STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455725	A. BUILDING _____ B. WING _____	**05/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OAKMONT HEALTHCARE AND REHABILITATION CENTER OF HU	**8450 WILL CLAYTON PKWY HUMBLE, TX 77338**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to establish and maintain an infection control program to provide a safe and sanitary environment to help prevent the development and transmission of disease and infections for 5 of 26 residents (Residents #1, #2, #3, #4, and #5) reviewed for infection control. -The facility failed, due to improper isolation procedures, and standard and droplett precautions, to prevent the spread of COVID-19 to 10 residents who were hospitalized , 33 residents in isolation at the facility, and 21 staff. -The facility failed to provide hand sanitizers at the COVID unit's only authorized entrance/exit door requiring staff to search for the medication cart to hand sanitize before donning PPE. -The facility's staff moved between the Observation/Quarantine hall and the Non-COVID without changing their PPE. -Facility Staff failed to perform hand hygiene when entering and exiting resident rooms. An Immediate Jeopardy (IJ) was identified on 4/22/2020. While the IJ was lowered on 5/12/2020, the facility remained out of compliance at a severity level of actual harm and a scope of pattern due to the facility still monitoring the effectiveness of the Plan of Removal These failures placed all residents and staff at risk infection or re-infection with the potential spread of infection to the public which could cause a decline in health or death. Findings Include: Record review of facility census report dated 04/29/2020 revealed there were 33 residents in the COVID positive unit, 10 COVID positive residents in the hospital, 8 residents in the Observation/Quarantine unit and 38 residents in the COVID negative unit. Record review of site visit assessment by the Local County Health Department Epidemiologist dated 04/25/2020 revealed: .Due to the quantity of positive, asymptomatic cases at this facility, we recommend following respiratory droplet precaution guidelines facility-wide . Typical, Standard COVID Transmission-Based Precautions are not being followed. Resident #1 Record review of Resident #1's admission record revealed an [AGE] year old female who was admitted on [DATE]. Her [DIAGNOSES REDACTED]. Record review of Resident #1's Admission's minimum data set ((MDS) dated [DATE] revealed a BIMS scored 7 indicating severe cognitive impairment. The functional status section revealed she required extensive assistance with bed mobility, transfers, dressing and grooming. She required supervision for eating. Record review of Resident #1's undated care plan, revealed she was at risk for infection of opportunistic infection related to (r/t): presence of signs and symptoms of respiratory infection and/or risk of respiratory infection due to [MEDICAL CONDITIONS]. She had a respiratory infection (r/t) COVID-19. Interventions included; .provide a clean, well-ventilated environment . Record review of Resident #1's physician order [REDACTED]. Record review of Resident #1's Nursing progress note dated 05/08/2020 revealed she was pronounced dead at the facility on 05/08/2020. Resident #2 Record review of Resident #2's admission record revealed a [AGE] year old female admitted on [DATE]. Her [DIAGNOSES REDACTED]. Her [DIAGNOSES REDACTED]. Record review of Resident #2's Quarterly MDS dated [DATE] staff assessment for mental status revealed she had a short term and long term memory problem and that her cognitive skills were severely impaired. The functional status section revealed she required extensive assistance with bed mobility, dressing and personal hygiene. She required total assistance with transfer and supervision for eating. Record review of Resident #2's undated care plan, revealed she was at risk for infection of opportunistic infection related to (r/t): presence of signs and symptoms of respiratory infection and/or risk of respiratory infection due to [MEDICAL CONDITION]. She had a respiratory infection r/t COVID-19. Interventions included: .provide a clean, well-ventilated environment . Record review of Resident #2's physician order [REDACTED]. Record review of Resident #2's nursing progress note dated 05/03/2020 revealed time of death at the facility on 05/03/2020 09:02 AM. In a telephone interview on 05/26/2020 at 4:40 p.m., the Local County Health Department Epidimiologist said that Resident #2's death was related to COVID. Resident #3 Record review of Resident #3's admission record revealed an [AGE] year old male re-admitted on [DATE] and original admission on 07/24/2015. His [DIAGNOSES REDACTED]. Record review of Resident #3's Quarterly MDS dated [DATE] revealed a BIMS score of 10 indicating moderate cognitive impairment. The functional status section revealed he required extensive assistance with bed mobility, toilet use and personal hygiene. He required supervision for eating. Record review of Resident #3's