STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28E199	A. BUILDING _____ B. WING _____	**07/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOLDEN OURS CONVALESCENT HOME	**902 CENTRAL AVENUE GRANT, NE 69140**

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 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation, interview, and record review, the facility failed to prepare food in accordance with professional standards for food service safety. Specifically, the facility failed to ensure staff filled containers with sanitizing solution at the appropriate concentration per manufacturer's specifications and failed to periodically test the sanitizing solution to help assure it maintained the correct concentration for 4 of 4 sanitization buckets. This failure had the potential to introduce chemical contamination on food surfaces and not prevent food-borne illness. Findings include: During an observation, record review, and concurrent interview on 7/15/20 at 2:10 PM, the Dietary Manager (DM) was asked for Sanitization Logs or evidence of monitoring by staff for the Dishwasher and Sanitization Buckets. The DM supplied the Dishwasher Daily chemical testing log, which was up to date (UTD) & within normal limits (WNL). The DM stated, there weren't chemical logs for the two sanitization buckets located in the kitchen and dishwashing areas; I didn't know we needed to. The DM then demonstrated testing of the sanitization bucket solution on both buckets, however, there was no chemical reaction on the test strip. The DM tried a second time with the same result. The DM then tested the undiluted chemical on the test strip. There was no chemical reaction. The DM stated she did not know if this was the correct test strip for this chemical. During an observation and concurrent interview on 7/15/20 at approximately 2:25 PM, two empty sanitization buckets were found in the upstairs kitchen/resident dining area. The DM stated there weren't chemical logs for these sanitization buckets. There was no evidence the facility had a system in place to monitor or evaluate the sanitizer concentration level. Specifically, the DM was unable to demonstrate how the facility tested and documented the concentration levels to ensure food safety. During an interview on 7/15/20 at approximately 4:00 PM, the Director of Nursing (DON) and the DM were asked to supply the Kitchen Sanitization Policy. On 7/16/20 at 11:04 AM the DON faxed the following documents; -Dietary Sanitizing Procedure dated and signed 7/16/20 -PH Test Log Sanitizing Solution for Dietary Department-template -Signed letter which stated, we are in process of acquiring the correct test strips for testing the sanitizing solution. The letter was signed 7/16/20 by the Dietician and Vice President of Support Services (VPSS). There was no evidence provided of kitchen sanitization policy prior to 7/16/20. During an interview and concurrent review of the sanitization log template on 7/16/20 at 12:59 PM, the VPSS stated the staff will be required to test the concentration of all four sanitization buckets every shift (approximately every eight hours). The VPSS stated the facility had previously thought, that because the solution was not mixed by the staff, the facility did not have to verify the concentration levels. Review of the Food and Drug Administration's (FDA) Food Code, section 4-501.116 accessed on 7/23/20 at https://www.fda.gov/media/ 2/download, revealed, Warewashing Equipment, Determining Chemical Sanitizer Concentration. Concentration of the SANITIZING solution shall be accurately determined by using a test kit or other device.
