STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366106	A. BUILDING _____ B. WING _____	08/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FAIRFAX HEALTH CARE CENTER	9014 CEDAR AVE CLEVELAND, OH 44106

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 0727 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.** Based on record review and interview, the facility failed to ensure a full-time Director of Nursing (DON) was consistently in place. This affected all 44 residents residing in the facility. Findings include: Review of Registered Nurse (RN) #109's personnel file revealed a start date of 02/05/20 for the DON position. A personnel change form dated 07/01/20 revealed RN #109 resigned and did not give proper notice of resignation. RN #109's license was valid and current. Review of the personnel file of RN #123, who served as the facility's current DON, revealed a hire date of 07/27/20. DON/RN #123's license was valid and current. Phone interview with the Administrator on 08/06/20 at 9:32 A.M. verified there had not been a DON in place at the facility from 07/01/20 until 07/27/20.
F 0732 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Post nurse staffing information every day.** Based on record review and staff interview the facility failed to ensure daily posted nursing staff information was updated timely. This had the potential to affect all 44 residents residing in the facility. Findings include: Observation of the posted nursing staff information on 08/11/20 at 10:48 A.M. revealed the posted nursing staff information included the staffing for 08/07/20 and 08/08/20. Interview on on 08/11/20 at 10:49 A.M. with Licensed Social Worker (LSW) #105 verified the posted staffing was not current.
F 0835 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Administer the facility in a manner that enables it to use its resources effectively and efficiently.** Based on record review and interview the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to ensure comprehensive and effective infection control policies and practices were developed and implemented to prevent the spread of COVID-19 within the facility. This affected all 44 residents residing in the facility. Findings include: The facility failed to implement effective and recommended infection control practices to prevent the spread of COVID-19 throughout the facility resulting in Immediate Jeopardy on 07/21/20 when the facility received notification of their first COVID-19 case, Resident #1, who tested positive at the hospital. There was no written evidence immediately after receiving notification of Resident #1 testing positive for COVID-19 that the facility quarantined all staff determined to have contact with Resident #1. A timeline provided by the facility on 08/05/20 at 11:48 A.M. revealed a lack of infection control measures implemented until 07/23/20 when the facility received general guidance on how to organize residents and general infection control procedures from the city health department. The timeline did not elaborate on what guidance was provided. On 07/24/20, State tested Nursing Assistant (STNA) #117 called off of work with COVID symptoms. STNA #117 was one of the 12 staff the facility identified that had come into contact with Resident #1. From 07/21/20 until 08/01/20, there were 10 residents positive for COVID-19 (Residents #1, #3, #5, #6, #9, #10, #11, #12, #13 and #14) and two presumptive-positive residents (Resident #7 and Resident #21). In addition, three staff members tested positive for COVID-19. During this time period, the facility failed to establish a comprehensive infection control program to provide early identification of and prevention of these additional positive COVID-19 resident cases. In addition, the facility failed to implement effective and recommended infection control practices, including the consistent use of isolation precautions and dedicated staff to care for exposed and presumptive positive residents. Through interviews it was determined the facility failed to coordinate with the city department in a timely manner to prevent and contain the spread of COVID-19 within the facility. The facility failed to ensure an infection control tracking system maintained via infection control log for July 2020 was readily available, accurate and contained adequate information to identify the necessary components related to the COVID-19 pandemic. Observations on 08/04/20 revealed infection control concerns which included but were not limited to the following: Residents on the 1-North unit, the facility's isolation unit, did not consistently have signage indicating isolation status. PPE was not readily available. The same staff were caring for a COVID-positive resident as well as presumptive positive residents and others on the 1-North unit. Continued observations on 08/06/20 revealed the facility had PPE but it was not accessible to staff on the 1-North unit. Staff did not use PPE appropriately when entering isolation rooms. The lack of a comprehensive infection control program in addition to the continued observations of infection control concerns placed all residents at risk for contracting COVID-19 and experiencing the potential for actual harm associated with COVID-19 including hospitalization and/or death. (See Findings at F880). During the COVID-19 Focused Infection Control Survey from 08/03/20 to 08/13/20, the facility failed to provide evidence of a completed CMS voluntary self-assessment. Interview with the Director of Nursing (DON)/Registered Nurse (RN) #123 and the Administrator on 08/07/20 at 2:08 P.M. confirmed the CMS voluntary self-assessment had not been completed. On 08/05/20 at 9:00 A.M. phone interview with the Administrator confirmed the 1-North isolation unit had not been in place prior to 07/21/20. New admissions were being isolated in a private room but did not go to a designated unit, 2-South, until 07/24/20. The Administrator verified the city health department had been contacted and had suggested keeping separate units of non-exposed residents, suspected residents and positive residents but due to not enough COVID tests, the facility held off on creating these units. The Administrator verified the facility had placed a COVID-positive resident amongst presumptive positive and exposed residents on the 1-North hall. On 08/06/20 at 9:32 A.M. interview with the Administrator again verified the facility did not follow the recommendations PHOPC #111 provided to the facility regarding three separate areas with dedicated staff as they were ideal recommendations. On 08/06/20 at 5:24 P.M. phone interview with Public Health Outbreak Practice Coordinator (PHOPC) #111 revealed during July 2020 the facility had their first COVID-19 case, then had three or four cases over a span of a few days so she was asked to visit the facility. PHOPC #111 shared the facility was trying to come up with an isolation area and a quarantine area and spoke of sectioning off an empty wing for sick residents. PHOPC #111 stated at the time of her visit on 07/29/20, the facility had not decided what to do regarding those residents coming back from the hospital especially if they were COVID-positive. PHOPC #111 stated she educated the DON/RN #123, Administrator and Licensed Social Worker (LSW) #105 on quarantine, isolation and PPE and discussed getting more resources. PHOPC #111 recommended cohorting residents including exposed residents in one area and positive/symptomatic residents in another area with dedicated staff for each of the negative, quarantine and isolation areas. PHOPC #111 stated for residents returning from the hospital, a 14-day quarantine was recommended and full PPE including a N95 respirator mask, gown, gloves and eye protection was needed for both positive residents and new admissions. PHOPC #111 explained each nursing home in Ohio was assigned to an organization within their zone and region and stated the facility was assigned to

