STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235201	A. BUILDING _____ B. WING _____	04/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MUNSON HEALTHCARE CRAWFORD CONTINUING CARE CENTER	1100 MICHIGAN AVE GRAYLING, MI 49738

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 follow infection control practices per their facility policy and the Center for Disease Control (CDC) current recommendations on infection control, infection isolation, and standard and transmission-based precautions for preventing and containing communicable disease outbreaks, including but not limited to: 1) the failure to implement appropriate infection control precautions for two confirmed Coronavirus (COVID-19) positive Residents (#1, #2) and seven Residents (#5, #6, #7, #8, #9, #10, #11) who exhibited symptoms of infection on the non-COVID-19 unit, and 2) the failure to implement appropriate transmission based precautions regarding the use of Personal Protective Equipment (PPE) per CDC guidelines for 14 COVID-19 positive Residents (#1, #2, #3, #4, #13, #14, #15, #16, #17, #18, #19, #20, and #21). These deficient practices had the increased likelihood to affect all residents (many of whom were at high risk due to age and co-morbidities) to be exposed to, or contract COVID-19 infection, increasing the risk of serious health complications of COVID-19, including death. The deficient pratice resulted in an Immediate Jeopardy (IJ) which began on 4/7/20, when the facility received notice of the first direct care staff testing positive for COVID-19, and the facility failed to implement their infection control policy to ensure prevention of COVID-19 transmission. The Administrator and Director of Nursing (DON) were notified of the IJ on 4/29/20 at 9:34 a.m. and a plan to remove the immediacy was requested. The IJ was removed on 4/29/20 at 3:00 p.m., based on the facility initiation of the plan of removal as verified by the Surveyors on-site. Although the IJ was removed on 4/29/20, the facility remained out of compliance at scope of widespread and a severity of potential for more than minimal harm that is not Immediate Jeopardy, until verification of adequate infection control procedures is completed. Findings include: On 4/28/20 at 10:30 a.m., an interview was conducted with the Administrator who reported there were 13 confimed positive cases of COVID-19 and two results (for Residents #1 and #2) had just come back positive this morning. When asked where Residents #1 and #2 were residing, the Administrator reported the two Residents would be moved to the COVID unit as soon as possible, but they were currently on the non-COVID unit. On 4/28/20 at 10:50 a.m., an interview was conducted with Registered Nurse (RN) E. RN E was asked about the two COVID-19 positive Residents (#1 and #2) on her hall. RN E stated Residents #1 and #2 would be moving to the COVID unit soon. When asked about the seven presumptive positive Residents (#5, #6, #7, #8, #9, #10, #11 as noted by RN E), RN E reported they were working on getting things in place for them. On 4/28/20 at 10:55 a.m., observations were made of the non-COVID unit. At 10:58 a.m., the door of the room for Resident #1 and Resident #2 was observed to be open. There was a sign on the door to alert staff that the Residents had an infection. There was a container with PPE in the hallway outside of this room. At 11:00 a.m., RN E was observed donning PPE to enter the room. RN E was wearing a surgical mask but no N95 respirator (particulate mask to prevent inhalation of [MEDICAL CONDITION] particles). On 4/28/20 at 11:01 a.m., Resident #6 was observed in her room with the door open, and was coughing. There was no signage on Resident #6's room door to indicate any infection control precautions were in place. On 4/28/20 at 11:06 a.m., Physical Therapist (PT) F was observed to enter the room of Resident #11 (presumptive positive) with only a surgical mask on. On 4/28/20 at 11:07 a.m., RN E was observed coming out of the room of Residents #1 and #2. She left the room wearing the same surgical mask that she wore into the room with the COVID-19 positive Residents. RN E was observed to go about her duties on the unit without changing the contaminated mask. RN E also left the door of Resident #1 and #2's room open to hallway. On 4/28/20 at 11:10 a.m., PT F was observed entering the room of Residents #5 and #6 (presumptive positive) with only a surgical mask on. On 4/28/20 at 11:14 a.m., a housekeeper/Staff G was observed going down the hallway with her cart. When asked which rooms she was supposed to clean she reported that she was supposed to stay in the 'healthy' Resident rooms and to stay out of rooms 161 (Residents #5 and #6), 162 (Residents #1 and #2), and 163 (Residents #7 and #8). Staff G then proceeded to enter the room of Residents #9 and #10 and clean their room while wearing a surgical mask and gloves. On 4/28/20 at 11:20 a.m., the DON was asked for a list of the presumptive positive Residents for