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 observation, interview, and record review, the facility failed to establish an infection prevention and control program designed to help prevent the development and transmission of communicable diseases and infections. Specifically, the facility failed to: Ensure two staff (S) did not work when they had symptoms of COVID-19 (S1 subsequently tested positive for COVID-19; S2 provided direct resident care); Ensure S1 and S2 notified the Employee Health Nurse of their symptom onset; Screen staff for all signs and symptoms of COVID-19 (facility wide); Ensure S1 wore a face covering during interactions with other staff members; Ensure residents were assessed for all signs and symptoms of COVID-19 (26 of 26 residents); Ensure residents were assessed for oxygen levels on every shift (26 of 26 residents); Encourage residents to wear a mask when they were outside of their rooms (26 of 26 residents); Ensure residents admitted /readmitted were quarantined on transmission based precautions (TBP) for 14 days (3 of 3 records reviewed for Resident (R)1, R2 and R3); Ensure staff knew the correct doffing (removal) sequence for personal protective equipment (PPE) (2 of 2 staff interviewed); Store surgical masks in a breathable container between uses (facility wide); Ensure staff followed manufacturer's instructions for cleaning and disinfecting a shared glucometer (1 glucometer used on 2 residents). These failures have the potential to expose all residents, staff, and visiting essential personnel to COVID-19 (a [MEDICAL CONDITION] infection that could lead to serious harm or death) or blood-borne pathogens. On 7/16/20 at 11:45 AM, an Immediate Jeopardy was identified when the facility failed to implement Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Specifically, the facility failed to ensure two staff (S) did not work when they had symptoms of COVID-19; failed to ensure S1 and S2 notified the Employee Health Nurse of their symptom onset; failed to ensure S1 wore a face covering during interactions with other staff members; failed to screen staff for all signs and symptoms of COVID-19; failed to ensure residents were assessed for all signs and symptoms of COVID-19; failed to ensure residents were assessed for oxygen levels at every shift; and failed to encourage residents to wear a mask outside of their rooms. The Immediate Jeopardy was found to have started on 7/7/20 when S2 was providing direct resident care while working with symptoms which were not reported by S2 and were not identified through the facility's screening process. A removal plan was accepted and the Immediate Jeopardy was removed on 7/17/20 at 12:40 PM after the implementation of the plan was verified by the surveyors. After removal of the Immediate Jeopardy, the scope/severity of this citation is level F. The facility provided the following acceptable removal plan on 7/17/20: - Preliminary root cause analysis of deficient practices. - Staff and residents with an exposure to S1 (16 staff) and S2 (7 staff and 26 residents) identified. - S1 was removed from the schedule on 7/13/20 until CDC return to work criteria met. - S2 was removed from the schedule on 7/14/20 until CDC return to work criteria met. - S1 was tested on [DATE] and S2 was tested on [DATE] for COVID-19. - Staff exposed to S1 were sent home on 7/15/20 and tested on [DATE]. Additional staff exposed to S2 were sent home on 7/17/20 awaiting testing. Staff will return to work based on test results. - All remaining facility staff and 26 residents will be tested for COVID-19. Testing kits were ordered on [DATE] and were to arrive 7/17/20. The Infection Preventionist (IP) and Director of Nursing (DON) will coordinate the testing along with the hospital DON and hospital Infection Control Coordinator. - On 7/16/20 the facility started a facility wide Yellow Zone (State issued quarantine zone due to possible exposure to S2). The zone will change based on resident symptoms and or test results. - Yellow Zone: All staff must wear a face mask. Staff providing direct resident care must wear an N95 mask with face shield and add a gown and gloves when entering resident rooms. Residents will be isolated to their rooms unless they have an emergent appointment. Communal dining has stopped. Activities will be provided in resident rooms. Visitation has been restricted. - On 7/16/20, resident assessments updated to include all COVID-19 signs and symptoms and oxygen saturation levels for every resident, on every shift, in the electronic medical record (EMR). - On 7/16/20, the facility assessed all 26 residents for signs and symptoms of COVID-19. - On 7/16/20, resident assessments updated to include asking residents to