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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 0835 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 1) (named facility) as well as a laboratory provider; if a facility had a shortage of COVID testing or PPE supplies, they were directed to contact the hospital organization. PHOPC #111 verified the facility had not reached out to her regarding any testing or PPE needs as of 08/06/20. On 08/08/20 at 12:51 P.M. interview with the Chief Quality Officer for MetroHealth (CQO) #118 confirmed the facility had made contact regarding COVID testing on 07/31/20. CQO #118 verified COVID testing for in-house residents had just been completed on 08/07/20. CQO #118 stated a webinar had been provided to all facilities assigned to their hospital that discussed how to contact the hospital if needs arose. CQO #118 verified the facility had not requested PPE or reached out for testing supplies prior to 07/31/20. Review of RN #109's personnel file revealed a start date of 02/05/20 for the DON position. A personnel change form dated 07/01/20 revealed RN #109 resigned and did not give proper notice of resignation. RN #109's license was valid and current. No infection control preventionist training was available for review. Review of DON/RN #123's personnel file revealed a hire date of 07/27/20. DON/RN #123's license was valid and current. Infection preventionist training was completed and available for review. Interview with DON/RN #123 on 08/04/20 at 10:35 A.M. revealed she was newly employed with the facility. When asked for a COVID line list or infection control log, DON/RN #123 verified no infection control log, surveillance or infection control policies were available from the previous DON. Phone interview with the Administrator on 08/05/20 at 9:00 A.M. revealed the facility's previous DON, RN #109 filled the infection preventionist (IP) role but did not have the formal training required. The Administrator stated RN #109 was the IP for three or four months but could not provide dates. The Administrator verified between RN #109 and DON/RN #123 there was a span of time where the facility did not have a DON or an IP. Phone interview with the Administrator on 08/05/20 at 9:00 A.M. revealed the facility had not had a medical director since 01/01/20 and was using facility physicians for guidance relating to COVID-19. Review of the facility's roster of medical staff, undated, revealed no medical director was listed. A phone interview with Physician #110 on 08/10/20 at 12:08 P.M. confirmed he resigned as medical director in October 2019. Physician #110 stated he had suggested three or four weeks ago that the facility test all residents and staff for COVID-19. A phone interview with Physician #120 on 08/11/20 at 3:17 P.M. denied the facility had asked him for any guidance regarding COVID-19. An e-mail was sent to Physician #112 on 08/12/20 at 10:16 A.M. requesting an interview but no return contact was received. A phone interview with Physician #119 on 08/12/20 at 10:21 A.M. denied the facility had asked him for any guidance regarding COVID-19.
F 0841 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility.** Based on record review and interview, the facility failed to procure a medical director in a timely manner. This affected all 44 residents residing in the facility. Findings include: Review of the facility's current roster of medical staff, undated, revealed no medical director was listed. Review of a letter dated 10/23/19 written by Physician #110 and addressed to the Administrator revealed Physician #110 had provided notice of resignation as medical director effective 11/23/19. A phone interview was conducted with the Administrator on 08/05/20 at 9:00 A.M. The Administrator verified the facility was looking for a medical director as one had not been in place since 01/01/20. The Administrator stated the facility currently utilized their physicians for any guidance needed but these physicians did not attend Quality Assurance meetings. An interview with the Administrator and Director of Nursing (DON)/Registered Nurse (RN) #123 on 08/07/20 at 2:08 P.M. revealed the DON/RN #123 had text-messaged a physician on 07/27/20 regarding the medical director position but no further follow-up had occurred. A follow-up interview with the Administrator and DON/RN #123 on 08/07/20 at 5:13 P.M. revealed the medical director position had not been run on a job website but rather the job description had been handed out to people when there was interest. A phone interview with Physician #110 on 08/10/20 at 12:08 P.M. confirmed he resigned as medical director in October 2019 and was aware the facility currently did not have a medical director in place. Review of the medical director job description, undated, revealed the medical director would participate on committees including quality assurance, infection control and patient care policies.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy and procedure review the facility failed to ensure clear and accurate records. This affected 10 residents (Resident #7, Resident #9, Resident #11, Resident #15, Resident #16, Resident #18, Resident #21, Resident #22, Resident #23 and Resident #27) of 28 resident records reviewed. The facility census was 44 residents. Findings include: 1. Review of Resident #23's medical record revealed an admission date of [DATE] and [DIAGNOSES REDACTED]. Review of physician's orders [REDACTED]. Review of a quarterly minimum data set (MDS) assessment dated [DATE] revealed Resident #23 was cognitively intact and required supervision of one staff for bed mobility. Review of census data in Point Click Care (electronic medical record) indicated Resident #23 resided on the 1-North unit and was moved to the 2-South unit on 08/08/20. Review of nurses' notes revealed no documentation regarding the room change. Review of resident COVID-19 test results from 08/07/20 indicated Resident #23 had a negative test result and there was a notation indicating the resident was moved to the second floor as a result of testing. Interview with Licensed Social Worker (LSW) #105 on 08/11/20 at 10:50 A.M. revealed she was responsible for documenting room changes in the medical record and stated she hadn't gotten to (Resident #23) yet. Interview with the DON and the Administrator on 08/11/20 at 11:57 A.M. revealed documentation of COVID test results should be documented in the medical record. 2. Review of Resident #9's closed medical record revealed an admission date of [DATE] and [DIAGNOSES REDACTED]. Review of census data revealed Resident #9 resided on the 1-North unit. A discharge-return anticipated MDS assessment dated [DATE] revealed Resident #9's memory was okay and Resident #9 required supervision with eating. Review of physicians' orders revealed an order dated 04/14/20 for temperature and lung sounds each shift and as needed, notify DON if temperature at 99 (degrees F) or higher every evening shift related to COVID-19. Review of the July 2020 Medication Administration Record [REDACTED].M. indicated the resident had a moist productive cough but was afebrile. A nurses' note dated 07/24/20 at 3:17 P.M. revealed Resident #9 was sent to the emergency room for increased shortness of breath, decreased pulse oximetry and hypertension. Interview with the DON on 08/10/20 at 12:34 P.M. verified nursing staff should have followed the order as written and notified the DON and/or the physician of Resident #9's elevated temperature as well as documented this in the medical record. 