STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175298	A. BUILDING _____ B. WING _____	05/01/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RIVERBEND POST ACUTE REHABILITATION	7850 FREEMAN AVENUE KANSAS CITY, KS 66112

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 protect all residents in the facility by not following acceptable infection control practice recommendations for COVID-19 from the Centers for Medicare and Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC). These failures had the likelihood to expose all residents in the facility to COVID-19 resulting in serious harm or death. The facility census was 87. I. The facility failed to conduct staff screenings for signs and symptoms of COVID-19, follow up on staff documented signs and symptoms of COVID-19 prior to staff providing care to residents, and allowed staff who had tested positive for COVID-19 to return to work and care for residents. As a result of the noncompliance, an Immediate Jeopardy (IJ) was identified on [DATE]. These facility failures to appropriately screen staff, restrict sick employees from providing care to the residents, and preventing staff from returning to work too soon after experiencing COVID-19 signs/symptoms and/or positive COVID-19 test results were found to have started on [DATE]. On [DATE] the IJ remained ongoing after surveyors determined continued noncompliance for the facility's failure to assess staff for signs and symptoms of COVID-19 and failure to follow up on staff documented signs and symptoms of COVID-19 prior to staff providing care to the residents on [DATE]. A determination was made that the facility's noncompliance placed all residents in immediate jeopardy. Findings include: Review of a facility provided document titled Riverbend Post Acute COVID-19 Timeline, completed and provided by the Director of Nursing (DON), showed the following: -[DATE], the facility initiated an employee log for tracking symptoms and monitoring the temperature of staff entering the facility. Any abnormal responses were to be reported to the Director of Nursing, Assistant Director of Nursing, Infection Control Nurse, House Supervisor or Weekend Supervisor. -[DATE]: Continuing to screen all employees as they come to work. During an interview on [DATE] at 10:00am, the Administrator stated that 25 employees had tested positive for COVID-19. The facility's employee screening logs were provided by the Administrator on [DATE]. On [DATE], review of the facility's employee COVID-19 screening logs from [DATE]-[DATE] showed the following: -[DATE]: Nurse Aide 8 (NA8), documented cough. -[DATE]: 10pm-6am shift, 10 employees had temperatures assessed and documented, but no screenings documented for any signs or symptoms of COVID-19. -,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], and [DATE]: NA6 documented cough. -[DATE] and [DATE]: NA2 documented cough. -[DATE]: No temperature assessed for dietary aide 1 (DA1). -[DATE]: No temperature assessed for NA3. -[DATE]: No temperature assessed for Speech Therapist 1 (SP1). -[DATE]: NA4 documented had had contact with someone with or under investigation for COVID-19. -[DATE]: NA5 No documentation of being screened. Name only. -[DATE]: No temperature assessed or documented for Licensed Practical Nurse 6 (LPN6). -[DATE]: Physical Therapy Assistant 4 (PTA4) documented cough. -[DATE]: No temperature assessed or documented for DA2. -,[DATE], ,[DATE], and [DATE]: Maintenance Supervisor documented cough. -[DATE] and [DATE]: LPN7 documented cough. -[DATE]: No temperature assessed or documented for Social Worker (SW). -[DATE]: Housekeeping 2 (HK2) documented cough. -,[DATE], ,[DATE], and [DATE]: DA3 documented cough. -[DATE]: DA4 documented cough. -,[DATE] and [DATE]: Maintenance Supervisor documented shortness of breath. The facility failed to follow up on employee reported signs/symptoms of COVID-19 and allowed staff to work and provide care for residents from [DATE]-[DATE]. Review of employee screening logs for [DATE] showed no documentation of any staff having their temperature assessed or being screened for signs/symptoms of COVID-19 on this date. Review of facility employee time clock records for [DATE] showed 46 employees (RNs, LPNs and NAs) worked on [DATE] and provided care to the residents. Review of employee screening sheets for Physical Therapy Aide (PTA1), showed she had documented had contact with someone with or under investigation for COVID-19 on [DATE], cough and had contact with someone with or under investigation for COVID-19 on [DATE] and cough on [DATE]. During an interview on [DATE], PTA1 stated she provided therapy services to residents who resided on the 3rd floor. She stated she was screened before providing care to the residents and reported having a cough on ,[DATE] and [DATE] and all of that week. She stated at first she thought it was just seasonal allergies [REDACTED]. She stated she became ill with a temperature of 101 degrees and loss of smell and taste on [DATE]. She stated she tested positive for COVID-19 on [DATE]. Review of PTA1's time clock records showed she worked and provided care to the residents on ,[DATE], ,[DATE], ,[DATE], ,[DATE] and [DATE]. The facility failed to follow up on reported signs and symptoms of COVID-19 on ,[DATE], ,[DATE] and [DATE] and allowed PTA1 to work and provide care to the residents. Review of the employee screening sheets for NA8 showed she documented cough on [DATE]. Review of NA8's time clock records showed she worked and provided care to residents on [DATE] on the 10pm. to 6am shift. She clocked in at 10:06pm on [DATE] and clocked out at 7:07am on [DATE]. Additionally, she worked on ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE] and [DATE]. NA8 was not on the list of staff who had positive or negative test results documented for COVID-19. Her COVID-19 status was an unknown to the facility. Review of the employee screening sheets for Registered Nurse (RN3), showed she documented cough on [DATE]. Review of RN3's time clock records showed she worked and provided care to residents on ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE] and [DATE]. Review of a list of employees who were tested for COVID-19, provided by the DON on [DATE], showed RN3 tested positive for COVID-19 on [DATE]. The facility failed to follow up on reported signs and symptoms of COVID-19 on [DATE] and allowed RN3 to work and provide care to the residents. Review of employee screening sheets for Occupational Therapy Assistant 2 (OTA2), showed she documented cough and had contact with someone with or being investigated for COVID-19 on [DATE]. Review of OTA2's time clock record for [DATE] showed she worked and provided care to residents from 8:19am until 4:32pm. During an interview on [DATE] at 9:55am, OTA2 stated she worked with residents who resided on the 3rd floor, which was the short term rehabilitation floor, and also with long term care residents who resided on the other floors of the facility. She stated she began having symptoms on [DATE] which included a bad headache, body aches and a fever. Review of a list of employees who had been tested for COVID-19, provided by the DON on [DATE], showed OTA2 tested positive for COVID-19 on [DATE]. The facility failed to follow up on reported signs and symptoms of COVID-19 on [DATE] and allowed OTA2 to work and provide care to the residents. Review of employee screening sheets for PTA2 showed she documented cough on ,[DATE], ,[DATE] and on [DATE]. Review of PTA2's time clock records showed she worked and provided care to residents on ,[DATE], ,[DATE], ,[DATE], ,[DATE] and [DATE]. Review of a list of employees who had been tested for COVID-19, provided by the DON on [DATE], showed PTA2 tested positive for COVID-19 on [DATE]. The facility failed to follow up on reported signs and symptoms of COVID-19 on ,[DATE], ,[DATE] and [DATE] and allowed PTA2 to work and provide care to the residents. Review of the employee screening sheets for the Assistant Business Office Manager (ABOM) showed she documented shortness of breath, cough and sore throat on [DATE]. Review of time clock records for the ABOM showed she worked on [DATE]. Review of a list of employees who had been tested for COVID-19, provided by the DON on [DATE], showed the ABOM tested positive for COVID-19 on [DATE]. During an interview on [DATE] at 11:50am, the ABOM stated her boss was sick about a week or two before she became sick. She stated the facility allowed her boss to come to work with a cough and a sore throat. She stated she went to work on [DATE] and left around noon because she didn't feel well. She stated she thought the policy was that if you didn't have a temperature or more than a few symptoms, you were supposed to report to work. The facility failed to follow up on reported signs and symptoms of COVID-19 on [DATE] and allowed ABOM to enter the facility and work. During an interview on [DATE] at 10:30am,

