STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165165	A. BUILDING _____ B. WING _____	**07/28/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NORTHCREST SPECIALTY CARE	**2001 HEATH STREET WATERLOO, IA 50703**

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 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation and interview during a COVID 19 survey, the facility failed to provide dignified care for 1 of 3 residents (Resident #3) reviewed. The facility identified a census of 78 residents. Findings include: The Minimum Data Set (MDS), dated [DATE] for resident #3, showed a Brief Interview for Mental Status (BIMS) Score of 15 indicating intact cognitive functioning. The resident required extensive assistance for bed mobility, transfer, dressing and toileting. The MDS listed a [DIAGNOSES REDACTED]. The MDS identified the resident received hospice services. The Care Plan, dated 5/08/20, directed the staff to assist the resident with activities of daily living (ADL's) and toileting needs. A Progress Note, dated 7/22/20 at 1:04 p.m., documented the resident as very confused, not talking coherently and having multiple episodes of incontinence. During an observation on 7/23/20 at 8:25 a.m. Staff A, Certified Nursing Assistant (C.N.A.) and Staff B, C.N.A., entered resident #3's room. Staff A wore a Niosh 95 (N95, special mask that filter out 95% of airborne particles) mask and a face shield positioned up on the forehead which did not cover Staff A's prescription glasses or the N95 face mask. Staff B wore an N95 face mask and protective eye goggles. Resident #3 lay in bed on their back with the head of the bed elevated. Staff A and B performed hand hygiene, provided privacy and donned gloves. Staff A went to the bedside, explained care to the resident and placed a package of disposable wipes in the resident's bed without placing it on a clean barrier. The resident had been incontinent of urine soaking through the adult brief, cloth chux (pad placed under a resident to absorb urine) and fitted mattress sheet into the mattress leaving an approximate twelve inch circular ring of urine under the resident. The resident had a wound dressing to both lower extremities that had drained an approximate ten inch circular area of light tan/brown drainage on to a cloth chux positioned under the resident's lower legs. Staff A looked at the wet bedding and stated the resident would be getting up later for a bath and placed a disposable chux under the resident to perform incontinence care. Staff A picked up the garbage can with her gloved hand and handed the garbage can over the top of the resident lying in bed to Staff B. Staff A and B failed to remove the dirty gloves and perform hand hygiene after touching the garbage can. Staff A cleansed the resident and Staff B assisted by touching the resident's skin with the same dirty gloves to complete incontinence care. Staff A and B placed the clean brief on the resident still wearing the same dirty gloves, positioned and covered the resident. Staff A and B failed to remove the wet fitted mattress sheet from under the resident. Staff A and B failed to remove the dirty cloth chux with wound drainage from under the resident's lower legs. During an observation on 7/23/20 at 8:45 a.m., Staff C, Registered Nurse (RN), removed four non-stick pads and four ABD (large absorbent pads) dressings from the packages and placed them on top of the treatment cart without a clean barrier underneath them and without completing hand hygiene prior to opening the dressings. Staff C cut one of the ABD dressings in half without disinfecting the scissors prior to use. Staff C took the treatment cart into Resident #3's room, provided privacy, performed hand hygiene, donned gloves and took supplies from the top of the treatment cart and placed on a clean towel by the resident's bed. The resident lay in bed supine still laying on the soiled chux pad, soiled fitted sheet and lower legs still resting on the cloth chux soiled with a ten inch circle of tan/brown drainage. Staff C placed a disposable chux pad under the resident's legs as Staff B, C.N.A. assisted. Staff C completed the wound care and Staff B assisted in repositioning the resident's lower extremities leaving the soiled cloth chux under the resident's legs. Staff B and C exited the resident's room with the resident still laying on the soiled fitted sheet and soiled cloth chux under his/her lower extremities. During an interview on 7/27/20 at 10:17 a.m., Staff B reported if a resident was incontinent of urine through to the mattress, they would be required to provide full peri-care using