3. Review of Resident #21's medical record revealed an admission date of [DATE] and [DIAGNOSES REDACTED]. Census data indicated Resident #21 resided on the 1-North unit. Review of an annual MDS assessment dated [DATE] revealed Resident #21 was cognitively intact and required the limited physical assistance of one staff for bed mobility. Review of physician's orders [REDACTED]. Review of the July 2020 and August 2020 MARs revealed no evidence the COVID test had been completed as ordered. Review of a nurses' note dated 07/27/20 revealed the resident was aware she was to be tested for COVID-19. Review of a nurse practitioner note dated 08/05/20 indicated Resident #21 was not positive for COVID-19 but was on precautions as her roommate had tested positive for COVID-19. Interview with the DON on 08/10/20 at 12:34 P.M. revealed the facility was sent several COVID-19 testing swabs but they were going to be used when it was time to retest residents. No resident COVID testing had been completed in-house prior to 08/07/20. The DON was made aware there was no evidence of Resident #21's COVID-19 swab in the electronic medical record and stated it may have not been done. 4. Review of Resident #11's closed medical record revealed an admission date of [DATE] and [DIAGNOSES REDACTED]. Review of census data revealed Resident #11 resided on the 1-North unit. The quarterly MDS assessment dated [DATE] revealed Resident #11 was cognitively intact and required the extensive assistance of one staff for bed mobility. Review of physician's orders [REDACTED]. Review of the July 2020 and August 2020 MARs revealed no evidence the COVID test had been completed as ordered. Review of nurses' notes revealed on 07/30/20 at 1:01 P.M. the nurse practitioner was informed Resident #11 had a change condition with poor appetite, lethargy and was shaking; new orders included a COVID-19 swab and to start intravenous (IV) fluids along with urinalysis and lab work. A nurses' note dated 07/31/20 at 1:00 P.M. revealed Resident #11 discharged to the hospital and tested positive for COVID-19. Interview with the DON on 08/10/20 at 12:34 P.M. revealed the facility was sent several COVID-19 testing swabs but they were going to be used when it was time to retest residents. The DON was made aware there was no evidence of Resident #11's COVID-19 swab in the electronic medical record. The DON indicated no resident COVID testing had been completed in-house prior to 08/07/20, including Resident #11. 5. Review of Resident #7's medical record

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F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) revealed an admission date of [DATE] and [DIAGNOSES REDACTED]. Review of census data indicated Resident #7 resided on the 1-North unit. Review of a quarterly MDS assessment dated [DATE] revealed Resident #7 was cognitively impaired and required the extensive assistance of one staff member for transfers. Review of current physician's orders [REDACTED]. Review of a nurses' note dated 08/01/20 at 12:15 P.M. revealed Resident #7 had a fever of 102.1 degrees F at 11:00 A.M.; the nurse practitioner was notified and ordered lab work, a chest x-ray and intravenous (IV) fluids. Review of a nurses' note dated 08/01/20 at 4:48 P.M. revealed Resident #7's white blood count was 2.9 and Resident #7 was suspected positive for COVID and in isolation. Review of a nurses' note dated 08/08/20 revealed Resident #7 tested positive for COVID-19. A nurses' note dated 08/09/20 indicated orders for contact/droplet/airborne isolation was put into place. Review of the July 2020 infection tracking log revealed Resident #7 was not listed as suspected COVID-positive. The Administrator was made aware of concerns including Resident #7's nurses' notes documenting isolation precautions which were not ordered until 08/09/20. 6. Review of Resident #18's medical record revealed an admission date of [DATE] and [DIAGNOSES REDACTED]. Review of census data indicated Resident #18 lived on the 1-North unit. Review of an admission MDS dated [DATE] revealed Resident #18 was cognitively impaired. Review of physician's orders [REDACTED]. Review of an August 2020 MAR indicated [REDACTED]. No nurses' notes were available that indicated the DON and/or the physician was notified of Resident #18's elevated temperature. Review of a nurses' note dated 08/08/20 revealed Resident #18 tested positive for COVID-19. A nurses' note dated 08/09/20 indicated orders for contact/droplet/airborne isolation was put into place. The DON and the Administrator were made aware of the lack of documentation related to notification of Resident #18's elevated temperature during an interview on 08/11/20 at 11:48 A.M. 7. Review of Resident #15's medical record revealed an admission date of [DATE] and [DIAGNOSES REDACTED]. A quarterly MDS assessment dated [DATE] revealed Resident #15 had a memory problem and required extensive assistance of one staff for transfers. Review of nurses' notes dated 08/07/20 revealed Resident #15 had increased confusion, poor appetite and temperatures of 99.1 degrees F to 99.7 degrees F and new orders were received to send the resident to the hospital [MEDICAL CONDITION]. Nurses' notes did not indicate Resident #15 had tested positive for COVID-19 during the facility-wide testing completed on 08/07/20. Interview with the DON and the Administrator on 08/11/20 at 11:57 A.M. revealed documentation of COVID test results should be documented in the medical record. 8. Review of Resident #27's medical record revealed an admission date of [DATE] and [DIAGNOSES REDACTED]. Review of a five-day MDS assessment dated [DATE] revealed Resident #27 had a memory problem and required the extensive staff assistance of one staff for mobility. Review of physician's orders [REDACTED]. No order for temperature or symptom monitoring for COVID-19 was available in the medical record. Review of a nurses' note dated 08/08/20 revealed Resident #27 tested positive for COVID-19 and was going to have a room change; orders were obtained for contact/airborne/droplet isolation. The DON and the Administrator were made aware of Resident #27's missing order during an interview on 08/11/20 at 11:48 A.M. 9. Review of Resident #16's medical record revealed an admission date of [DATE] and [DIAGNOSES REDACTED]. Review of a quarterly MDS assessment dated [DATE] revealed Resident #16 was cognitively impaired and required the extensive assistance of one staff for bed mobility. Review of census data revealed Resident #16 lived on the 1-North unit but moved to the 2-South unit on 08/08/20. Review of physician's orders [REDACTED]. No orders for isolation precautions were noted. Review of nurses' notes revealed on 08/08/20 Resident #16 tested negative for COVID-19 but was having a room change with isolation precautions. Interview with the DON and the Administrator on 08/11/20 at 11:57 A.M. revealed Resident #16 was on quarantine and per the COVID-19 resource binder, staff were to place an order for [REDACTED].#22's medical record revealed an admission date of [DATE] and [DIAGNOSES REDACTED]. Review of a quarterly MDS assessment dated [DATE] revealed Resident #22 had a memory problem and required the extensive assistance of one staff for bed mobility. Review of census data revealed Resident #22 resided on the 1-North unit and had a room change to the 2-South unit on 08/08/20. Review of physician's orders [REDACTED]. No orders for isolation precautions were noted. Review of a nurses' note dated 08/08/20 revealed Resident #22 was notified of a room change. There was no documentation of negative COVID-19 test results available in the resident record. Review of resident COVID-19 test results from 08/07/20 indicated Resident #22 had a negative test result and there was a notation indicating the resident was moved to the second floor as a result of testing. Interview with the DON and the Administrator on 08/11/20 at 11:57 A.M. revealed documentation of COVID test results should be documented in the medical record. Review of a policy, Nursing Documentation, effective October 2016 revealed the facility was to provide clear, accurate documentation including medication records, patient clinical parameters and changes in condition.