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) wear a mask outside of their rooms. - Training on the new resident assessment was initiated on 7/16/20 and will continue until all charge nurses and nursing staff have been trained. - Training on the yellow zone, hand hygiene and PPE donning (putting on), doffing (taking off), storage and cleaning was initiated on 7/16/20 and will continue until all staff have been trained. - The charge nurses and DON will be responsible for staff screening on new screening tool. Training and implementation of new screening tool/procedure, including when to notify the Employee Health Nurse, initiated on 7/16/20. Training will continue until all staff have been trained. - The charge nurses and DON will monitor for compliance to the yellow zone, hand hygiene and PPE daily. - The DON and IP will monitor staff daily for signs and symptoms of COVID-19, the DON will review the screening tool three times a week and the DON and IP will meet weekly with the Employee Health Nurse to review updates related to employee health screening. - The DON and Assistant DON (ADON) will do biweekly audits on the resident assessments. Findings include: A. The facility failed to ensure S1 and S2 did not work when they had symptoms of COVID-19 and failed to ensure S1 and S2 reported their symptoms to the Employee Health Nurse on the day of symptom onset. Review of a facility letter (untitled and undated), provided on 7/15/20 showed: 3. Report any illness for yourself or family to Employee Health for guidelines. Do NOT come to work sick; call and talk with your supervisor or Employee Health when possible. Review of the facility policy titled, Infection Control-General Policies Year: 2019, provided on 7/15/20 showed: I.2. Employees must report to their Director/Manager if they have any acute respiratory illness, such as colds, sinusitis, sore throats or intestinal disorders. During an interview on 7/16/20 at 7:40 AM, S1 stated she was at work on 7/10/20 when she started having an itchy throat and sweating. S1 stated she had not notified anyone of her symptoms on 7/10/20. S1 stated she returned to work on 7/13/20 because she was the scheduled registered nurse (RN) for the day. S1 stated, on 7/13/20, she still had an itchy throat, sinus congestion and was sweating. S1 stated she left work on 7/13/20 to go see the doctor and was tested for COVID-19. S1 stated she knew she was not supposed to come to work when she felt sick but she thought it was only a sinus infection. S1 stated she tested positive for [DIAGNOSES REDACTED]-CoV-2 on 7/14/20. During an interview on 7/16/20 at 9:30 AM, S2 stated she thought she had a sinus infection and continued to work when she did not feel well. Specifically, S2 stated she worked on 7/7, 7/10, 7/13 an 7/14/20. S2 stated on 7/7, she felt unwell, dizzy when she stood up and moved and had a stuffy nose. She stated she went to the doctor on 7/10 and was prescribed antibiotics for a sinus infection. On 7/13 she had new symptoms: slight dry cough and could not taste or smell. S2 stated she had been trained on the symptoms of COVID-19 and on not coming to work sick. S2 stated she also was trained to notify the Employee Health Nurse when she was sick but she stated she did not follow protocol and did not tell anyone about her symptoms. Review of the facilities, Staff Screening For Source Control, on 7/16/20, revealed S1 and S2 did not identify any symptoms of illness. Specifically: - S1 screened in on 7/8, 7/9, 7/10 and 7/13 and answered no each time to the question, Have you had a fever (over 100.4 degrees), new cough, or S.O.B. (shortness of breath)? - S2 screened in on 7/2, 7/5, 7/6, 7/7, 7/10 and 7/13 and answered no each time to the question, Have you had a fever (over 100.4 degrees), new cough, or S.O.B.? During an interview on 7/15/20 at 12:45 PM, the Director of Nursing (DON) stated S1 came into work sick on 7/13 and did not follow facility policy to stay home. The DON stated she was not aware S1 had been feeling unwell until she was notified of the positive COVID-19 test result on 7/14/20. During an interview on 7/15/20 at 2:38 PM, the back-up Administrator stated that no one should come to work when they don't feel well. During an interview on 7/16/20 at 2:34 PM, the Employee Health Nurse stated staff should not enter the building when they are feeling sick because we have too many people that are vulnerable. She stated she had repeated this message to all new recruits and management. She stated management was responsible to train their employees in the organization (nursing home, assisted living and hospital). Review of the facility's Employee Illness Worksheets and Employee Absence Spreadsheets for the month of July 2020, revealed no evidence S1 or S2 notified the Infection Preventionist or Employee Health Nurse of their symptoms. During an interview on 7/16/20 at 3:12 PM, the Infection Preventionist (IP) stated staff have been trained to call her first if they are feeling sick. The IP stated if she was not at work, staff were to call one of the three Employee Health Nurses. The IP stated it was not a great system because she and the main Employee Health Nurse did not work five days a week. B. The facility failed to screen staff for all signs and symptoms of COVID-19. Review of the (facility name) LTC (Long term care) Response Planning Tool, provided on 7/15/20, showed, Screening: All departments will be screened for temperature at the beginning of their shift at (facility name). (Universal Source Control) Screening questions include recent travel, S&S (signs and symptoms) of infectious disease, a loss of taste or smell. Symptom list posted at screening station. Review of the Symptom list posted at the screening station revealed the following symptoms: fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting and diarrhea. However, review