clean to dirty technique, provide all new clean linens under the resident and sanitize the mattress. Staff B stated a resident should not be laying on dirty linens. During an interview on 7/27/20 at 10:29 a.m., Staff M, Licensed Practical Nurse, (LPN), reported if a resident has been incontinent through to the mattress, the C.N.A.'s would be required to provide complete peri-care, change out all the dirty linen to clean linen and sanitize the mattress. She reported if a resident has had wound drainage or any dirty linens, the linens should be replaced with clean linens during resident care anytime it is needed for the dignity of the resident. During an interview on 7/27/20 at 1:45 p.m., the Director of Nursing, (DON), reported she would expect the resident to be treated with dignity for all cares. She reported it is not dignified to lift a trash can over a resident or to leave a resident laying on dirty linens. She would expect that any dirty linens would be changed out to clean linens and dignity be provided to all residents. The Resident's Bill of Rights, dated 2017, provided by the facility,documented the following under Resident Rights: The resident has the right to a dignified existence, self-determination and communication with and access to persons and services inside and outside the facility including those specified in this section. (1) A facility must treat each resident with respect and dignity for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation and interview, the facility failed to implement a physician's order after a fall for 1 out of 3 residents (Resident #4) reviewed. The facility identified a census of 78 residents. Findings include: The Minimum Data Set (MDS) Assessment, dated 6/25/20 for resident #4, documented a Brief Interview for Mental Status (BIMS) Score of 2 indicating severe cognitive deficits. The resident required extensive assistance of two people for transfers, and extensive assistance of one for dressing, eating and personal hygiene. The MDS listed a [DIAGNOSES REDACTED]. An incident report, dated 6/12/20 at 6:15 a.m., documented the resident was observed on the floor in a sitting position with legs extended. A Occupational Therapy note, dated 6/17/20, documented nursing as checking on the weight bearing of the resident. A Physician Order, dated 6/18/20, ordered for Physical Therapy to evaluate and treat the resident. A Orthopedic Consult Form, dated 6/19/20, directed the resident was able to be weight bearing as tolerated to both lower extremities. During an interview on 7/27/20 at 1:20 p.m., Staff S, Certified Occupational Therapy Assistant, (COTA), verified a physician's order for Physical Therapy to evaluate and treat signed by the physician on 6/18/20. Staff S reviewed therapy records and reported a Physical Therapy evaluation had not been done and no treatment had been started on the resident. She stated she remembered that Staff C, Registered Nurse, told her to hold up on the order, but she didn't know what had happened after that or why the order had not been implemented. During an interview on 7/28/20 at 3:05 p.m., the Director of Nursing (DON) verified a Physical Therapy evaluation and treatment order for 6/18/20. She reported that somehow it fell

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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NORTHCREST SPECIALTY CARE	**2001 HEATH STREET WATERLOO, IA 50703**

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F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) through the cracks. The DON stated they have a nursing orientation list that goes over the noting of orders process and follow through with physician orders. The DON stated she would expect the nurses to implement physician's orders or get the order discontinued. She reported the facility did not have a policy on implementing physician orders.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation and interview the facility failed to use appropriate personal protective equipment (PPE) for isolation precautions, disinfect PPE, disinfect equipment and perform appropriate incontinence care for 3 of 7 residents (Resident #1, #2, #3) reviewed during a COVID-19 infection control survey. The facility identified a census of 78 residents. Findings include: 1. The Minimum Data Set (MDS) Assessment, dated 5/20/20 for Resident # 1, showed a Brief Interview for Mental Status (BIMS) Score of 8 indicating moderate cognitive loss. The resident required extensive assistance of two staff with transfers, dressing, toilet use and extensive assistance of one for personal hygiene. The MDS listed a [DIAGNOSES REDACTED]. The Care Plan, dated 5/24/20, identified the resident went out of the facility three days a week for [MEDICAL TREATMENT]. On 7/21/20 at 8:00 a.m. the surveyor observed a Stop Precaution sign on the resident's door. The sign directed staff to wear a face mask, gloves and faceshield for direct care. Examples of direct care on the sign included any and all activities of daily living and giving medications. The Resident's door also had a Droplet Precautions Sign. The Droplet precaution sign stated everyone must clean their hands before entering and when leaving the room, make sure eyes, nose and mouth are fully covered to enter the room and to remove face protection before exiting the room. The Resident's room had a quarantine sign that identified the quarantine date as ongoing and directed staff to wear a mask, goggles/face shield, gloves and gown. The door also posted a Center for Disease Control and Prevention (CDC) sign on how to safely remove personal protective equipment (PPE). The CDC PPE poster documented the outside of the goggles, front of the mask and face shield are contaminated. If the items are reusable, place in the designated receptacle for reprocessing, otherwise discard them in the appropriate waste container. During an observation on 7/21/20 at 8:00 a.m., Staff G, Certified Nursing Assistant (C.N.A.) performed hand hygiene, took off his/her face shield and placed it on top of the three drawer bin. Staff G put on an isolation gown, gloves and already had a Niosh 95 (N95, a special facemask that filters out 95% of airborne particles) face mask on. Staff G knocked on the resident's door and asked permission to come in to assist with putting on his/her pants. Staff G entered the room wearing an isolation gown, N95 mask and gloves. Staff G failed to don the face shield before entering Resident #1's room. Staff G's face shield remained laying on top of the three drawer bin. During an observation on 7/21/20 at 8:12 a.m., Staff J, Licensed Practical Nurse, (LPN), performed hand hygiene, applied an isolation gown, and wearing an N95 mask and face shield, entered the resident's room to administer medication. Staff J exited the room, took off the isolation gown, performed hand hygiene and returned to the medication cart. Staff J did not sanitize the face shield or change the N95 mask when exiting the droplet precaution room. Staff J continued to enter multiple contact isolation rooms to do administer medication to other residents wearing the same N95 mask and face shield. During an interview on 7/21/20 at 8:33 a.m., Staff J, Licensed Practical Nurse, (LPN), reported all staff are to wear an N95 mask and faceshield or eye goggles for resident care. She stated they communicate through shift report who is on isolation precautions and what PPE should be worn for cares. She stated she had not received any training on changing N95 masks or disinfecting face shields after providing cares in a droplet precaution room or before leaving the isolation unit. During an interview on 7/22/20 at 7:31 a.m., Staff K, Infection Preventionist, reported that Resident #1 is on droplet precautions, ongoing, due to going out of the facility for [MEDICAL TREATMENT]. She reported staff should be disinfecting the face shield or goggles and N95 masks when coming out of the droplet precaution rooms before entering any of the contact precautions rooms or going out of the isolation unit into the general nursing home area. She reported there are signs on the rooms that direct staff. 2. The MDS, dated [DATE] for resident #2, documented the resident had a BIMS Score of 15 indicating intact cognitive functioning. The resident required extensive assistance of two staff for transfers and toileting and extensive assistance of one staff for ambulation and dressing. The MDS listed a [DIAGNOSES REDACTED]. A Progress Note, dated 7/15/20 at 7:02 a.m., documented the resident left the facility for an injection. A Progress note, dated 7/15 20 at 8:48 a.m., documented the resident returned from the appointment and was in isolation. On 7/23/20 at 9:20 a.m., the surveyor observed the resident's room door had a quarantine sign that identified a quarantine end date of 7/30/20 and directed staff to wear PPE consisting of a mask, goggles/face shield, gloves and gown for care. During an observation on 7/23/20 at 9:20 a.m., Staff A, C.N.A., entered the resident's room wearing an N95 mask and face shield. The face shield was observed to be worn high on the forehead so that it failed to cover her eyeglasses or N95 mask. Staff A did not apply an isolation gown before entering the room. Observation