F 0868 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Have the Quality Assessment and Assurance group have the required members and meet at least quarterly** Based on record review and interview, the facility failed to ensure the Quality Assurance (QA) committee met at the required frequencies and included the medical director and a member in a leadership role as required. This affected all 44 residents in the facility. Findings include: Review of contents of the facility's Quality Assurance Performance Improvement (QAPI) book revealed meeting sign-in sheets and a policy. Review of a meeting dated 04/28/20 did not have a member sign in sheet; this meeting discussed topics including wounds, therapy and falls. Review of a meeting dated 05/05/20 did not have a member sign in sheet; this meeting discussed topics including wounds and restorative services. Review of a meeting dated 05/26/20 revealed the Administrator and the Medical Director were not present; seven staff were in attendance. Review of a meeting dated 06/02/20 revealed the Administrator and the Medical Director were not present; eight staff were in attendance. Review of a meeting dated 06/12/20 revealed the Administrator and the Medical Director were not present; five staff were in attendance. Review of a meeting dated 06/16/20 revealed the Administrator and the Medical Director were not present; five staff were in attendance. Review of a meeting dated 06/23/20 revealed the Administrator and the Medical Director were not present; six staff were in attendance. Information prior to 04/28/20 was not available for surveyor review. Interview with the Director of Nursing (DON)/Registered Nurse (RN) #123 on 08/07/20 at 3:16 P.M. revealed all of the facility's QA documents available since 01/01/20 were provided to the surveyor for review. Interview with the DON/RN #123 and the Administrator on 08/07/20 at 5:23 P.M. revealed the Administrator tried to attend the QA meetings but did not always attend. QA meetings were held quarterly but documentation provided did not show evidence of this. The surveyor went through the provided QA documentation with the Administrator and his signature was not on any of the sign in sheets. The Administrator stated he needed to check his calendar to see when he attended the QA meetings. Review of the facility policy, Quality Assurance Improvement Plan, effective 07/05/18 revealed the QAPI committee will consist of representation from housekeeping, laundry, dietary, nursing, maintenance and activities. Our therapy department and human resources will be asked for input or sit on a performance improvement project as requested. The QAPI committee will provide the backbone and structure for QAPI. This group includes the DON, MDS, Environmental Services, Maintenance, Dietary, Medical Director and Special Projects nurse. The policy did not specify how often the QAPI committee would meet.
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 the unprecedented global pandemic that resulted in the Presidential declaration of a State of National Emergency dated 03/13/20, Department of Health and Human Services, Centers for Medicare & Medicaid (CMS) Memos, Nursing Home Guidance from the Centers for Disease Control (CDC), data contained on the State of Ohio's coronavirus.ohio.gov dashboard, observations, record reviews, review of the facility Coronavirus (COVID-19) policy, review of the facility's timeline, interview with the local health department and staff and resident interview, the facility failed to implement effective and recommended infection control practices including proper isolation of residents and the appropriate use of personal protective equipment (PPE) to prevent the spread of COVID-19 throughout the facility. This resulted in Immediate Jeopardy on 07/21/20 at 8:22 A.M. when Resident #1 had a temperature of 100.1 degrees Fahrenheit (F). New orders were received to send the resident to the emergency room (ER). A follow up nurses ' note dated 07/21/20 at 6:53 P.M. revealed Resident #1 was admitted to the hospital for COVID-19. The lack of investigation and effective infection control practices and prevalence of continued positive cases in the facility placed all residents in the facility at risk for harm, complications and/or death related to the facility's failure to control the COVID-19 outbreak. In addition, the facility failed to ensure consistent and timely infection control interventions were in place to promptly identify and isolate residents with potential exposure to staff members who tested positive for COVID-19, failed to ensure a root cause analysis was determined related to the COVID-19 outbreak in the facility, failed to ensure all staff received education on infection control and PPE use, failed to create and maintain an effective infection control program and failed to consistently have a

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 3) qualified infection control preventionist. The facility census was 44 residents. From 07/21/20 through 08/01/20, there were 10 residents positive for COVID-19 (Residents #1, #3, #5, #6, #9, #10, #11, #12, #13 and #14) and two presumptive-positive residents (Resident #7 and Resident #21). In addition, three staff members tested positive for COVID-19. Through investigation including the use of a facility timeline as well as through interviews it was determined the facility failed to coordinate with the local health department in a timely manner to prevent and contain the spread of COVID-19 within the facility. The facility's previous Director of Nursing (DON)/Registered Nurse (RN) #109, who also served as the facility's infection control preventionist, was no longer employed by the facility as of 07/01/20. The current DON/RN #123 started her employment with the facility on 07/27/20. On 08/05/20 at 1:37 P.M. the Administrator and the current DON/RN #123 were notified by phone that Immediate Jeopardy began on 07/21/20 when Resident #1 was sent to the hospital and tested positive for COVID-19. No resident testing was completed as a result of the positive COVID-19 case and no quarantine or COVID unit was available for use at the facility prior to 07/21/20. The facility failed to have a policy regarding Coronavirus (COVID-19) until 08/04/20, failed to have any evidence of an infection control log or COVID-19 timeline list until 08/04/20 and failed to appropriately cohort residents by infection status. No contact tracing for residents or staff had been completed with any COVID-positive residents. On 08/04/20, 08/06/20, 08/07/20 and 08/10/20 onsite observations and interviews revealed ongoing infection control concerns including but not limited to the following: the 1-North unit contained positive COVID-19 cases, presumptive cases and exposed