undated care plan revealed he was at risk for infection (progression/onset of opportunistic infection) r/t: presence of signs and symptoms of Respiratory infection. Interventions included: .provide a clean, well-ventilated environment . Record review of Resident #3's physician order [REDACTED]. Resident #4 Record review of Resident #4's admission record revealed a [AGE] year old female admitted on [DATE]. Her [DIAGNOSES REDACTED]. Record review of Resident #4's Quarterly MDS dated [DATE] revealed a BIMS score of 13 indicating she was cognitively intact. The functional status section revealed she was independent with all activities of daily living (ADLs). Record review of Resident #4's undated care plan revealed he was at risk for infection (progression/onset of opportunistic infection) r/t: presence of signs and symptoms of Respiratory infection and/or risk of respiratory infection due to [MEDICAL CONDITION] etc. The interventions included: .provide a clean, well-ventilated environment .wash hands before and after all care contacts . Record review of Resident #4's physician order [REDACTED]. Resident #5 Record review of Resident #5's admission record revealed a [AGE] year old female admitted on [DATE]. Her [DIAGNOSES REDACTED]. The section on skin condition revealed she had a pressure ulcer. Record review of Resident #5's Quarterly MDS dated [DATE] revealed a BIMS score of 11 moderate cognitive impairment. The functional status section revealed she required extensive assistance in all ADLs and was totally dependent for toilet use. Record review of Resident #5's undated care plan revealed he was at risk for infection (progression/onset of opportunistic infection) r/t: presence of signs and symptoms of Respiratory infection and/or risk of respiratory infection due to [MEDICAL CONDITION] etc. The interventions included: .provide a clean, well-ventilated environment .wash hands before and after all care contacts . Record review of Resident #5's April 2020 Medication Administration Record [REDACTED]. Record review of Epidemiologist notes from visit on 04/24/2020 revealed notes/areas of improvement Health care professional (HCP) dedicated to COVID care are on an isolated unit, and under no circumstances interact with non COVID units. 11 COVID+ staff are still working, but isolated to COVID+ unit. Use separate door of entry, and under no circumstances are allowed in other areas of facility . In an interview and observation on 04/29/2020 at 11:30 AM revealed the Administrator showing where residents were located in the facility on the floor plan. She said residents who were recently transferred from hospital or had recently left facility and returned and were in 14 day quarantine in the Observation/Quarantine unit or transitional hall, rooms 115-121. Residents positive for COVID-19 were located in the COVID unit. She said there was only one entrance to this unit and staff entered and exited through an the outside door. Staff working on the COVID unit were not permitted to enter or exit unit through the building. In an observation on 04/29/2020 at 12:00 PM, of the Observation/Quarantine hall revealed it was occupied by 7 residents, at the far end of the Observation/Quarantine hall there was one resident who was symptomatic. The double doors to the hall were closed. The doors to resident rooms were open. There was a cart outside only one room. In a telephone interview on 04/30/2020 at 9:30 AM, the local county Epidemiologist said each room in the Observation/Quarantine unit should have closed doors and isolation carts. He said these residents were being monitored for 14 days and were presumptive positive for COVID. Record review of the COVID-19 Response for Nursing Facilities, Version 2.5 dated 4/27/20, Attachment 1: Immediate Response Guidelines revealed .Create an isolation wing/unit In an observation and interview on 04/29/2020 at 12:45 AM, revealed there was no hand

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 -** Many	(continued... from page 1) sanitizer on the PPE cart located at the entrance/exit door to COVID positive unit. In an observation and interview on 04/30/2020 at 12:00 PM in the COVID positive unit, revealed the COVID Positive Unit Manager assisted the Surveyor by opening doors, checking residents behind curtains, checking paper towels and soap supply at sinks inside resident rooms. She had gloves on while in the hallway and did not change the gloves or perform hand sanitizer when entering and exiting rooms. She entered the semi-private room for Resident #1 and Resident #2, both in bed. She touched the privacy curtain, paper towel dispenser and soap dispenser all which are touched by all staff entering the room provide resident care. She exited the room. When asked when should gloves be changed and hand hygiene performed she said, it depended on what she will be doing and would start with a new pair of gloves if doing resident care. She said she was not doing resident care, so she did not need to change gloves. Record review of CDC instructions on when to use