revealed Staff A stood within 3 feet of the resident, took the resident's menu slip, and removed the breakfast tray. Staff A failed to wear an isolation gown, wear the face shield correctly, disinfect the face shield or change the N95 mask when exiting the room. During an interview on 7/23/20 at 8:45 a.m., the Director of Nursing, (DON), reported she would expect that staff follow the quarantine PPE sign on the room and wear the required PPE including a face shield, as directed, into a droplet isolation room. The DON stated the face shield should be worn to protect the face and N95 mask. She stated she would expect that staff would disinfect the face shield and N95 mask when exiting a droplet precaution room before entering any other room in the isolation unit as well as when exiting the isolation unit to the general care area. 3. The MDS, dated [DATE] for resident #3, showed a BIMS Score of 15 indicating intact cognitive functioning. The resident required extensive assistance of two for bed mobility, transfer, dressing and toileting. The MDS listed a [DIAGNOSES REDACTED]. The MDS identified the resident received hospice services. The Care Plan, dated 5/08/20, directed the staff to assist the resident with activities of daily living (ADL's) and toileting needs. During an observation on 7/23/20 at 8:25 a.m., Staff A, Certified Nursing Assistant (C.N.A.) and staff B, C.N.A., entered resident #3's room. Staff A wore a N95 mask and a face shield positioned up on the forehead so that it did not cover Staff A's prescription glasses or the N95 mask. Staff B wore an N95 mask and protective eye goggles. Resident #3 lay in bed on back with the head of the bed elevated. Staff A and B performed hand hygiene, provided privacy and donned gloves. Staff A went to the bedside, explained care to the resident and placed a package of disposable wipes in the residents bed without placing them on a clean barrier. The resident had been incontinent of urine through the adult brief, cloth chux and fitted mattress sheet into the mattress leaving a approximate twelve inch circular ring of urine under the resident. The resident had wound dressings to both lower extremities that had drained an approximate ten inch circular area of light tan/brown drainage on to a cloth chux (pad placed under residents to absorb urine) positioned under the resident's lower legs. Staff A stated the resident would be getting up later for a bath and placed a disposable chux under the resident to perform peri-care. Staff A picked up the garbage can with her gloved hand and handed the garbage can over the top of the resident to Staff B. Staff A and B failed to remove their dirty gloves and perform hand hygiene after touching the garbage can. Staff B cleansed the resident and assisted by touching the resident's skin with dirty gloves to complete the peri-care. Staff A touched a clean brief with dirty gloves and handed to Staff B to apply. Staff A and B placed the clean brief on the resident still wearing the same dirty gloves, positioned, and covered the resident. Staff A and B failed to use a clean barrier for supplies, remove dirty gloves and perform hand hygiene, and remove the fitted mattress sheet which had a twelve inch circular area of urine soaked into the mattress. Staff A and B failed to remove the dirty cloth chux from under the resident's lower legs. During an observation on 7/23/20 at 8:45 a.m., Staff C, Registered Nurse (RN), removed four non-stick pads and four ABD dressings from the packages and placed the items on top of the treatment cart without a clean barrier underneath them and without completing hand hygiene prior to opening. Staff C cut one of the ABD dressing in half without disinfecting the scissors prior to use. Staff C took the treatment cart into the resident's room, provided privacy, performed hand hygiene, donned gloves and took supplies from the top of the treatment cart and placed them on a clean towel by the resident's bed. The resident lay in bed supine still laying on the soiled fitted sheet, soiled cloth chux pad, and with the lower legs resting on a cloth chux soiled with a ten inch circle of tannish brown drainage. Staff C placed a disposable chux pad under the resident's legs as Staff B, C.N.A. assisted. Staff C completed the wound care and Staff B assisted in repositioning the resident's lower extremities leaving the soiled cloth chux under the resident's legs. Staff B and C exited the resident's room with the resident still laying on the soiled fitted bed sheet and soiled cloth chux under his/her lower extremities. During an interview on 7/27/20 at 10:17 a.m., Staff B, C.N.A. reported if a resident has been incontinent through to the mattress, they would be required to provide full incontinence care using clean to dirty technique, provide all new clean linens under the resident and sanitize the mattress. During an interview on 7/27/20 at 10: 29 a.m., Staff M, LPN reported if a resident has been incontinent through to the mattress, the C.N.A.'s would be required to provide complete peri-care, change out all the dirty linen to clean linen and sanitize the mattress. She reported if a resident has had wound drainage or any dirty linens, the linens should be replaced with clean linens