clarification. Then DON asked RN E to write a list of Residents. The list of Residents revealed Residents #5, #6, #7, #8, #9, #10, and #11 were all presumptive positive for COVID-19 infection. When asked about the lack of signage and PPE for these rooms, the DON asked RN E how they were coming along with getting the PPE in place. RN E stated, We're getting it together. On 4/28/20 at 11:22 a.m., RN E was observed entering the room for Resident #11 with only a surgical mask on, no gown and no gloves. On 4/28/20 at 11:25 a.m., an interview was conducted with the DON and the Administrator regarding the facility documents required for Focused Infection Control survey review. When asked why the presumptive positive Residents still had no signs in place at room entrance or PPE in place for staff to use when caring for them, the DON stated, We're working on it. A review of Resident #1's medical record revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Resident #1 started to exhibit symptoms of cough on 4/27/20, and was tested for COVID-19 which came back positive on 4/28/20. A review of Resident #2's medical record revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Resident #2's medical record revealed she had complaints of nausea on 4/25/20 but had a history of [REDACTED]. On 4/28/20 at 1:12 p.m., the Administrator was asked what time the DON was notified of Resident #1 and and Resident #2's positive COVID-19 test results, and reported the DON was notified 4/28/20 at 6:31 a.m. A review of the facility Patient/Resident COVID-19 Tracking log revealed the 7 presumptive positive Residents were noted with symptoms as follows: Resident #5 on 4/28/20 of lethargy and congestion. Resident #6 on 4/28/20 of cough, nasal congestion, and weakness. Resident #7 on 4/28/20 of cough. Resident #8 on 4/28/20 of malaise. Resident #9 on 4/28/20 of malaise. Resident #10 on 4/28/20 of cough. Resident #11 on 4/28/20 of malaise. On 4/28/20 at 12:28 p.m. during a phone interview the DON was asked who was the facility's infection Control Coordinator. The DON stated, That would be me. When asked about the supply of N95 respirators, the DON stated, We can get them from the hospital (that is attached to the facility). When asked how many they had access to, the DON stated, A few dozen. The DON indicated that they felt they did not need to be using them yet. A review of the document titled, Patient/Resident COVID-19 Tracking revealed only Date of Onset, Date Resolved and whether or not the test was Negative or Positive. There was no indication on the log of when the residents were tested or when the test came back positive. Further review of this log revealed two staff were documented being tested Positive and one Presumed Positive prior to the first Resident case. This tracking log revealed a lack of consistent and collective monitoring of the staff and Resident illnesses. On 4/28/20 at 5:05 p.m., the Administrator was asked to provide what Health Department guidance the facility was following. The Administrator reported that they had been using the state guidance and provided a document titled, Guidance to Protect Residents of Long-Term Care Facilities (upon readmission or current stay) dated 4/9/20. This document revealed, .Certified Nursing Homes must comply with CMS (Centers for Medicare & Medicaid Services) and CDC guidance related to infection control . Identify Infection Early: Screen residents daily for fever and respiratory symptoms: immediately isolate if symptomatic . If COVID-19 is diagnosed in the healthcare worker, Residents should be cared for using recommended PPE until 14 days after last exposure and prioritized for testing if they develop symptoms . HCP (health care professionals) should use recommended PPE . for the care of Residents in the affected area (or facility) . On 4/28/20 at 5:25 p.m. the Administrator was asked to clarify the dates on the Patient/Resident COVID-19 Tracking log. The Administrator reported the date of onset was when the symptoms started, but

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235201	A. BUILDING _____ B. WING _____	04/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MUNSON HEALTHCARE CRAWFORD CONTINUING CARE CENTER	1100 MICHIGAN AVE GRAYLING, MI 49738