of the facilities Staff Screening For Source Control form on 7/16/20, revealed the form only included: the date of the screening, the name of the employee, the current temperature result and the question, Have you had a fever (over 100.4 degrees), new cough, or S.O.B.? with a yes/no indicator. There was no evidence staff were screened for recent travel or the list of symptoms posted at the screening station. In addition, the temperature threshold of 100.4 degrees did not follow CDC guidance which states: *For the purpose of this guidance, fever is defined as subjective fever (feeling feverish) or a measured temperature of 100.0oF (degrees Fahrenheit) (37.8oC) (degrees Celsius) or higher. Note that fever may be intermittent or may not be present in some people, such as those who are elderly, immunocompromised, or taking certain fever-reducing medications (e.g., nonsteroidal anti-[MEDICAL CONDITION] drugs (NSAIDS)). Taken from the CDC Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to COVID-19 accessed on 7/17/20. During an interview on 7/17/20 at 12:00 PM, the DON stated the previous screening form was not sufficient to identify all the COVID-19 symptoms. The DON stated the screening form had now been updated to include the full list of signs and symptoms, including the recommended temperature threshold of 100.0oF. The DON stated she would also be alert to multiple temperatures in the 99.0oF to 100.0oF range. The DON stated staff will no longer self-screen and will be required to screen-in with the DON or a charge nurse. Review of the new screening form on 7/17/20 confirmed the screening form had been updated with the full list of COVID-19 signs, symptoms and correct temperature threshold. C. The facility failed to ensure S1 wore a face covering during interactions with other staff members. Review of the (facility name) LTC Response Planning Tool, provided on 7/15/20, showed, PPE outbreak Masks: Blue surgical masks for nurses, direct care, any staff who interact with resident within 6 ft. (feet) distance. Cloth or yellow masks for administration, housekeeping, dietary .All departments to wear masks in halls, resident care areas, and resident rooms. However, review of the CDC's Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, accessed on 7/16/20 at https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html, showed, HCP (health care professionals) should wear a facemask at all times while they are in the healthcare facility, including in breakrooms or other spaces where they might encounter co-workers. In addition, review of email correspondence between the State Public Health Department and the DON, dated 7/16/20 at 7:55 AM, revealed, Anytime a healthcare worker is exposed to another healthcare worker while both are wearing masks that is considered a low risk exposure and for that kind of exposure exclusion from work/quarantine is not recommended. However, if anyone of them is not wearing a mask than the risk of exposure may be higher, and in that case CDC recommends exclusion from work or quarantine for 14 days from last exposure. During an interview on 7/16/20 at 7:40 AM, S1 stated, I probably don't always wear a mask in my office and I have people coming in and out of my office all day. During an interview on 7/16/20 at 9:23 AM, S3 stated that during an approximately 20 minute interaction on 7/7/20 or 7/8/20 in S1's office, S1 was not wearing a mask. S3 stated she was wearing a mask but she may have pulled her mask down to talk to S1 during the interaction. During an interview on 7/16/20 at 9:30 AM, S2 stated she was wearing a mask when she went to S1's office on 7/13/20 but she did not think S1 was wearing a mask. S2 stated she was at the doorway and S1 was behind her desk. S2 stated staff may take off a mask with other employees so that they can hear each other better. S2 stated she always wore a mask around residents but that she may take it off by the nursing station if she was alone. During an interview on 7/17/20 at 12:00 PM, the DON stated she would ensure all staff in the facility, including administrative and kitchen staff would wear a mask during all interactions with staff and residents. The DON also stated she would continue to work with the State to determine the mask type (N95, surgical or cloth) and eye protection required for all departments while the facility was in the yellow zone. During a tour of the facility on 7/17/20 at 12:00 PM, all staff were observed wearing a mask except S15 who was preparing a COVID-19 unit alone, behind closed doors. D. The facility failed to ensure residents were assessed for all signs and symptoms of COVID-19 and failed to ensure residents were assessed for oxygen levels at every shift. Review of the (facility name) LTC Response Planning Tool, provided on 7/15/20, showed: Residents: Screen and monitor residents q (every) shift .Documentation of screening will be done through (EMR name). Review of the Medication Administration Record (MAR) Resident Screening Orders,