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 2) during resident care anytime it is needed. During an interview on 7/27/20 at 10:26 a.m. Staff Q, Assistant Director of Nursing (ADON), reported if a resident has been incontinent of urine through to the mattress, staff should complete peri-care, replace all dirty linen with clean linens and the mattress would need to be disinfected. She reported any linens contaminated with wound drainage should be changed out with clean linens. She stated peri-care should be done moving from clean to dirty areas, and clean items should not be contaminated with dirty gloves. During an interview on 7/27/20 at 1:45 p.m., the Director of Nursing (DON) reported she would expect staff to remove all dirty linens any time resident is care is done and if the mattress is contaminated it should be disinfected. She stated she would expect that all areas of a resident skin that contact a dirty brief or linens should be cleansed and C.N.A.'s should not touch the resident with dirty gloves or any of the clean care items. Infection control should be maintained. The Incontinence Care/Peri-Care Policy, dated January 2015, provided by the facility, listed the following guidelines: 1. Gather equipment and take to bedside. 2. Identify resident and explain procedure 3. Screen resident for privacy. 4. Drape the resident for privacy. 5. Lower head and foot of bed. 6. Wash your hands. 7. Put on gloves. 8. If incontinent of stool, remove as much as possible with toilet paper. 9. Fold soiled linens under resident to provide a clean work area. Remove (dirty linens) when turning resident. 10. Cleanse all soiled areas front to back using clean area of cloth/wipe, especially skin folds, turning resident as necessary. 11. Remove gloves; wash hands. 11a. Put on gloves, apply moisture barrier as directed. 12. Remove gloves, wash hands. 13. Make sure call light is accessible and resident is comfortable. 14. Remove soiled linen from room. 15. Report irritated areas to charge nurse. During an observation on 7/21/20 at 7:55 a.m. Staff J, Licensed Practical Nurse (LPN) exited room [ROOM NUMBER] wearing a isolation gown, N95 mask, face shield, and gloves. room [ROOM NUMBER] had a droplet precaution sign posted on the door. Staff J removed the isolation gown. Staff J did not complete hand hygiene, disinfect the face shield or change the N95 mask after being in a droplet isolation precaution room. During an interview, Staff J reported she had not been directed that face shields had to be disinfected or N95 masks needed to be changed after leaving a droplet precaution room or the isolation unit. During an interview on 7/21/20 at 8:21 a.m., Staff G, reported staff follow the PPE sign on the room door to know what PPE is required to be worn in the room for resident care on the isolation unit. Staff G stated she cleaned her face shield with the 256 spray at the end of every shift and as needed, but did not know the contact time for use of the 256 spray to disinfect the face shields. No 256 spray was observed in any of the isolation bins in the isolation unit to disinfect the face shields. During an observation on 7/21/20 at 12:47 p.m., Staff L, Occupational Therapist-Registered (TOR), removed a gown and gloves coming out of an isolation room, but failed to disinfect or change the N95 mask when exiting the isolation unit to go to the general nursing home area. Staff L stated she usually cleaned the face shield when she came out of a droplet precaution room but had not been sanitizing her face shield or mask when she exited the isolation unit to go to the general resident care area. She reported she had not been directed to do that. During an observation on 7/21/20 at 1:00 p.m., Staff I, Admission Coordinator, was observed on the isolation unit. Staff I exited isolation room [ROOM NUMBER] and proceeded to exit the isolation unit to the general nursing home area without disinfecting her face shield or changing the N95 mask. Staff I reported she did