STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255338	A. BUILDING _____ B. WING _____	08/20/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAMAR HEALTHCARE & REHABILITATION CENTER	6428 US HIGHWAY 11 LUMBERTON, MS 39455

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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, staff interview, and facility policy review, the facility failed to follow the COVID-19 Infection Control Guidelines to prevent the spread of the [MEDICAL CONDITION] which likely led to the death of three (3) residents who had not been outside the facility, Residents #25, #26 and #27 and prevent the possible spread of the COVID-19 virus between positive and negative COVID-19 residents. This concern was identified for Residents #1, #2, #12, #13, #14, #15, #18, #19, #20 and #23, as evidenced by the facility's failure to change gloves and wash hands or use hand sanitizer between resident rooms, failure to change Person Protective Equipment (PPE) between positive and negative Covid-19 residents, and wear full PPE in positive Covid-19 residents rooms. The facility staff also failed to clean an oxygen concentrator before transferring the machine from a contaminated room to a non-contaminated room, and then placed the oxygen mask on the resident's face. The concerns was identified for 13 of 68 residents in the facility. On [DATE], the State Agency (SA) surveyor made observations of the facility's staff members failure to perform hand hygiene, change PPE when entering and exiting positive COVID-19 residents and then entering and exiting negative resident rooms with the same PPE on. The facility staff also failed to clean an oxygen (O2) concentrator that was in a positive COVID-19 resident's room prior to transferring the machine to a negative COVID-19 resident room, and then placed the oxygen mask on the resident's face. Record review revealed the facility had a total of three (3) COVID-19 related deaths. Two of the deaths occurred in the hospital and one in the facility. The Immediate Jeopardy (IJ) was determined to exist on [DATE], at the time of Resident #27's death, who was one of the three COVID-19 deaths in the facility and one of those three residents who had not left the building except for their transfer to the hospital related to COVID-19. The facility's failure to follow appropriate COVID-19 infection control guidelines for not wearing PPE, sanitizing hands, changing PPE between positive and negative residents and cleaning an oxygen concentrator when transferring from a contaminated room to non-contaminated room has caused, or likely to cause serious injury, harm, impairment or death to residents who tested positive for the COVID-19 virus while residing solely in the facility. The affected three (3) of 60 Covid-19 positive Residents who had not been out of the facility. Resident # 25, #26 and #27 expired due to, or as consequence of COVID-19, as indicated on the certificate of death or physician documentation. Findings include: Review of the facility's policy titled, Isolation Policy, with a revision date of [DATE] revealed: Transmission precautions are initiated when a resident develops signs and symptoms of a transmissible infection; arrives for admission with symptoms of an infection; or has a laboratory confirmed infection; and is at risk of transmitting the infection the infection to other residents. Masks, gloves, gowns and goggles will be worn when entering a Residents room. Review of the facility's policy titled, For Suspected or Confirmed Coronavirus (COVID-19), revised ,[DATE], revealed; the facility leadership and clinical staff are implementing all reasonable measures to protect the health and safety of residents and staff during the current outbreak of coronavirus disease (COVID-19). The response to the current outbreak of coronavirus disease is based on the most current recommendations from health policy officials, state agencies and the federal government. Infection prevention and control measures are based on established guidelines governing all communicable diseases. Residents with suspected or confirmed COVID-19 infection are placed in a separate room or cohorted with other residents with the same infection status. Residents who cannot be treated adequately or safely separated from other residents will be transferred. Standard precautions are utilized when caring for all residents. Contact and droplet precautions are implemented for any residents with symptoms of respiratory infection. Current CDC guidelines will be followed for infection prevention and control of residents diagnosed with [REDACTED]. and the Occupational Safety and Health Administration (OSHA) bloodborne pathogens standard. Durable Medical Equipment (DME) such as oxygen concentrators must be cleaned and disinfected before removing from a contaminated area and moved to a non-contaminated area for reuse by another or same resident. During the facility's initial observation tour, on [DATE] at 10:10 AM, observations revealed the facility did not have a designated COVID-19 unit. The facility had COVID-19 positive Residents located on each of the halls in the building, hall 100, 200, 300 and 400. The facility had precaution signs on the