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 2) on 7/15/20 for all 26 residents, revealed two times a day (every shift) monitoring of cough, fever, shortness of breath and sore throat. However, the orders did not include the symptoms of chills, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, congestion or runny nose, nausea, vomiting or diarrhea. Further review also revealed no evidence the facility was monitoring all 26 residents for oxygen saturation levels on every shift. During an interview on 7/15/20 at 12:45 PM, the DON stated all residents were screened for COVID-19 during every 12 hour shift. The screening was performed by licensed nursing staff and documented on the MAR. The DON stated the facility was not checking the oxygen saturation levels for every resident at every shift. The DON stated that only those residents on supplemental oxygen would have their oxygen saturation levels checked. However, review of the CDC Preparing for COVID-19 in Nursing Homes, accessed 7/16/20 at https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html, revealed: Evaluate and Manage Residents with Symptoms of COVID-19: - Ask residents to report if they feel feverish or have symptoms consistent with COVID-19. - Actively monitor all residents upon admission and at least daily for fever (T (temperature) 100.0oF) and symptoms consistent with COVID-19. Ideally, include an assessment of oxygen saturation via pulse oximetry. If residents have fever or symptoms consistent with COVID-19, implement Transmission-Based Precautions as described below. -Older adults with COVID-19 may not show common symptoms such as fever or respiratory symptoms. Less common symptoms can include new or worsening malaise, headache, or new dizziness, nausea, vomiting, diarrhea, loss of taste or smell. Additionally, more than two temperatures >99.0oF might also be a sign of fever in this population. Identification of these symptoms should prompt isolation and further evaluation for COVID-19. During an interview on 7/17/20 at 12:00 PM, the DON stated the MAR had been updated to include the complete list of COVID-19 symptoms and an oxygen saturation level at every shift. During an interview and concurrent record review on 7/17/20 at 12:19 PM, the Licensed Practical Nurse (LPN) 14 stated the night shift charge nurse trained her this morning on the new resident COVID-19 screening tool and oxygen saturation. LPN 14 stated the new resident screening began on the night shift (7/16/20). The LPN 14 showed the new screening tool and oxygen saturation orders in the MAR for three sampled residents (R1, R2 and R4). The LPN 14 demonstrated how to enter the screening results into the MAR using a drop down list of COVID-19 symptoms and a comments field for the nurse to add additional information. The LPN 14 also demonstrated how to enter the resident's oxygen saturation level into the MAR. Further review of R1, R2 and R4's MAR, revealed the new screening tool and oxygen saturation orders had been completed for the night shift (7/16/20) and day shift (7/17/20). E. The facility failed to encourage residents to wear a mask when they were outside of their rooms. During the initial facility tour on 7/15/20 at 12:30 PM, five residents were seen outside of their rooms eating near the nurses' station and walking in the hallway. All five residents were not observed wearing a face covering. Review of the (facility name) LTC Response Planning Tool, provided on 7/15/20, showed: PPE resident use: Residents distanced in public areas, yellow mask to be worn for outside appts, (appointments). Further review revealed, Activities: Group activities restricted to 4 residents with social distancing. During an interview on 7/15/20 at 12:45 PM, the DON stated the facility had not offered face coverings to residents when they were outside of their rooms because the facility had not had any positive cases. The DON stated the facility allowed four residents to a group for activities to ensure social distancing of six feet but the residents did not wear face coverings during the small group activity. The DON stated that residents would only be required to wear a mask for appointments outside of the facility. However, review of CDC Preparing for COVID-19 in Nursing Homes (updated 6/25/20), accessed 7/16/20 at https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html, revealed: Implement Source Control Measures. Residents should wear a cloth face covering or facemask (if tolerated) whenever they leave their room, including for procedures outside the facility. Cloth face coverings should not be placed on anyone who has trouble breathing, or anyone who is unconscious, incapacitated, or otherwise unable to remove the mask without assistance. In addition to the categories described above cloth face coverings should not be placed on children under 2. During an interview and concurrent record review on 7/17/20 at 12:00 PM, the DON stated that during the yellow zone implementation, which began on 7/16/20, residents were isolated to their rooms except for emergency appointments. However, the facility had decided to add an order to the MAR for each resident that revealed: Offer resident a mask when they are leaving their room. Complete the special requirement to indicate resident's wishes for each shift. The documentation also included the resident response of Yes, No, Resident Refused and Cognitively Impaired. The DON further stated that she had trained her nursing staff to include resident education on the use and reason for the mask. Review of the EMR on 7/17/20 at 12:00 PM