gloves revealed: -Use disposable gloves when cleaning and disinfecting the area around the person who is sick or other surfaces that may be frequently touched in the home. -Use disposable gloves when touching or having contact with blood, stool, or body fluids, such as saliva, mucus, vomit, and urine. -After using disposable gloves, throw them out in a lined trash can. Do not disinfect or reuse the gloves. -Wash your hands after you have removed the gloves. https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/gloves.html In an observation and interview on 04/30/2020 at 12:30 PM, revealed the entrance/exit to COVID positive unit had personal protective equipment (PPE) cart and no hand sanitizer. The COVID positive Unit Manager said there were hand sanitizers on the med carts. The Med carts were not close to the entrance or PPE cart. The Med carts were approximately 20 feet away at each end of nurse station. She said they usually moved hand sanitizer to the back door between shifts. When asked when hand hygiene was supposed to be performed and why it was important, she said hand hygiene was done after removing gloves. She said hand hygiene was done in order to prevent transmission of germs from the outside into the unit; and to prevent transmission of germs from unit to the outside. In an interview on 05/01/2020 at 11:35 AM, LVN A said infection control was to keep from spreading germs, hand hygiene was supposed to be done before entering residents' rooms, after every task, and to wash hands when tasks were completed. If soap and water were not available, they could use hand sanitizer. In an observation and interview on 05/01/2020 at 12:30 PM in the COVID negative unit revealed CNA A was wearing gloves. CNA A removed a meal tray from cart and delivered the tray to Resident #3. She touched overbed table before she exited the room. She did not change her gloves or perform hand hygiene. CNA A touched every tray in the cart (6 trays) and the outside of the cart. Then, she took a tray to Resident #4's room and touched the overbed table. She exited the room without performing hand hygiene and changing her gloves. She touched the coffee cart, coffee cup, coffee dispenser, and returned to room and gave coffee mug to Resident #4. She exited Resident #4's room and returned to the lunch cart without performing hand hygiene and changing gloves. CNA A picked up a tray, entered Resident #5's room, and touched overbed table. She exited the room and picked up a beverage glass, entered Resident #5's room, placed beverage on Resident #5's lunch tray, assisted resident with items on the tray and exited room. CNA A said she just started working at the facility about a month ago. When asked about when gloves should be used, she said she did not know how to answer because she spoke a different language. Then, CNA A said that she knew that during care, like changing or cleaning residents or touching their blankets, she should wash hands. When asked why hand hygiene was important, she said hand washing was to keep from spreading germs. In an observation on 05/01/2020 at 11:35 AM, revealed there were multiple staff in the hallways of the COVID negative and Observation/Quarantine units wearing gloves; not changing and hand sanitizing before they entered another room. They were not providing resident care. Record review of the CDC website revealed: Nonsterile disposable patient examination gloves, which are used for routine patient care in healthcare settings, are appropriate for the care of patients with suspected or confirmed COVID-19. https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirator-use-faq.html#Gloves In an observation and interview on 05/01/2020 at 1:45 PM, revealed a staff member entered unit from outside door and placed belongings on a side table. She took an isolation gown from PPE cart. She did not have a mask on when she walked away from the PPE cart to a nearby office. She returned wearing a N95 respirator. The COVID Unit Manager said she kept the N95 respirators in her office and not in the PPE cart so they did not disappear. In an interview on 05/04/2020 at 2:15 PM, the Administrator said as of the current date, 11 COVID positive staff were asymptomatic, assigned to working COVID positive unit, and they were moved around during staffing crises. This meant that they would work on the COVID negative hall as well. Eight staff were quarantined and 2 were in the hospital. Record review of the facility employee list dated 5/4/2020, comparing the list with time sheets of team members tested positive for [MEDICAL CONDITION]. Revealed that 3 out of 21 COVID positive employees had worked in the COVID negative unit between April 24 and May 5. -CNA A worked on the Negative unit on 05/01/2020, 05/02/2020 and 05/03/2020 CNA C worked on the negative unit on 04/24/2020, 04/25/2020, 04/26/2020, 05/30/2020 and 05/01/2020. COVID Positive Unit Manager worked on the Negative Unit on 05/01/2020. In an interview on 05/04/2020 at 2:30 PM, the Wound Care Nurse said she provided care to residents