not always clean her face shield when she left the isolation unit and continued to wear the same face shield and N95 mask for resident care outside of the isolation unit. During an observation on 7/21/20 at 1:23 p.m., Staff G, C.N.A. and Staff H, C.N.A. were observed working in the isolation unit. Staff G and H each wore an isolation gown, N95 mask and face shield. Staff G and H took off the isolation gowns and continued to walk out of the isolation unit to dispose of garbage without disinfecting the face shield, changing the N95 mask or completing hand hygiene. During an interview on 7/22/20 at 7:31 a.m., Staff K, Infection Preventionist, stated staff should be disinfecting the face shield or goggles and N95 masks when coming out of the droplet precaution rooms before entering any of the contact precautions rooms or going out of the isolation unit into the general nursing home area. During an observation on 7/23/20 at 7:53 a.m., Staff B, C.N.A., came to the doorway of room [ROOM NUMBER] from inside the room wearing an N95 mask. The protective eye goggles were on top of her head. Staff B looked out of the room doorway and asked for assistance with the resident, then went back in the room without putting the goggles down over her eyes. Staff B came out of the room at 8:04 a.m. still wearing the N95 mask and the goggles still on top of her head. During an observation on 7/23/20 at 8:16 a.m., Staff N, Dietary Aide, noted to be wearing an N95 mask and eye goggles on top of his head serving drinks to two residents in the dining room Staff N was within 3 feet of each resident. During an interview on 7/23/20 at 12:41 p.m., Staff O, Dietary Services Manager, reported dietary staff are to wear an N95 mask and a face shield when serving in the dining room or for any resident care. She stated Staff N had been approved by the Administrator to wear sealed goggles over his glasses, but the goggles should be over the glasses with any resident contact and not worn on top of the head. During an interview on 7/23/20 at 12:50 p.m., the DON stated all staff are expected to wear a N95 mask, face shield or goggles for resident care, including when serving food/fluids to residents in the dining room. She expected that staff would wear all PPE correctly, including having face shields over the N95 mask and eye goggles down over the eyes. She would expect staff to correctly use all PPE and wear the appropriate PPE as listed on the Quarantine and isolation precaution signs. During an interview on 7/27/20 at 10:23 a.m., Staff P, R.T., stated she was not a regular staff member, and had never received any instruction on sanitizing the face shields or what to do with the masks when coming out of an isolation room or the isolation unit. During an interview on 7/27/20 at 10:26 a.m., Staff Q, Assistant Director of Nursing (ADON), reported the facility did not have any policies in effect that addressed sanitizing the face shield or what to do with the N95 mask after being in an isolation room or when coming out of the isolation unit to direct the staff on appropriate infection control. During an interview on 7/27/20 at 1:45 p.m., the DON reported she would expect that staff would follow the PPE signs posted on isolation rooms, wear the identified PPE correctly and sanitize the face shields when exiting an isolation room or isolation unit. A document labeled Admission Screening/Isolation/Quarantine for New Admission/Re-admission/Residents Who Leave the Facility Policy, revised 7/22/20, directed the following: 1. Resident's admitted /readmitted /leave the facility for appointments or emergency room visits will be treated as suspect or positive (COVID-19). If the resident does not have any symptoms a quarantine sign will be placed on the door and the following PPE will be used: Gown Gloves Facemask Face shield or goggles 2. Resident's admitted with signs and symptoms of COVID-19 or a known positive case will be placed on transmission based isolation with the following PPE use: Gown Gloves Facemask Face shield or goggles The Policy outlined anyone entering a Quarantine room shall wear the following: Gloves Gowns-disposable or washable Mask-paper/surgical Face shield/goggles or glasses (safety style) The Policy outlined anyone entering a transmission based isolation room (Standard, Contact and Droplet) shall wear full proper PPE including: Gloves Gowns-disposable or washable N95/N95 Mask if available Face shield/goggles/glasses (safety style) The Policy lacked direction on disinfecting of equipment or reprocessing of PPE equipment after use in a transmission based isolation room or quarantine room.