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	(continued... from page 1) that an occupational health nurse from the hospital (RN C) tracked the date of testing (and the date it came back as positive or negative). A review of the CDC document titled, Guidance to Protect Residents of Long-Term Care Facilities (Upon Return or Current Stay) dated 4/9/2020 revealed, Key Concepts: .Isolate symptomatic patients as soon as possible. Set up seperate, well ventilated triage areas, place patients with suspected or confirmed COVID in private rooms with the door closed . On 4/28/20 at 10:55 AM, on the COVID-19 designated unit housekeeper/ Staff L was observed performing a terminal cleaning of the first room (room [ROOM NUMBER]) directly on the left upon entering the unit. Staff L was wearing a medical grade facemask, and not an N95 mask or comparable respirator protection during this observation. On 4/28/20 at 11:00 AM, there were a total of five staff, Staff L, RN H, Certified Nurse Aide (CNA) I, CNA J, and CNA K present on the COVID-19 designated unit. All staff were wearing medical grade disposable facemasks, and not an N95 or comparable respirator. There were a total of 11 COVID-19 positive Residents (#3, #4, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21) on the hall at the time of this observation. On 4/28/20 at 11:05 AM, CNA I and CNA J were observed performing a two-person pivot transfer for Resident #4. The top gown ties for CNA J were not tied upon entry to the room of Resident #4. Resident #4 was observed with oxygen provided at two (2) liters per minute via nasal cannula (oxygen tubing inserted into the nose). During the tasks involved with caring for Resident #4, CNA J had to reach up and pull the isolation gown being worn back toward the neck to keep it protecting CNA J's clothes. During this process CNA J contaminated the clothing underneath during one of these occasions with a gloved hand which had already come into contact with Resident #4. CNA I and J proceeded to transfer Resident #4 with their faces within one foot of Resident #4's face. Resident #4 was not wearing any face mask during the procedure. Resident #4 produced a loose non-productive cough while in proximity to the CNAs during the process of the transfer. CNA J continued to have difficulty with keeping the isolation gown up around the neck area while in the process of stripping the bed, and incidentally contaminated self again when reaching to bring the gown back up to their neck area. A review of the Electronic Medical Record (EMR) for Resident #4 revealed the following: Resident #4 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the line listing for residents who developed COVID-19 revealed Resident #4 developed symptom onset of fever on 4/11/20 and subsequently tested positive for COVID-19. Resident #4 was the first positive COVID-19 in the facility according to the line listing, which gave no date for when the test was done or when the positive result was received. A review of vital signs in the EMR revealed Resident #4 first developed a temperature of 101.8 Fahrenheit (F) on 4/11/20 at 08:49 AM. Two additional temperatures were recorded on 4/11/20. One at 8:49 AM of 102.3 F, and one at 10:50 AM of 100.6 F. A review of the Physician Note by Physician A related to a chief complaint of Fever on 4/8/20 at 16:48 (4:48 PM) revealed the following: . This am patient (Resident #4) noted with Temp 102.1. Staff also note he is much weaker and requiring assistance with transfers . Has chronic cough. States no different than normal . Low suspicion of COVID 19. Keep in isolation tonight. Re-eval (re-evaluation) coming out of isolation tomorrow. There was no record of Resident #4's temperature on 4/8/20 recorded in the progress note of Physician A in the vital sign section of the EMR (referenced above). A review of the progress notes for Resident #4 revealed the following: Progress Note 4/8/20 at 5:19 PM . Resident (#4) placed on droplet isolation . Progress Note 4/9/20 at 12:20 AM . (Resident #4) continues on droplet precautions at this time . Physician A Note 4/9/20 12:48 AM: .I do not feel patient has COVID-19. D/C (discontinue) isolation precautions . Progress Note 4/9/20 at 1:10 PM: . Currently on droplet contact precautions due to fever within last few days . Resident removed from isolation precautions per (Physician A). New orders received and processed. Progress Note 4/11/20 at 2:45 PM: . Resident (#4) placed on precaution due to temp (temperature) of 101.8 F and increased to 102.3 F. Cold compresses applied temp decreased to 99.2 F. At approximately (9:30 AM) temp elevated to 100.6 F. At 1050 (AM) temp decreased (temperature) 98.6 F. At (sic) temp 97.7 F. On call provider notified with elevated temps and placed on isolation precautions Progress Note 4/11/20 at 10:24 PM: . (Resident #4) remains on droplet precautions at this time . Progress Note 4/12/20 at 10:47 PM: . (Resident #4) continues on droplet precautions and has been sneezing this evening . I have no energy. I feel like I have run out of gas before going back to sleep. BP (Blood Pressure) 160/74, P (Pulse) 63, R (Respirations) 20, O2 (Oxygen) sat (Saturations) 90% RA (Room Air) . Physician ANote 4/13/20 at 3:46 PM: . (Resident #4) has had some intermittent fevers . despite appropriate ATB (antibiotic)based on urine cx (culture) results . Fevers 4-11: 102.3 (F), 100.6 (F), 4-12: 99.9 (F), 4-13: 99.4 (F) . Fever. (Resident#4) recently hospitalized and potentially exposed to COVID (-19). Will check swab . Continue to monitor and continue isolation. CBC (Complete Blood Count) does demonstrate leukopenia (low white blood cells) with lymphopenia (low lymph cells (infection fighters)) possibly associated with [MEDICAL CONDITION] infection . Progress Note: 4/14/20 at 10:31 PM: . He continues on droplet precautions and remains PUI (Person Under Investigation(Presumptive Positive)) for (COVID-19) . Physician M Note: 4/16/20 at 12:14 . (Resident #4) was swabbed for COVID-19 and tested positive. Resident (#4) complained of shortness of breath last night. Vital signs were stable at the time with oxygen 92% room air. Supplemental oxygen was placed and (Resident #4) symptoms improved . [DIAGNOSES REDACTED] (Sudden Acute Respiratory Syndrome) CoV2 (Coronavirus) RNA (Ribonucleic Acid (virus coding identifier)) detected (COVID-19). 