with on the COVID unit and residents in the Observation/Quarantine hall. She said her schedule for COVID unit was Monday, Wednesday, and Friday. In an observation on 05/04/2020 at 2:45 PM, revealed CNA A and MA A both wearing gowns, were in in resident rooms on the Observation/Quarantine unit. MA A was passing medication in a resident room in the Observation/Quarantine unit, MA A entered the Observation/Quarantine unit from the COVID negative hall through double doors with CNA A. MA A returned to Observation/Quarantine Unit to get the med cart and brought it to room [ROOM NUMBER] which was in the COVID negative hall (residents who have not recently left building). MA A said she was assigned to residents in Negative area as well as Observation/Quarantine Hall. She did not change her PPE when moving between the halls. In an interview on 05/04/2020 at 2:45 PM, the ARNP, the physician's nurse practitioner who visits the facility almost daily, said residents in Observation/Quarantine unit are the same as the rest of the residents in hall 100, it was really an extension of the non-COVID unit. They are all COVID negative, asymtomatic, and being monitored for development of symptoms. Record review of HHS website regarding how to implement quarantine revealed: Quarantine separates and restricts the movement of people who were exposed to a contagious disease to see if they become sick. These people may have been exposed to a disease and do not know it, or they may have the disease but do not show symptoms. https://www.hhs.gov/answers/public-health-and-safety/what-is-the-difference-between-isolation-and-quarantine/index.html In a telephone interview on 05/05/2020 at 10:00 AM, COVID negative Unit Manager said the Observation/Quarantine hall was for residents who were newly admitted or readmitted and returned from the hospital. They were to be monitored for 14 days. All the residents on the unit tested negative for COVID. If they were symptom-free after 14 days, they would return to the COVID negative hall. She said the staff were not expected to change gowns if they entered these rooms. Gowns were required when entering one of the designated Isolation rooms at the end of hall. Record review of the admission records for the residents quarantined on the Observation/Quarantine hall revealed Resident 6 was readmitted on [DATE], Resident 7 on 4/13/2020, Resident 8 on 4/17/2020 and 3 residents on 4/27/2020. Resident 9 was admitted on [DATE] and had not been moved out of the hall when the hall was converted to an observation or quarantine hall. Record review of CDC Guidelines for Transmission-Based Precautions revealed: Transmission-Based Precautions are the second tier of basic infection control and are to be used in addition to Standard Precautions for patients who may be infected or colonized with certain infectious agents for which additional precautions are needed to prevent infection transmission . Contact Precautions, Use Contact Precautions for patients with known or suspected infections that represent an increased risk for contact transmission . . Use personal protective equipment (PPE) appropriately, including gloves and gown. Wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment. Donning PPE upon room entry and properly discarding before exiting the patient room is done to contain pathogens . .Droplet Precautions Use Droplet Precautions for patients known or suspected to be infected with pathogens transmitted by respiratory droplets that are generated by a patient who is coughing, sneezing, or talking . . https://www.cdc.gov/infectioncontrol/basics/transmission-based-precautions.html During a telephone interview on 5/10/2020 at 4:35 PM, regarding a facility inspection conducted on 05/05/2020, the Epidemiologist he said he observed a male staff member in the Observation/Quarantine hall entering resident rooms serving food trays and not performing hand hygiene. He said he saw same staff member picking up trays with gloves on and not doing hand hygiene. He said he observed another male staff in the Observation/Quarantine hall walking in and out of the isolation rooms not performing hand hygiene. He said he saw this staff do this twice. During a telephone interview on 05/12/2020 at 9:00 AM, regarding a facility inspection conducted on 05/05/2020, the Public Health Nurse said approximately 12:30 or 1:00 PM she was on the COVID negative unit. She observed the male dietary staff providing meals on both COVID negative unit and the Observation/Quarantine hall passing trays with gloved hands. She said the male dietary staff did not remove gloves and perform hand hygiene between resident rooms. She said she observed the same practice on the Observation/Quarantine hall and that she did not observe removal of gloves. Record review of Epidemiologist follow-up visit notes dated 05/05/2020 revealed .Rather than donning and doffing