revealed the mask order had been added to the MAR for the residents. F. The facility failed to ensure residents admitted /readmitted were quarantined on TBP for 14 days as recommended by the CDC. Review of the CDC's Responding to Coronavirus (COVID-19) in Nursing Homes (updated 4/30/20), accessed 7/16/20 at https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html revealed: Considerations for new admissions or readmissions to the facility - Newly admitted and readmitted residents with confirmed COVID-19 who have not met criteria for discontinuation of Transmission-Based Precautions should go to the designated COVID-19 care unit. - Newly admitted and readmitted residents with COVID-19 who have met criteria for discontinuation of Transmission-Based Precautions can go to a regular unit. - If Transmission-Based Precautions have been discontinued, but the resident with COVID-19 remains symptomatic (i.e., persistent symptoms or chronic symptoms above baseline), they can be housed on a regular unit but should remain in a private room until symptoms resolve or return to baseline. These individuals should remain in their rooms to the extent possible during this time period. If they must leave their rooms, facilities should reinforce adherence to universal source control policies and social distancing (e.g., perform frequent hand hygiene, have the resident wear a cloth face covering or facemask (if tolerated) and remain at least 6 feet away from others when outside of their room). - Create a plan for managing new admissions and readmissions whose COVID-19 status is unknown. Options include placement in a single room or in a separate observation area so the resident can be monitored for evidence of COVID-19. - All recommended COVID-19 PPE should be worn during care of residents under observation, which includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown. - Testing residents upon admission could identify those who are infected but otherwise without symptoms and might help direct placement of asymptomatic [DIAGNOSES REDACTED]-CoV-2-infected residents into the COVID-19 care unit. However, a single negative test upon admission does not mean that the resident was not exposed or will not become infected in the future. Newly admitted or readmitted residents should still be monitored for evidence of COVID-19 for 14 days after admission and cared for using all recommended COVID-19 PPE. Testing should not be required prior to transfer of a resident from an acute-care facility to a nursing home. - New residents could be transferred out of the observation area or from a single to a multi-resident room if they remain afebrile and without symptoms for 14 days after their last exposure (e.g., date of admission). Testing at the end of this period could be considered to increase certainty. However, during an interview on 7/15/20 at 12:45 PM, the DON stated the facility policy for new admissions was to ensure the resident had a recent COVID-19 negative test result prior to admission and then isolate the resident to their room for 14 days. The DON stated these residents were not placed in any additional transmission based precautions. During a subsequent interview at 2:18 PM, the DON provided the facility policy for admission and stated the facility was only accepting admissions from the adjacent assisted living facility and the adjacent hospital which was governed by the same infection control policies and organization. The DON stated, because all three of the facilities practiced the same COVID-19 procedures, and because there was no identified COVID-19 community transmission, they had not implemented TBPs for the admission/re-admissions. Review of the facilities Protocol for Admissions under COVID-19 Precautions, provided on 7/15/20, revealed: Requests for admission from the hospital, swing bed, and (facility name) Assisted Living will be considered if the following criteria are met: - Recent COVID negative test - Clinical signs of acute respiratory illness absent or mitigated per treatment in the acute care setting - Availability of an appropriate room . - Availability of adequate staff . Potential Admission from outside the (corporation name) will considered (sic) if the following criteria are met. - History of travel in the last two weeks indicates no exposure risk factors. - No symptomatic respiratory illness present. - Potential admission has been isolated in their existing setting for 72 hours. - Obtain COVID-19 test after 72 hours of isolation and continue in isolation in existing setting. When test returns negative, will be considered for admission. - Availability of an appropriate room . - Availability of adequate staff . i) Review of R2's Face Sheet on 7/16/20, revealed R2 was admitted on [DATE]. [DIAGNOSES REDACTED]. Review of the Hospital Lab Report revealed R2 had tested negative for COVID-19 on 6/27/20. Further record review revealed no evidence R2 had been isolated to her room (per facility policy) with TBP (per CDC guidelines) after admission. Specifically, review of Departmental Notes, revealed on: - 7/1/20 at 2:29 PM, R2 was moved into a room with another resident. - 7/1/20 at 3:43 PM, Resident followed Covid 19 (sic) admission policy. Negative test results were received. - 7/10/20 at 11:10 AM, R2 was invited to a group activity but declined. During an interview on 7/16/20 at 2:16 PM, the DON stated R2 was a new admission