4/13/20 . COVID-19 with cough and intermittent SOB (shortness of breath): VSS (vital signs stable). Tylenol for fever. Add [MEDICATION NAME] (mucous relief) ER (extended relief) 600 mg (milligram) BID (twice daily) x (times) 7 days. Remain in isolation . On 4/28/20 at 11:15 AM, CNA I was observed doffing (removing) PPE and used gloved hands to doff the gown touching clothing underneath and contaminating clothing. RN H after observing CNA I contaminate herself instructed CNA I how to properly doff PPE. On 4/28/ 20 at 11:15 AM, RN H was observed performing a glucometer check for Resident #3. While gathering supplies for the glucometer check, CNA K was observed squeezing between RN H and CNA J who had their backs to each other. CNA K had gloves and a gown on and came into contact with the exposed backs of RN H and CNAJ. CNA K also placed gloved hands on the exposed back of RN H while maneuvering between RN H and CNA J. RN H proceeded to the room of Resident #3 with the glucometer supplies and situated supplies on the bedside table of Resident #3. The glucometer was placed on papers already sitting on the bedside table of Resident #3 with no barrier provided. RN H then explained to this Surveyor the machine had timed out and had to retrieve another test strip. RN H then proceeded to the hallway and went to the medication cart to retrieve another test strip for the glucometer. RN H then brought the glucometer and supplies back into the room and again set the glucometer on the bedside table with no barrier provided. A review of the EMR for Resident #3 revealed the following: Resident #3 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the resident line listing for COVID-19 revealed onset date was recorded as 4/26/20 with symptoms of changed lung exam, and unspecified pain and subsequently tested positive for COVID-19. A review of the progress notes in the EMR for Resident #3 revealed the following: Physician M Note: 4/24/20 12:44 PM: . [AGE] year-old male admitted [DATE] after a fall at home resulting in a left humeral head fracture, treated non-operatively. Resident (#3) was transferred to our facility for rehabilitation. The first 2 weeks he was making some progress with therapy. Approximately 2 weeks ago he began to exhibit some regression in his functional status. He is having increased difficulty with transfers. Requires much motivation to work with therapy. Remains moderate assistance x (times) 2 (staff)to stand. Newer behaviors include yelling and swearing at staff. Staff feel (Resident #3) may be giving up . Known exposure to COVID-19. Swab and send to (Hospital) lab .Generalized weakness and debility: Has regressed with therapy, possibly related to [MEDICAL CONDITION] infection . Physician M Note 4/24/20 16:59 COVID-19 swab is positive. On 4/28/20 at 11:30 AM, an interview with CNA K revealed the following: When asked about trying to move between other staff members with isolation PPE worn, CNA K stated, I shouldn't have touched either one of them. CNA K then tried to explain her actions and stated she needed to get to the light being responded to because the Resident (#16) was impulsive. On 4/28/20 at 11:35 AM, Housekeeper Staff L was observed doffing PPE following terminal cleaning of the same room as this Surveyor observed upon entry. Staff L took off the face shield and immediately placed it between his torso and right arm, contaminating their clothing while trying to continue doffing other PPE. On 4/28/20 at 12:15 PM, an interview with the DON revealed the following: When asked if a barrier should be provided for a glucometer prior to setting it down in a resident's environment, the DON stated, Yes, I'll talk to (RN H). On 4/29/19 at 2:00 PM, this Surveyor was entering the COVID-19 unit and observed Physician A exiting the COVID-19 unit. Physician A was wearing a medical grade facemask, not an N95 or comparable respirator. On 4/29/20 at 2:05 PM, CNA K was observed in the COVID-19 unit wearing only a medical grade facemask and not an N95 or comparable respirator. CNA K was assisting Resident #21 with fluid intake. A review of the EMR revealed Resident #21 had a [DIAGNOSES REDACTED]. On 4/29/20 at 2:10 PM, RN H was observed entering the COVID-19 unit, and donned PPE. RN H donned a medical grade facemask and not an N95 or comparable respirator. On 4/29/20 at 2:15 PM, upon exiting the COVID-19 unit a personal stainless steel drinking glass was observed sitting on a supply cart located on the COVID-19 unit. RN H was asked who the cup belonged to, and if it was supposed to be sitting out on a supply cart in an isolation unit. RN H stated the drinking glass belonged to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235201	A. BUILDING _____ B. WING _____	**04/30/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MUNSON HEALTHCARE CRAWFORD CONTINUING CARE CENTER	**1100 MICHIGAN AVE GRAYLING, MI 49738**