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 1) LPN3 stated she began to have symptoms of headache and feeling weak on [DATE]. She stated that she had missed the cut off time to call in sick to work so she took some Tylenol before going to work on [DATE]. She stated she didn't have a fever or symptoms when she completed the screening form, but she just did not feel well. She stated she went to the Human Resources (HR) office after clocking in and let them know she was not feeling well. She said HR found a replacement for her and she clocked out and went home. She stated she was tested on [DATE] and was notified on [DATE] she was positive for COVID-19. She stated she had no other symptoms and returned to work on [DATE]. Review of LPN3's time clock records for [DATE] showed she clocked in at 6:20am and clocked out at 7:04am. Review of a list of employees who had been tested for COVID-19, provided by the DON on [DATE], showed LPN3 had tested positive for COVID-19 on [DATE]. Review of LPN3's time clock records showed she worked and provided care to the residents on ,[DATE], ,[DATE] and ,[DATE] after testing positive for COVID-19 on [DATE]. Review of the Riverbend Post Acute COVID-19 Timeline, provided by the Director of Nursing (DON), showed NA7 had stated late in the morning that she was not feeling well. She was sent home when she told the nursing supervisor that she was unwell. During an interview on [DATE] at 1:04pm, NA7 stated on [DATE] she was at work and had to go outside multiple times due to it being hot in the facility and not being able to breathe. She stated she went to work at 2:30pm on [DATE] and stated she was not feeling well and noticed she had a metallic taste in her mouth after eating a sandwich on her way to work. She stated she was not able to finish her shift and left the facility around 8:00pm that evening. She stated she tested positive for COVID-19 on [DATE]. She stated prior to her becoming sick she had cared for residents who were sick with symptoms of COVID-19, but she had not been instructed to wear PPE when caring for them. She stated she was told by the DON that a mask was not needed when caring for these residents. Review of the employee screening sheets for signs and symptoms of COVID-19 showed no documentation of NA7 being screened on [DATE] for signs and symptoms of COVID-19 prior to allowing NA7 to work, providing care to the residents. Review of a list of employees who had been tested for COVID-19, provided by the DON, on [DATE], showed Certified Medication Assistant 1 (CMA1) tested positive for COVID-19 on [DATE]. Review of time clock records showed CMA1 worked on ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE] and [DATE]. Review of employee screening logs showed no documentation of CMA1 being screened for signs and symptoms of COVID-19 on [DATE]. Review of staff time clock records showed CMA2, CMA3, NA11 and NA12, worked on [DATE]. Review of staff screening log for [DATE] showed no screening for signs or symptoms of COVID-19 and no temperature assessed for CMA2, CMA3, NA11 and NA12. Review of the employee screening sheets dated [DATE] showed the following: -Office Services employee documented headache. -DA5 documented cough. -NA9, no temperature assessed. -LPN8 documented cough. -NA10, no temperature assessed. -CMA2, no documentation of a screening for signs or symptoms of COVID-19 for [DATE]. The facility failed to screen staff and follow up on staff documented signs and symptoms of COVID-19 prior to providing care to the residents. During interview on [DATE] at 3:30pm, the Administrator stated all staff were screened by a staff person upon entering the front of the building. If there were any concerns regarding the information obtained on the screening sheet, a nurse was notified to review the form. The night shift nurse would come in about 15 minutes early and conduct the employee screenings for the employees who were working the night shift. If there were any concerns regarding the screenings, a supervisor was notified. The facility failed to provide any documentation of follow up from staff reported signs and symptoms of COVID-19 prior to working and providing care to the residents. During an interview on [DATE] at 4:00pm, the DON stated they did not have any staff that worked while having symptoms of COVID-19. She stated that after a staff tested positive for COVID-19, they had to be 3 days without a fever and 7 days without any symptoms before returning to work. Review of CMS QSO Memo ,[DATE]-NH, dated [DATE], provided guidance to long term care facilities which included screening all staff at the beginning of their shift for fever and respiratory symptoms. Actively take their temperature and document absence of shortness of breath, new or change in cough and sore throat. If they are ill, have them self-isolate at home. Review of the CDC's Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings, dated [DATE], showed the following: -Screen all healthcare professionals (HCP) at the beginning of their shift for fever and symptoms consistent with COVID-19. -Actively take their temperature and document absence of symptoms consistent with COVID-19. If they are ill, have them keep their cloth face covering or facemask on and leave the workplace. -Fever is either measured temperature >100.0 degrees Fahrenheit or subjective fever. Respiratory symptoms consistent with COVID-19 are cough, shortness of breath, and sore throat. Review of a policy