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 2) between encounters, staff wear same PPE for entirety of shift. This may provide an exposure risks if there are additional asymptomatic COVID+ residents . . COVID negative unit - Staff are instructed by facility to don PPE at beginning of work shift and doff prior to exiting unit. - We observed nurses off unit wearing full PPE - We observed patient care interaction with a symptomatic resident (Pending tested results) where staff member entered and exited room without donning and doffing PPE. - We observed several patient care interactions where gloves were not disposed upon exiting patient room. Record review of the COVID-19 Response for Nursing Facilities, Version 2.5 dated 4/27/20, Attachment 1: Immediate Response Guidelines .Create an isolation wing/unit revealed . .Health care worker (HCW)/staff leaving and entering isolation wing/unit - Directly after entering the isolation area and prior to donning PPE, perform hand hygiene - Put on proper PPE . In an interview on 5/6/2020 at 11:15 AM, the Administrator said that the reason the facility had as many COVID positive cases is because they tested all the staff and residents. In an interview on 05/08/2020 at 11:40 AM, the COVID Negative Unit Manager said she expected staff to perform hand hygiene after touching surfaces in resident rooms. She said gloves were used for resident contact and gloves should then be removed and hand hygiene performed. In an interview on 5/10/2020 at 11:30 AM, the Regional Director of Clinical Operations and the Regional Clinical Nurse were asked about the facility expectation for staff delivering meal trays to resident rooms. Both said it would be just like delivering trays in the dining room; staff should perform hand hygiene between trays, that was why there are hand sanitizers on the walls. They said hand hygiene between trays was to prevent the spread of infection. Record review of facility policy for Droplet Precautions, COVID-19 Education, Prevention & Response Guide, Diversicare, dated 14 April 2020 revealed Advise healthcare personnel to observe droplet precautions (i.e wearing a surgical or procedure mask for close contact), in addition to Standard Precautions, when examining a patient with symptoms of a respiratory infection, particularly if fever is present. These precautions should be maintained until it is determined that the cause of symptoms is not an infectious agent that requires Droplet Precautions. Record review of facility policy for Handwashing/Hand Hygiene, Diversicare, 14 April 2020, effective date: March 2020 revealed on page 7; General Infection Control Practices .7. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene was recognized as the best practice for preventing healthcare-associated infections. 8. Single-use disposable gloves should be used: c. When in contact with a resident, or the equipment or environment of a resident, who is on contact precautions .page. 21 COVID-19 Education, Prevention & Response Guide If COVID-19 cases WIDE SPREAD in the surrounding community for (patient) referrals with (a) COVID-19 positive test or with clinically suspected COVID symptoms . place patient in droplet and contact precautions . . page 60 Appendix E. Suspected/Confirmed COVID-19 [DIAGNOSES REDACTED].Prior to entering and exiting the unit and a patient room, team members must perform hand hygiene The facility Administrator was notified on 5/6/2020 at 11:15 AM that an Immediate Jeopardy (IJ) had been identified in the above areas and a Plan of Removal was requested. A copy of the IJ Template was left with the Administrator. A Plan of Removal was submitted by the Administrator on 5/6/2020. After several revisions, the final Plan of Removal was accepted on 5/9/2020 at 11:20 AM. The plan of removal included the following: - Assessments conducted on negative (100 unit) by licensed nurses and residents remain with no change in condition and in no apparent distress - Assessments conducted on positive (200 unit) by licensed nurses and residents remain with no change in condition and in no apparent distress - Assessments conducted on dedicated observation area by licensed nurses and residents remain with no change in condition and in no apparent distress - Residents residing on the 100 unit, 200 unit, and dedicated observation area remain under stringent screening and infection control processes --- Initiated on 5/6/20 and completed on 5/7/20 responsible staff ADNS/Designee All potentially affected residents were reviewed for changes in condition via an IDT analysis, which encompassed: - An inquiry of nursing progress notes - An evaluation of documentation for monitoring signs and symptoms of COVID-19 - A critique of temperature reports set to trigger temps > 99 - An exploration of laboratory and imaging interpretations --- Initiated on 5/6/20 and remains on-going; responsible staff ADNS/Designee Modification and locality of hand sanitizer dispensers within immediate vicinity of entering and exiting COVID positive unit (completed 5/5/20). Modification and locality of team member break room within the COVID positive unit (completed 5/5/20). All residents with a change in condition will