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	(continued... from page 2) CNA K and stated, Probably not, I will have it removed. On 4/29/20 at 2:30 PM, the DON was asked why staff were not wearing N95 or comparable respirators on the COVID-19 unit. The DON stated the facility was utilizing droplet and contact precautions. The DON stated an N95 was not required for those isolation types. The DON and Physician A confirmed they were not aware of the latest CDC guidance for long term care facilities to implement N95 or comparable respirators for the care of COVID-19 residents. Review of the facility policy Novel [MEDICAL CONDITION] Prevention and Response dated 3/3/20 revealed the following: . 5. Interventions to prevent the spread of respiratory germs within the facility: . b. Monitor residents and employees for fever and respiratory symptoms. ii. In general, for care of residents with undiagnosed respiratory infection use Standard, Contact, and Droplet Precautions with eye protection unless suspected [DIAGNOSES REDACTED].g., [MEDICAL CONDITION]) . . 6. Procedure when COVID-19 is suspected: . f. Implement standard, contact, and airborne precautions (droplet precautions if no airborne isolation room is available). Wear gloves, gown, goggles/face shields, and masks (respirators) upon entering the room and when caring for the resident . . 7. Environmental infection control: . b. Housekeeping staff shall adhere to transmission based precautions . A review of the CDC guidance for Long Term Care facilities https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html (accessed 4/13/20) revealed the following: In addition to the actions described above, these are things facilities should do when there are cases in their facility or sustained transmission in the community . Consider having HCP (Health Care Personnel) wear all recommended PPE (gown, gloves, eye protection, N-95 respirator, if not available, a facemask) for the care of all residents regardless of the presence of symptoms. Implement protocols for extended use of eye protection and facemasks. A review of the CDC guidance for Long Term Care facilities accessed on 4/28/19 revealed the following: . If COVID-19 is suspected, based on evaluation of the resident or prevalence of COVID-19 in the community, follow the Interim Infection Prevention and Control Recommendations for Patients with suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings. This guidance includes detailed information regarding recommended PPE, which includes use of an N-95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e. goggles, or disposable face shield that covers the front and sides of the face), gloves, and gown . because of the higher risk of unrecognized infection among residents, universal use of all recommended PPE for the care of all residents on the affected unit (or facility wide depending on the situation) is recommended when even a single case among residents or HCP (Health Care Professional) is identified in the facility; this should also be considered when there is sustained transmission in the community . A review of a COVID-19 outbreak timeline provided by the facility revealed the following: 3/26/20 .1. First confirmed case of COVID-19 in (community) . 4/4/20 .1. Pandemic response level raised to level orange. 2. Universal masking begins system wide . 4/6/20 .1. Two confirmed cases of COVID-19 in (community) . 4/7/20 . 3. Employee (Staff N) notified of positive COVID-19 results. 5. Five confirmed cases in (community) . 4/9/20 . 4. COVID-19 widespread in the community at this time . 4/16/20 . (Resident #4) with positive result for COVID-19. First case noted within the facility . Two additional staff members tested positive for COVID-19. 4/18/19 Three additional residents positive for COVID-19. 4/21/20 four additional residents test positive for COVID-19. On 4/30/20 an interview with the DON revealed the following: We started fit testing (masks) yesterday. We did find it (N95 Use recommendations for COVID-19 in Long Term Care) in the CDC guidance. A review of the doffing procedure from the CDC revealed the following: 1. Gloves . Outside of gloves is contaminated! . 2. Goggles or face shield . 3. Gown .4. Mask or Respirator . A review of the facility's Standard Precautions and Transmission Based Precautions policy dated 3/1/19 revealed the following: . Refer to Centers for Disease Control and Prevention (CDC) for transmission based precaution guidelines and recommendations