titled Riverbend Post Acute Rehabilitation Policy/Procedure for Staffing during Emergency, dated [DATE], documented the following: -If staff are ill, have a fever, cough or upper respiratory compromise, or have other symptoms consistent with a contagious process, they should not present to the facility for regular or emergency duty, unless it is in response to a pandemic outbreak involving the facility itself (such as COVID-19). In that case, if the facility has confirmed cases of COVID-19, staff who have confirmed or suspected COVID-19 or have mild to moderate symptoms, will report to duty to work with only COVID-19 positive residents who are segregated from other residents and staff. II. The facility failed to ensure COVID-19 positive residents remained in their rooms and failed to ensure staff and residents wore personal protective equipment (PPE) appropriately in an attempt to prevent the spread of COVID-19. As a result of the identified non-compliance, the facility was notified on [DATE] of Immediate Jeopardy related to the facility's failure to follow the guidance and recommendations from the CDC for COVID-19 by not restricting COVID-19 positive residents to their rooms, by not ensuring staff and residents wore the appropriate PPE to prevent the spread of COVID-19, and failed to have an area designated to care for residents with suspected or confirmed COVID-19. The IJ cited on [DATE] was removed on [DATE] after surveyors verified implementation of an acceptable removal plan. Findings include: During an interview on [DATE] at 9:15am, the Administrator reported the facility was deemed a COVID-19 Positive Facility meaning (most all residents had tested positive for COVID-19 after respiratory tract specimens were taken and the qualitative detection procedures were performed). The facility Administrator indicated he suspected the COVID-19 death number was higher than 32 since many residents died with symptoms for COVID-19, but were not confirmed as COVID-19 positive prior to their death, but more residents had died with COVID-19 symptoms that had not been tested . During an interview on [DATE] at 10:12am, the Director of Nursing (DON) and the Infection Control Nurse (ICN) both reported in an effort to conserve personal protective equipment (PPE) and to decrease resident cohorting, residents were no longer required to wear masks or stay in their rooms regardless of if a resident tested positive or negative or showed signs or symptoms of COVID-19. The facility had consulted with the local health department and made a decision on [DATE] to discontinue those efforts to decrease the spread of [MEDICAL CONDITION] because all residents in the facility were now considered positive for COVID-19. The DON further indicated the facility was aware of the CDC and CMS regulatory guidance related to infection control and COVID-19. The CDC Coronavirus Disease 2019 (COVID-19) guidance, located at www.cdc.gov, entitled Preparing for COVID-19: Long-term Care Facilities, Nursing Homes provided guidance that indicated all recommended PPE should be worn during care of residents under observation; this includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gowns. The CDC provided further guidance located at www.cdcgov/coronavirus/2019 and contained an update dated [DATE] entitled,Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings and provided the following guidance: Cancel communal dining and all group activities, such as internal and external activities. Remind residents to practice social distancing and perform frequent hand hygiene. Have residents wear a cloth face covering or facemask whenever they leave their room, including for procedures outside of the facility. During a tour of the facility on [DATE], the following observations were made at the following times: - 9:30am, therapy staff wore masks but did not wear eye protection, gowns or gloves while providing therapy to four residents (R2, R3, R4 and R5 all tested positive for COVID-19 during the month of April, 2020) in the therapy room. -12:12pm, Registered Nurse 1 (RN1) stood within two to three feet from R6 who tested positive for COVID-19 on [DATE], who was coughing in the common area and not wearing a mask. RN1 was not wearing appropriate PPE such as gloves or goggles/face shield. RN1 stated, I don't know if he is positive for COVID, but he is sick with respiratory symptoms, has decreased oxygen saturation, fever and is lethargic. RN1 said she chose not to wear goggles or a face shield because they fog up but she did not state a reason for not wearing gloves. -12:20pm, observation of the first floor dining room revealed R8, R1, R9, R10, R11, R12, R13 and R14 sat eating together and not [MEDICATION NAME] social distancing, some were fed by staff. Occupational Therapy Aide 1 (OTA1) and Licensed Practical Nurse 4 (LPN4) sat approximately two feet away from R1 and R14 while they assisted them to eat. OTA1 and LPN4 were not wearing appropriate PPE such as goggles or a face shield. RN2 sat at the nursing station near and in view of the dining room and reported she was the Charge Nurse who cared for eight of the residents who were eating in the dining room. She was not sure which residents in the dining room were positive for COVID-19, but she was able to look up the information in the computer. She further reported all eight of her residents had tested positive for COVID-19 and one resident assigned to her tested negative. She also stated the resident who tested negative did not have any symptoms of

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 2) COVID-19, mostly stayed in his room, but was able to come out and eat in the dining room if he chose to do so. Staff did not treat the resident who tested negative for [MEDICAL CONDITION] differently from the residents who tested positive and did not attempt to separate the residents from each other. -12:50pm, observation of the second floor dining room revealed six residents ate in the dining room, three of those residents sat close together at a dining room table. NA1 assisted residents to eat in the dining room and did not wear gloves or any type of PPE for her eyes. NA1 was within two feet of the residents that she assisted. LPN7 sat at the nursing station near and in view of the dining room and was not wearing PPE for her eyes. LPN7 stated she provided supervision for NA1 and the residents who were in the dining room, but did not instruct NA1 to wear gloves or PPE for her eyes. LPN7 said the goggles hurt her eyes and so she preferred not to wear them. LPN7 reported all of the residents on the second floor were positive for COVID-19 except two residents who tested negative and did not have any symptoms of [MEDICAL CONDITION]. She explained all of the residents are considered as positive for COVID-19, even those residents who tested negative so staff did not have to change PPE when caring for residents, only glove changes and hand washing were done. Negative and positive COVID-19 residents were all able to use the common areas of the second floor. -1:05pm, observation on the second floor revealed Housekeeper 1 (HK1) cleaned a room wearing gloves and a mask, wiped down the bathroom, cleaned the floors and took out the trash. When she exited the room she removed her gloves and put on new gloves without sanitizing her hands. HK1 said she did not know which resident rooms were COVID-19 positive residents. She said she cleaned all of the rooms the same way and it did not matter what residents were positive or negative for [MEDICAL CONDITION]. She chose to only wear gloves and not the rest of the PPE the facility had provided to her because it made her hot and sweat. HK2 worked with HK1 on cleaning the rooms. He said this was the second day he worked at the facility and he was being trained by HK1 since he was new to the job. He was told to wear goggles when he worked, but the facility did not provide him with any PPE except gloves. -1:32pm, observation on the first floor revealed OTA1 walked next to R12, identified by RN2 as a positive COVID-19 resident. The resident pulled herself holding onto the hand rail with her right hand while propelling in the wheelchair. R12 was not wearing a mask or gloves and OTA1 was not wearing full PPE, only a mask and gown. RN1 was in this same area and was wearing a gown and mask, but did not wear gloves or eye protection. She stood in the hall holding onto the hand rail with her right hand. She said possibly two residents who lived on the first floor were negative for COVID-19, but she was not sure. She stated the facility directed staff to treat all residents as if they were positive for COVID-19 and to wear the same PPE when going from caring for one resident to the next. During a tour of the facility on [DATE], the following interviews were obtained at the following times: -12:35pm, RN1 reported residents who tested negative and did not have symptoms of COVID-19 should be on reverse isolation and staff needed to change out the N95 mask for a surgical mask when they entered those resident rooms. - 1:03pm, RN2 reported she did not wear goggles or a face shield, but did wear the same gown and mask for the entire shift and did not change PPE after caring for the COVID-19 positive residents and prior to caring for the COVID-19 negative and asymptomatic residents. -1:10pm, LPN2 stated she took care of R15 on the second floor who had tested COVID-19 negative and who did not have any symptoms of the disease. That resident was a Loner, preferred to stay in her room, but was not in isolation or kept away from the other residents. She