be immediately referred to medical providers for further assessment via a telehealth platform (initiated 5/6/20). Implemented droplet precaution signage and door closure to residents in observation areas (5/7/20). Implemented dedicated team members for negative (100 unit), positive (200 unit), and observation area (5/7/20). To slow the spread of infectious outbreaks, any resident or team member exhibiting COVID symptoms will result in: - Testing - Investigation and elicitation (via daily tracking tool) - Trace (Process: identify, contact, enlighten) - Quarantine or isolate - Follow-up - Notification of local health authority, HHSC, and CDC (NHSN) regarding confirmed cases Team members (all departments) educated by ADNS on: - Hand hygiene to include handwashing and hand sanitizing - Donning and doffing of PPE - Proper disposal of PPE - Droplet Precautions - Mitigating access and spread of COVID-19 (meal tray pass, affixed appropriate isolation signage and secured doors on residents' rooms, identified and initiated dedicated team members). Monitoring: In an observation and interview on 05/08/2020 at 11:40 AM the COVID Negative Unit Manager said the facility had now instituted no gloves in hallways. She said she expected staff to hand hygiene after touching surfaces in resident rooms. She used hand sanitizer, donned clean gloves and was pushing a resident in his wheelchair. She said gloves are used for resident contact and gloves should then be removed and hand hygiene performed. Observation on 05/09/2020 at 09:45AM, revealed CNA R picking up meal trays. She was masked, gowned and using hand sanitizer between resident rooms. Observation starting on 5/9/2020 at 9:55 AM revealed the Wound Care Nurse and another staff are at the nurses' station without gloves. None of the staff were wearing gloves in the halls. They were using hand sanitizer before they entered and after they exited rooms. room [ROOM NUMBER], in the Observation/Quarantine unit, had a closed door. Housekeeping staff was cleaning hand rails. The MA was performing hand hygiene when he entered and exited resident room. Staff were not moving between the COVID negative unit, the Observation/Quarantine unit and the COVID positive unit. In an observation and interview on 04/30/2020 at 11:45 AM the COVID negative Unit Manager said some resident rooms had hand sanitizer. She said there were sinks in residents' rooms and the facility encouraged hand washing with soap and water instead of alcohol based rub. Hand sanitizer dispensers were mounted in the hallway every 2-3 rooms apart. In an interview on 05/09/2020 at 10:00 AM, LVN D said he worked in the COVID negative hall yesterday and today he was assigned to just to work in the Observation/Quarantine hall. He said he did not work in the other halls. In an interview on 05/09/ at 10:25 AM, the COVID Positive Unit Manager said we staff were not to wear gloves anymore unless we enter residents' rooms or to provide resident care. Observation on 5/9/2020, at 10:25 AM revealed a red sign on outside of entrance/exit door for full PPE before entering COVID unit. At the exterior door there was a hand sanitizer dispenser, a tracking log, a thermometer, a PPE cart, and a biohazard container. Three nurses were in the lobby and they were not wearing gloved hands. All staff were wearing blue gown, goggles, and N95 masks. Staff entering were screened by nurse at the screening table. There was no trash can outside the entrance/exit door. Observation of the Observation/Quarantine unit on 05/10/2020 at 11:50 AM revealed the LVN passing medications was performing hand hygiene between residents and staff passing meal trays performing hand hygiene between residents. In an interview on 11/10/2020 at 11:50 AM, LVN B said she was in charge of doing all care for residents in Observation/Quarantine hall today. She said she was assigned to work in this hall only and did not leave the area or work in the other halls. She said each resident's room had a PPE cart. She said she put on a new gown when entering each room, then the gowns were placed in a biohazard bag in the resident's bathroom. Observation of the COVID negative hall on 05/10/2020 at 12:15 PM revealed when the beverage cart arrived, staff performed hand hygiene prior to entering residents' rooms and after exiting residents' rooms. No staff observed moving between the units. On 05/11/2020 at 8:40 AM, Record review of facility's new infection control inservices completed by staff revealed pre/post tests and audit checklists on the following topics: handwashing/hand hygiene, droplet precautions, PPE, Alcohol-based hand rub. In an interview on 05/11/2020 at 09:30 AM the PT Director said she had 7 staff working and split between the 2 units. She said she only assigned COVID negative staff working permanently on 100 Hall. While the IJ was lowered on 05/12/2020 at 1:00 PM, the facility remained out of compliance at a severity level of actual harm and a scope of pattern due to the facility still monitoring the effectiveness of the Plan of Removal.
