droplet precautions. The