residents, where the same staff would serve all residents on the unit. Observations and interviews revealed staff were provided with one N95 mask and one face shield or set of goggles for use during the entire shift. PPE was not readily available outside residents ' rooms. Housekeeping staff wore the same set of PPE as rooms with COVID-19 positive, presumptive positive and exposed residents were cleaned. Through observation and interview, staff were not knowledgeable about isolation precautions or PPE use. Through record review, all residents were not appropriately screened for symptoms of coronavirus. The Immediate Jeopardy was removed on 08/12/20 when the facility implemented the following corrective action: On 07/30/20 the Ohio National Guard tested staff for COVID-19. Those who were not tested were not allowed to work until they provided the facility with a negative test result. These individuals were pulled from the schedule and sent letters on 08/04/20. In an effort to identify anyone who might be infecting others, the facility will continue to test staff with a goal of twice per month. On 07/30/20 and 07/31/20 DON/RN #123 conducted a training for 30 staff on PPE use and location of supplies. On 08/05/20 and continuing through 08/09/20 DON/RN #123 provided morning and afternoon education sessions to 42 of 65 staff on hand hygiene, donning and doffing PPE and signs/symptoms of respiratory illness. These sessions will continue until 8/14/20 for staff who have not attended the training. Staff will not be able to work until training has been received. On 08/06/20, a COVID-19 policy and procedure notebook was developed by DON/RN #123. The books were introduced to all staff and are available for staff use at each of the nurses ' stations. On 08/06/20 at 4:00 P.M. a sealed plastic barrier wall with a zipper entrance was set up to separate the one known COVID-positive patient from other suspected COVID patients near the end of the hallway on the 1-North unit, creating a COVID-positive unit of four rooms. On 08/07/20 all 41 residents in-house were tested for COVID-19 On 08/07/20 DON/RN #123 developed a paper COVID-19 screening tool that will be used daily to evaluate each resident in the building and verbally shared the tool with staff. Feedback from the tool will be gathered from staff and presented at the September Quality Assurance (QA) meeting. On 08/08/20 at 3:00 P.M. resident COVID-19 test results were received and allowed the facility to accurately separate residents into three distinct units (positive on the 1-North unit; suspect on the 2-South unit; negative on the 2-North unit). On 08/08/20 starting at 4:00 P.M. 15 residents were moved according to the COVID-19 test results. On 08/08/20 at 7:00 P.M. the plastic barrier was moved on the 1-North unit to accommodate a full COVID-positive unit due to facility need. Signage posted by DON/RN #123 on the entrance of the 1-North unit indicated that N95 masks and face shields were required. On 08/08/20 at 8:00 P.M. PPE was stocked at the entrance and inside of the 1-North/COVID-positive unit, with appropriate signage placed to indicate droplet and contact precautions. On 8/08/2020 at 8:00 P.M. the Administrator installed hooks in each resident bathroom on the COVID-positive unit for staff to hang their isolation gowns when they leave a resident ' s room. On 08/09/20 the local City Health Department was notified of the resident COVID testing results and helped to set up a Tele-ICAR meeting (an infection prevention and control assessment and response program that is conducted via phone or video conferencing). On 08/10/20 at 4:30 P.M. the Administrator had a conference call with the State Agency to discuss the Bridge Team as a staffing resource. On 08/11/20 at 10:00 A.M., the DON and the Administrator had a meeting with the Tele-ICAR team. On 08/11/20 the Administrator had a call with MetroHealth to obtain more PPE supplies and an order for [REDACTED]. On 08/11/20 from 11:09 A.M. to 11:25 A.M. and on 08/13/20 from 11:23 A.M. to 11:55 A.M. interviews with State tested Nursing Assistant (STNA) #107, Housekeeper #126, STNA #115, Licensed Practical Nurse (LPN) #104, Dietary Staff (DS) #103, LPN #127, Licensed Social Worker (LSW) #105 and Manager of Environmental Services (MES) #128 revealed staff were knowledgeable on PPE use, the COVID resource books and hand washing protocols. On 08/11/20 the facility reached out to a staffing agency to hire four nurses for an eight-week contract. After eight weeks, the facility will re-evaluate the need for supplemental staff. On 08/11/20 the facility interviewed three LPNs, which are moving through the hiring process. On 08/12/20 an electronic COVID-19 Screening was placed into Point Click Care, the facility's electronic medical record. This screening was to be completed three times a day for residents on the COVID-19 unit and once a day for all other residents. Although the Immediate Jeopardy was removed on 08/12/20, the facility remained out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility was still in the process of implementing their corrective actions and monitoring to ensure on-going compliance. Findings include: 1. Review of the Department of Health and Human Services, Centers for Medicare & Medicaid (CMS) Memo QSO 20-20-ALL dated 03/20/20 revealed The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). As part of CMS guidance the Focused Infection Control Survey was made available to every provider in the country to make them aware of Infection Control priorities during this time of crisis, and providers and suppliers may perform a voluntary self-assessment of their ability to meet these priorities. The QSO Memo included additional instructions to Nursing Homes. We are disseminating the Infection Control survey developed by CMS and CDC so facilities can educate themselves on the latest practices and expectations. We expect facilities to use this new process, in conjunction with the latest guidance from CDC, to perform a voluntary self-assessment of their ability to prevent the transmission of COVID-19. This document may be requested by surveyors, if an onsite investigation takes place. We also encourage nursing homes to voluntarily share the results of this assessment with their state or local health department Healthcare-Associated Infections (HAI) Program. Furthermore, we remind facilities that they are required to have a system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility, and when and whom possible incidents of communicable disease or infections should be reported (42 CFR 483.80(a)(2)(i) and (ii)). On 08/07/20 at 2:08 P.M. interview with the DON/RN #123 and the Administrator confirmed the CMS voluntary self-assessment had not been completed. 