F 0921 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** Based on observation, interview and record review, the facility failed to provide a safe and sanitary environment for residents, staff and the public, as evidenced by; -a blue isolation gown was hanging halfway out of a general trash bin

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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 0921 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) outside the COVID unit entrance/exit door. -a pair of purple gloves was lying on ground next to general trash bin outside the COVID unit entrance/exit door. These failures placed all 79 residents and the general public at risk of infection. Findings include: Record review of facility census report dated 04/29/2020 revealed there were 33 residents in the COVID positive unit, 8 residents in the Observation unit and 38 residents in the COVID negative unit. In an interview on 04/29/2020 at 11:30 AM, the Administrator identified the exterior door through which staff were to enter the COVID positive unit. COVID unit staff were not permitted to walk through the building. In an observation on 04/29/2020 at 12:45 PM, there was a general trash bin immediately outside the exterior of the COVID unit (200 Hall). There was a blue isolation gown hanging out of the bin and a pair of purple latex gloves laying on the ground next to trash bin. The PPE cart that contained clean gowns was inside and immediately next to exterior door. The biohazard bin was also in this area. The biohazard bin had used gowns inside. In an interview on 04/29/2020 at 12:45 PM the unit manager for COVID unit said she did not know why the gown and gloves were out there. She said she thought the maintenance man was responsible for trash bins outside building. She said since the Surveyor identified the problem, she would ask Housekeeping to pick up and remove the gown and gloves from the trash bin. In an observation on 04/29/2020 at 1:00 PM, in the COVID unit, there were cardboard boxes lined with red biohazard bags outside of each resident room. Some had used disposable meal trays and containers. In an interview on 5/12/2020 at 11:50 AM, the Regional Director of Clinical Operations and Regional Clinical Nurse both said they expected nursing staff to hand hygiene prior to donning PPE, after doffing PPE and then place PPE in biohazard bags. In an interview on 5/12/2020 at 1:00 PM the Administrator said they did not have a policy on waste or garbage handling. In a telephone interview on 5/12/2020 at 3:00 PM, the Housekeeping Manager said there was a policy for trash, medical waste handling, biohazards located in a binder. He said he would ask the Administrator to email the documents to the Surveyor. No facility policy and procedure for trash, medical waste handling or biohazards was received prior to exit. Record review of facility policy for COVID-19 Education, Prevention & Response Guide, Diversicare, 14 April 2020 revealed: . for (resident) referrals with (a) COVID-19 positive test or with clinically suspected COVID symptoms . place patient in droplet and contact precautions . . Record review of CDC Guidelines for Transmission-Based Precautions revealed in part: Transmission-Based Precautions are the second tier of basic infection control and are to be used in addition to Standard Precautions for patients who may be infected or colonized with certain infectious agents for which additional precautions are needed to prevent infection transmission . Contact Precautions, Use Contact Precautions for patients with known or suspected infections that represent an increased risk for contact transmission . . Use personal protective equipment (PPE) appropriately, including gloves and gown. Wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment. Donning PPE upon room entry and properly discarding before exiting the patient room is done to contain pathogens . .