said the resident came out of her room and down the hall for showers and staff should give her a mask to wear when she is in the hall. I wash my hands prior to going into her room, but I wear the same PPE when I go in there, I don't change PPE. LPN2 further stated she wore the same PPE with both positive and negative COVID-19 residents and did not change between going from a positive tested resident to care for a negative tested and symptom free resident. LPN2 indicated she wore the same mask for five days and wore the same gown for one day before she discarded the worn mask and gown and donned clean PPE. -1:30pm, LPN3 reported she provided cares to R16, R17, R18 and R19 who tested negative for COVID-19. She said she wore the same PPE in all resident rooms irrespective of their positive or negative COVID-19 tested status. She said one of the four residents, R16, did have symptoms of [MEDICAL CONDITION] and had fevers, but tested negative. That resident was a roommate to a resident who tested negative, R17 and did not have symptoms of [MEDICAL CONDITION]. She said staff treat both residents in the room the same as far as using the vitals tower (mobile medical equipment used to assess vital signs that is placed in contact with a resident's body), pulse oximeter and thermometer, which was cleaned between resident uses. (Review of the clinical records and the Differential Testing for Isolation Residents report showed the report indicated R16 and R17 shared a room together and were not isolated in their own spaces. R16 tested negative for COVID-19 on [DATE]. R17 tested positive for COVID-19 on [DATE]. R16 was retested for COVID-19 on [DATE] and the result was positive.) LPN3 further stated she wore the same PPE when caring for both residents in the shared room space. LPN3 wore her goggles up on her forehead instead over her eyes and her mask covered her chin and not her mouth or nose. She said the facility had instructed her to wear the mask at all times, but it was easier to talk when the mask was not covering her mouth. Observation on [DATE] at 1:29pm, showed PTA3 walking down the hallway on the second floor of the facility with R2. PTA3 was holding hands with R2, and neither were wearing gloves. During an interview on [DATE] at 2:00pm, PTA3 stated it was not a facility policy but rather his own policy not to wear gloves while in the hallways of the facility. Review of R2's electronic medical record (EMR) showed she tested positive for COVID-19 on [DATE]. During an interview on [DATE] at 9:27am, PTA3 stated he began experiencing symptoms of chills and then a fever of 102 degrees and tested positive for COVID-19 on [DATE]. - 4:30pm, the Administrator and Director of Nursing reported 21 residents who reside in the facility had tested negative for COVID-19 on [DATE], but since a large number of residents had tested positive, staff were directed to consider all residents as positive for [MEDICAL CONDITION] and there was no longer any need to keep the residents separated. The facility reported they had plenty of PPE available currently for all staff and training was conducted with all staff on the use of PPE. Staff were instructed to wear the same gown between caring for all residents along with eye protection and masks. Staff cleaned the eye protection at the end of the shift and used it again. During an interview on [DATE] at 4:45pm, the Administrator indicated the facility recently tested for COVID-19 and out of those 21 residents who had previously tested negative on [DATE], nine residents remained negative for COVID-19 and remain symptom free. The CDC guidance, dated [DATE], entitled Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings indicated the following: HCP (Healthcare Professionals) (see Section 5 for measures for non-HCP visitors) who enter the room of a patient with known or suspected COVID-19 should adhere to Standard Precautions and use a respirator (or facemask if a respirator is not available), gown, gloves, and eye protection. The CDC Coronavirus/2019 guidance entitled Preparing for COVID-19:Long-term Care Facilities, Nursing Homes directs the following guidance: Dedicate space in the facility to care for residents with confirmed COVID-19. This could be a dedicated floor, unit, or wing in the facility or a group of rooms at the end of the unit that will be used to cohort residents with COVID-19. Assign dedicated HCP to work only in this area of the facility. Have a plan for how residents in the facility who develop COVID-19 will be handled (e.g., transfer to single room, prioritize for testing, transfer to COVID-19 unit if positive). Closely monitor roommates and other residents who may have been exposed to an individual with COVID-19 and, if possible, avoid placing unexposed residents into a shared space with them.