2. Review of the Centers for Disease Control and Prevention (CDC) website updated 07/22/20 revealed Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated 07/15/20. To limit health care personnel (HCP) exposure and conserve PPE, facilities could consider designating entire units within the facility, with dedicated HCP, to care for patients with suspected or confirmed [DIAGNOSES REDACTED]-CoV-2 infection. Dedicated means that HCP are assigned to care only for these patients during their shift. Limit transport and movement of the patient outside of the room to medically essential purposes. Assign dedicated HCP to work only on the COVID-19 care unit. At a minimum this should include the primary nursing assistants (NAs) and nurses assigned to care for these residents. HCP working on the COVID-19 care unit should ideally have a restroom, break room, and work area that are separate from HCP working in other areas of the facility. Information obtained as part of the COVID-19 Focused Infection Control Survey between 08/03/20 and 08/13/20 from the Administrator and DON/RN #123 revealed the first resident (Resident #1) tested positive on 07/21/20 while at the hospital. The following concerns were identified as part of the survey: a. Review of Resident #1's closed medical record revealed an admission date of [DATE] and [DIAGNOSES REDACTED]. Review of admission physician's orders [REDACTED]. Review of census data indicated Resident #1 resided on the 1-North unit as a new admission and discharged to the hospital on [DATE]. A nurses' note dated 07/21/20 at 8:22 A.M. revealed the physician was notified Resident #1 had a temperature of 100.1 degrees Fahrenheit (F). New orders were received to send the resident to the emergency room . A follow up nurses' note dated 07/21/20 at 6:53 P.M. revealed Resident #1 had an admitting [DIAGNOSES REDACTED]. Review of the corresponding timeline, no date, listed 12 staff that had come into contact with Resident #1. On 07/22/20, the facility reported the case to the CDC and spoke with the staff that had been in contact with

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	366106	A. BUILDING _____ B. WING _____	08/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FAIRFAX HEALTH CARE CENTER	9014 CEDAR AVE CLEVELAND, OH 44106

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 4) the resident. On 07/23/20 the facility reached out to the (City) Department of Public Health (CDOPH) and Public Health Outbreak Practice Coordinator (PHOPC) #111. On 07/24/20, State tested Nursing Assistant (STNA) #117 called off of work with symptoms and was told to not report to work until she was tested . STNA #117 was one of the staff listed that had cared for Resident #1. On 08/05/20 at 9:00 A.M. phone interview with the Administrator revealed no COVID or isolation area had been in place at the facility prior to 07/21/20 so he made the 1-North unit the isolation hall. The Administrator stated prior to the isolation unit, new residents were isolated in a private room but not on a designated unit in the facility. The Administrator verified no in-house resident COVID-19 testing had been done at the time of the interview. In a follow-up interview on 08/10/20 at 10:55 A.M. the Administrator revealed no contact tracing had been done with residents or staff when positive COVID-19 cases occurred and there had been no root cause analysis of cases within the facility. The Administrator stated it could have been Resident #1 that brought COVID into the facility as a new admission or Resident #14, who was a [MEDICAL TREATMENT] patient, but he didn't know. b. Review of electronic mail (e-mail) communication between the Administrator and the CDOPH dated 07/26/20 at 8:53 P.M. revealed the facility requested PHOPC #111 come to the facility to review how the positive COVID-19 case was being handled. On 08/06/20 at 5:24 P.M. phone interview with PHOPC #111 revealed during July 2020 the facility had their first COVID-19 case, then had three or four cases over a span of a few days so she was asked to visit the facility. PHOPC #111 shared the facility was trying to come up with an isolation area and a quarantine area and spoke of sectioning off an empty wing for sick residents. PHOPC #111 stated at the time of her visit on 07/29/20, the facility had not decided what to do regarding those residents coming back from the hospital especially if they were COVID-positive. PHOPC #111 stated she educated DON/RN #123, the Administrator and Licensed Social Worker (LSW) #105 on quarantine, isolation and PPE and discussed getting more resources. PHOPC #111 recommended cohorting residents including exposed residents in one area and positive/symptomatic residents in another area with dedicated staff for each of the negative, quarantine and isolation areas. PHOPC #111 stated for residents returning from the hospital, a 14-day quarantine was recommended and full PPE including a N95 respirator mask, gown, gloves and eye protection was needed for both positive residents and new admissions. PHOPC #111 explained each nursing home in Ohio was assigned to an organization within their zone and region and stated the facility was assigned to (named hospital) as well as a laboratory provider; if a facility had a shortage of COVID testing or PPE supplies, they were directed to contact the hospital organization. PHOPC #111 verified the facility had not reached out to her regarding any testing or PPE needs as of 08/06/20. On 08/06/20 at 9:32 A.M. interview with the Administrator verified the facility did not follow the recommendations PHOPC #111 provided to the facility regarding three separate areas with dedicated staff as they were ideal recommendations. c. Continued review of the undated facility timeline indicated on 07/31/20 the facility contacted Metro Health Nurse (MHN) #122 to request immediate testing of all residents; MHN #122 could not authorize this but would speak to a supervisor. On 08/08/20 at 12:51 P.M. interview with the Chief Quality Officer for the designated hospital (CQO) #118 confirmed the facility had made contact regarding COVID testing on 07/31/20. CQO #118 verified COVID testing for in-house residents was not completed until 08/07/20. CQO #118 stated a webinar had been provided to all facilities assigned to their hospital that discussed how to contact the hospital if needs arose. CQO #118 verified the facility had not requested PPE or reached out for testing supplies prior to 07/31/20. On 08/10/20 at 11:25 A.M. e-mail from CQO #118 and General Counsel (GL) #125 indicated as of 08/10/20 the facility did not have a contract in place for routine testing of residents and staff. 