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(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	(continued... from page 3) from the adjacent assisted living facility and the policy was to isolate the resident in their room but the facility did not initiate COVID-19 TBPs. ii) Review of R3's Hospital Transfer to Nursing Home on 7/16/20, revealed R3 was re-admitted on [DATE]. [DIAGNOSES REDACTED]. Further review showed no evidence of a COVID-19 test/result. In addition, R3's record revealed no evidence R3 had been isolated to her room with TBP after re-admission. Specifically, review of Departmental Notes, dated 6/17/20 revealed R3 went to the dining room for both meals. During an interview on 7/16/20 at 2:16 PM, the DON stated R3 had been sent to the hospital on [DATE] for abdominal pain and a colonoscopy. The DON stated the facility had not been isolating residents with TBP for re-admissions from the adjacent hospital. The DON stated R3 had had a COVID-19 negative test result prior to re-admission. However, the test result was not provided by survey exit on 7/17/20. iii) Review of R1's Hospital Transfer to Nursing Home on 7/16/20, revealed R1 was re-admitted on [DATE]. [DIAGNOSES REDACTED]. Review of the Hospital Lab Report revealed R1 had tested negative for COVID-19 on 5/17/20. Further record review revealed no evidence R1 had been isolated to her room with TBP after re-admission. During an interview on 7/16/20 at 2:16 PM, the DON stated R1 had been transferred to the hospital on [DATE] for low oxygen saturations and a chest x-ray. The DON confirmed that R1 had not been isolated with TBP after re-admission on 5/18/20. G. The facility failed to ensure staff knew the correct sequence for PPE. Review of the CDC's Sequence for How to Safely Remove Personal Protective Equipment (PPE) Example 1, provided on 7/15/20, revealed all PPE (glove, gown, eye protection) can be removed before exiting the patient room except for the mask or respirator which must to be removed after leaving the patient room and closing the door. According to the procedure, the sequence for removing PPE is: gloves, then eye protection (goggles or face shield), then gown (inside the resident room), followed by mask removal outside of the resident room. The final step of doffing requires staff to perform hand hygiene (hand washing with soap and water; or the use of an alcohol-based hand sanitizer). During an observation and concurrent interview on 7/15/20 at 3:30 PM, the LPN 8 stated she had been trained in May 2020 on the facilities donning and doffing procedure. However, when LPN 8 started to remove her PPE, she began to take off her goggles and then stopped and stated she was confused with the order to doff her PPE. During an interview on 7/15/20 at 4:05 PM, the IP stated she had trained the nursing staff on donning and doffing using the CDC's Sequence for How to Safely Remove PPE Example 1. Review of the Donning and Doffing In-service record revealed training had been completed on 5/15/20. In addition, the IP stated if staff missed the In-Service she would do a one-on-one training and have the nurse sign the procedure. Review of a copy of the CDC Sequence for removing PPE showed evidence of a nurse who signed the procedure on 6/5/20 with a co-signature by the IP. During the same interview, the IP stated she was responsible for training nursing staff in the correct donning and doffing of PPE. The IP stated the sequence for removing PPE was to take off the gown and gloves together, then eye protection, then mask and then hand hygiene. The IP stated doffing was completed just outside of the resident room or at the doorway. However, during review of the doffing procedure utilized by the facility, the IP stated she had incorrectly identified where PPE was to be doffed. The IP stated she would make sure to provide a refresher for all the nursing staff and she would make sure there were garbage cans both inside and outside the resident room so that the disposal of PPE procedure could be followed. H. The facility failed to store surgical masks in a breathable container between multiple uses. Review of the CDC's Strategies for Optimizing the Supply of Facemasks (updated 6/28/20), accessed 7/15/20 at https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/face-masks.html revealed: HCP (health care professionals) should leave patient care area if they need to remove the facemask. Facemasks should be carefully folded so that the outer surface is held inward and against itself to reduce contact with the outer surface during storage. The folded mask can be stored between uses in a clean sealable paper bag or breathable container. Review of the facilities, Reuse of N95 Masks during Times of Shortages, provided on 7/15/20, showed: If using hands-free doffing: - Place plastic container over the mask while it is still on your face. - Remove each strap and wrap it around the outside of the container towards the front of the mask (or the bottom of the container). - Close the container. If re-using surgical masks, they should be carefully folded so that the outer surface is held inward and against itself to reduce contact with the outer surface during sto