3. On 08/04/20 from 10:02 A.M. to 12:12 P.M. onsite observations and interviews conducted at the facility revealed the following concerns: a. Review of the previous DON,RN #109's personnel file revealed a start date of 02/05/20 for the DON position. A personnel change form dated 07/01/20 revealed RN #109 resigned and did not give proper notice of resignation. RN #109's license was valid and current. No infection control preventionist training was available for review. Review of DON/RN #123's personnel file revealed a hire date of 07/27/20. DON/RN #123's license was valid and current. Infection preventionist training was completed and available for review. Interview with DON/RN #123 on 08/04/20 at 10:35 A.M. revealed she was newly employed with the facility. When asked for a COVID timeline list or infection control log, DON/RN #123 revealed no infection control log, surveillance or infection control policies were available from the previous DON. Phone interview with the Administrator on 08/05/20 at 9:00 A.M. revealed the facility's previous DON, RN #109 filled the infection preventionist (IP) role but did not have the formal training. The Administrator stated RN #109 was the IP for three or four months but could not provide dates. The Administrator verified between RN #109 and DON/RN #123 there was a span of time where the facility did not have a DON or an IP. b. Interview with DON/RN #123 on 08/04/20 at 10:35 A.M. revealed the facility was running low on gowns, so they were to be hung up in the resident's bathroom. For isolation residents, staff were to use a gown, surgical mask and gloves. As Resident #6 readmitted to the facility on [DATE], staff were required to use a N95, face shield, gown and gloves when providing care to this resident as Resident #6 was on contact/droplet isolation. Interview with Licensed Practical Nurse (LPN) #104 on 08/04/20 at 10:53 A.M. revealed both exposed residents and positive residents were to be on Contact Airborne Droplet isolation precautions and this required a N95 respirator, gown, face shield and gloves. However, to enter the isolation unit on the 1-North hall only a N95 respirator was required. Interview with State tested Nursing Assistant (STNA) #107 on 08/04/20 at 11:22 A.M. revealed they had not received infection control training since March 2020 and no training on PPE at all from the facility. Review of education dated 07/21/20 to 07/25/20 revealed 46 out of 58 staff completed training on handwashing and PPE use. c. Review of an infection control map for July 2020, provided on-site, identified eight residents with respiratory infection. No log was available for review with this infection control map to indicate which residents had been affected, what symptoms they had or what course of action was taken. Observation of the 1-North isolation unit with the DON/RN #123 on 08/04/20 at 11:41 A.M. revealed Resident #6's door had signage indicating isolation status. PPE carts were sporadically placed throughout the hall. All doors on the unit did not have isolation signage and it was not clear what residents were under isolation and what PPE was required to enter these rooms. Review of a resident census list dated 08/04/20 requested by the surveyor while on-site to determine spread of infection throughout the facility and provided by DON/RN #123 revealed the facility had identified one positive resident (Resident #6), two presumptive positive residents P (Resident #7 and #21) and eight residents who tested positive for COVID at the hospital (Residents #1, #3, #5, #9, #10, #11, #13, #14) as well as one resident on contact droplet airborne precautions (Resident #8). The census document itself indicated five residents on isolation (Residents #2, #6, #8, #21 and #25). Phone interview with the Administrator and DON/RN #123 on 08/04/20 at 4:21 P.M. revealed there was no facility policy regarding COVID-19 and no COVID timeline list available for review at the time of interview. The Administrator and DON/RN #123 stated all residents on the first floor had been exposed. Both the Administrator and the DON/RN #23 verified all residents on the 1-North unit were to be considered presumptive positive. Review of the facility's Coronavirus policy, dated 08/04/20 and received by e-mail on 08/04/20 at 6:57 P.M. revealed guidance for positive and presumptive positive residents. For positive residents, an isolation period would commence, [MEDICATION NAME] 10-14 days (to be determined by DON). Positive or presumptive positive residents would have two signs on the door a) keep door closed and b) Contact/Droplet precautions. All staff must wear N95 masks, gown and gloves while giving patient care. A face shield must be worn if possible splash should occur. Gowns and gloves must be taken off and appropriate hand hygiene performed before leaving room. Dedicated equipment would be utilized in caring for positive and presumptive positive residents and cleaned with [MEDICATION NAME] alcohol or bleach wipes between use. Disposable dining products would be utilized in positive and presumptive positive rooms. The policy did not address exposed residents, new residents or readmissions or where these different groups of residents would reside within the facility. Review of an infection control log for July 2020, provided to the surveyor via e-mail on 08/04/20 at 6:57 P.M. revealed 10 residents with COVID-19 and three staff. There was one positive case on 07/21/20 (Resident #1), two positive cases on 07/24/20 (Resident #9 and Resident #14), one positive case on 07/25/20 (Resident #5), two positive cases on 07/26/20 (Resident #10 and Resident #12) and four positive cases on 07/31/20 (Residents #3, #6, #11, and #13). Residents identified as presumptive positive on the census document (Resident #7 and Resident #21) were not on the infection control log. Record review completed on 08/04/20 revealed 11 residents on the 1-North unit (Residents #2, #4, #14, #15, #16, #17, #18, #19, #20, #22 and #23) did not have orders for isolation precautions and a presumptive positive resident (Resident #7) did not have orders for isolation precautions. Phone interview with the Administrator on 08/05/20 at 9:00 A.M. confirmed the 1-North isolation unit had not been in place prior to 07/21/20. New admissions were being isolated in a private room but did not go to a designated unit, 2-South, until 07/24/20. The Administrator verified the city health department had been contacted and had suggested keeping separate units of non-exposed residents, suspected residents and positive residents but due to not enough COVID tests, the facility held off on creating these units. The Administrator verified the facility had placed a COVID-positive resident amongst presumptive positive and exposed residents on the 1-North hall. Review of the CDC's

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 5) Responding to Coronavirus (COVID-19) in Nursing Homes (https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html) revised 04/30/20 revealed residents with suspected or confirmed COVID-19 were to be cared for using all recommended COVID-19 PPE (N95 or higher-level respirator, eye protection, gloves, and gown). If a resident was confirmed to have COVID-19 regardless of symptoms they should be transferred to the designated COVID-19 care unit. Roommates of residents with COVID-19 should be considered exposed and potentially infected. Health care providers should use all recommended COVID-19 PPE for the care of all residents on affected unit including asymptomatic and symptomatic residents. Record review of the facility's positive and presumptive COVID cases revealed the following concerns: i. Review of Resident #9's closed medical record revealed an admission date of [DATE] and [DIAGNOSES REDACTED]. Review of physicians' orders revealed an order dated 04/14/20 for temperature and lung sounds each shift and as needed notify DON if temperature at 99 (degrees F) or higher every evening shift related to COVID-19. Review of the July 2020 Medication Administration Record [REDACTED]. A nurses' note dated 07/23/20 at 10:22 P.M. revealed the resident had a moist productive cough but was afebrile. A nurses' note dated 07/24/20 at 3:17 P.M. revealed Resident #9 was sent to the emergency room for increased shortness of breath, decreased pulse oximetry and hypertension. Interview with the DON on 08/10/20 at 12:34 P.M. verified nursing staff should have followed the order as written and notified the DON and/or the physician of Resident #9's elevated temperature as well as documented this in the medical record. ii. Review of Resident #21's medical record revealed an admission date of [DATE] and [DIAGNOSES REDACTED]. Review of physician's orders [REDACTED]. Review of the July 2020 and August 2020 MARs revealed no evidence the COVID test had been completed as ordered. Review of a nurses' note dated 07/27/20 revealed the resident was aware she was to be tested for COVID-19. Review of a nurse practitioner note dated 08/05/20 indicated Resident #21 was not positive for COVID-19 but was on precautions as her roommate had tested positive for COVID-19. Interview with the DON on 08/10/20 at 12:34 P.M. revealed the facility was sent several COVID-19 testing swabs but they had not been used. No resident COVID testing had been completed in-house prior to 08/07/20. The DON was made aware there was no evidence of Resident #21's COVID-19 swab in the electronic medical record and stated it may have not been done. iii. Review of Resident #11's medical record revealed an admission date of [DATE] and [DIAGNOSES REDACTED]. Review of physician's orders [REDACTED]. Review of the July 2020 and August 2020 MARs revealed no evidence the COVID test had been completed as ordered. Review of nurses' notes revealed on 07/30/20 at 1:01 P.M. the nurse practitioner was informed Resident #11 had a change condition with poor appetite, lethargy and was shaking; new orders included a COVID-19 swab and to start intravenous (IV) fluids along with urinalysis and lab work. A nurses' note dated 07/31/20 at 1:00 P.M. revealed Resident #11 discharged to the hospital and tested positive for COVID. Interview with the DON on 08/10/20 at 12:34 P.M. revealed the facility was sent several COVID-19 testing swabs but they had not been used. No resident COVID testing had been completed in-house prior to 08/07/20, including Resident #11. iv. Review of Resident #7's medical record revealed an admission date of [DATE] and [DIAGNOSES REDACTED]. Review of current physician's orders [REDACTED]. Review of a nurses' note dated 08/01/20 at 4:48 P.M. revealed Resident #7's white blood count (can detect hidden infections in the body) was 2.9 (low) and Resident #7 was suspected positive for COVID and in isolation. Review of the July 2020 infection tracking log revealed Resident #7 was not listed as suspected COVID-positive. The Administrator was made aware of these concerns during interview on 08/06/20 at 9:32 A.M. v. All 28 resident records reviewed (Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27 and #126) were noted to lack evidence of COVID-19 symptom monitoring. Review of physician orders [REDACTED]. No other assessments were available for review in the medical records. Interview with the Administrator on 08/06/20 at 9:32 A.M. revealed nursing staff completed pulse oximetry to monitor residents for COVID-19 but was unsure if any other assessment was completed. Review of CMS memorandum, QSO-20-30-NH dated 05/18/20 revealed 100% of residents were to be screened with temperature checks and questions about/observation for other signs and symptoms of COVID-19 at least daily. 4. Phone interview with the Administrator on 08/05/20 at 9:00 A.M. revealed the facility had not had a medical director since 01/01/20 and was using facility physicians for guidance relating to COVID-19. Review of the facility's roster of medical staff, undated, revealed no medical director was listed. A phone interview with Physician #110 on 08/10/20 at 12:08 P.M. confirmed he resigned as medical director in October 2019. Physician #110 stated he had suggested three or four weeks ago that the facility test all residents and staff for COVID-19. A phone interview with Physician #120 on 08/11/20 at 3:17 P.M. denied the facility had asked him for any guidance regarding COVID-19. An e-mail was sent to Physician #112 on 08/12/20 at 10:16 A.M. requesting an interview but no return contact was received. A phone interview with Physician #119 on 08/12/20 at 10:21 A.M. denied the facility had asked him for any guidance regarding COVID-19. 5. On 08/06/20 from 9:19 A.M. to 12:41 P.M. onsite observations and interviews conducted at the facility revealed the following concerns: a. Observation of the facility's PPE supplies with the Administrator on 08/06/20 starting at 10:26 A.M. revealed in the conference room there were five jugs plus partial containers of alcohol to make hand sanitizer; six containers plus partial containers of hand sanitizer; 1000 extra large gloves; 1400 small gloves; 240 N95 respirators plus partial packs; 1450 surgical masks; 18 face shields; a partially opened large box of goggles; 60 isolation gowns. Observation of the facility's PPE storage on the second floor with the Administrator on 08/06/20 at 10:36 A.M. revealed the doorknob had been taken off of the door to the storage room to deter staff from taking the PPE. In the room there were 1000 face shields plus open boxes; 675 isolation gowns and 2400 hand sanitizer wipes. Phone interview with the Administrator on 08/05/20 at 9:00 A.M. revealed he felt uncomfortable regarding the quantity of supplies on hand. The Administrator stated they were working with vendors and the county to get more suppl