doors and PPE carts placed outside all of the positive COVID-19 residents rooms. The positive COVID-19 residents also had two barrels in their room for linen and trash. The facility held a license for 120 beds. Review of the Resident Census and Condition report, dated [DATE] revealed a census of 68. Review of the facility's census printed, on [DATE] at 10:05 AM, revealed there was four (4) positive COVID-19 residents and 14 negative COVID-19 residents on the 400 hall; one (1) positive COVID-19 and 12 negative COVID-19 residents on the 300 hall; one (1) positive COVID-19 and 19 negative COVID-19 residents on the 200 hall and 11 positive COVID-19 and five (5) negative COVID-19 residents on the 100 hall. During an interview, on [DATE] at 10:00 AM, the Administrator (ADM) and Director of Nursing (DON) revealed the DON confirmed the facility had positive COVID-19 residents all over the building. The DON said the facility tried to make the 300 hall a designated COVID-19 hall, but the facility had several hospital returns in which they had to place them on 14-day quarantine. The facility was unable to keep the wing closed for positive COVID-19 residents because there were more positive residents than negative. The DON said the facility decided to put positive residents in the room together and negative residents together. The Administrator and DON reported the facility had a total of 60 Residents and 15 staff members to test positive with COVID-19. The DON said as of [DATE], there was 18 residents that are currently COVID-19 positive. An observation, on [DATE] at 10:30 AM, revealed Certified Nursing Assistant (CNA) #2 transferred Resident #1's oxygen (O2) concentrator from room [ROOM NUMBER], a room with a positive COVID-19 Resident (#2) across the hall to room [ROOM NUMBER], where a negative COVID-19 resident resided and then placed the oxygen mask on the Resident #1's face. CNA #2 did not clean the O2 concentrator prior to moving it out into the hall and transport it from room [ROOM NUMBER] to room [ROOM NUMBER]. CNA #2 did not cover the O2 concentrator either prior to transferring it from room [ROOM NUMBER] to room [ROOM NUMBER]. During an interview, on [DATE] at 2:40 PM, CNA #2 confirmed she failed to clean the oxygen concentrator. CNA #2 confirmed she transferred Resident #1's contaminated oxygen concentrator from room [ROOM NUMBER] down the hallway to room [ROOM NUMBER] without cleaning it. CNA #2 said she was told at the last minute to transfer Resident #1 from room [ROOM NUMBER] to room [ROOM NUMBER]. CNA #2 said she was not thinking when she removed the oxygen concentrator. CNA #2 confirmed she was trained to clean the concentrator before removing it from one room to another. CNA #2 said she had been in-serviced on COVID-19 and infection control several times. Record review of the facility's Face Sheet for Resident #1, revealed, Resident #1 was admitted by the facility, on [DATE], with [DIAGNOSES REDACTED]. Resident #1 resided in Room ,[DATE]. Resident #1 tested for COVID-19 on [DATE] and the results on [DATE] was negative. Record review of the facility's Face Sheet for Resident #2, revealed, Resident #2 was admitted by the facility on [DATE], with the included [DIAGNOSES REDACTED]. Resident #2 resided in room ,[DATE]. Resident #2 was tested for COVID-19 on [DATE] and the results on [DATE] was positive. Review of the facility's census list, dated [DATE] at 10:05 AM, revealed the resident in Room ,[DATE] was identified by the Director of Nurses (DON) as a negative COVID-19 resident. The DON identified the positive COVID-19 residents with a yellow highlight marker. Review of the facility's Training Sign In Sheets revealed CNA #2 attended in-service training that addressed COVID-19 and infection control [DATE], [DATE] and [DATE]. During an interview, on [DATE]

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) at 10:40 AM, the Medical Director (MD) confirmed the facility had an outbreak of COVID-19 positive residents in [DATE]. The MD said he thinks the outbreak started with a [MEDICAL TREATMENT] resident on the 300 hall that was a dementia resident. The MD said the [MEDICAL TREATMENT] resident was on the same hall as Resident #27. The MD said both residents were confused and refused to wear a mask appropriately. Resident #27 was non-compliant and traveled all over the facility with his mask off and under his chin. The MD also said he recommended the facility designate the 300 hall as the COVID-19 hall and to only use recovered staff on that hall. An observation, on [DATE] at 12:00 PM, revealed CNA #1 was sitting on Resident #4's bed feeding her lunch with full PPE on. After feeding Resident #4 her lunch, CNA #1 proceeded to remove the Styrofoam lunch trays from the 400 hall. Rooms 401 to 414 by placing them in a large black garbage bag sitting in a wheelchair. CNA #1 failed to change her PPE when she entered and exited a positive COVID-19 resident's room. CNA #1 left the 400 hall and placed the garbage bag in the biohazard room. CNA #1 failed to change her PPE gown or gloves or perform hand hygienge at any time during this observation. A review of the facility's census list printed on [DATE] at 10:05 AM, revealed the Director of Nurses (DON) identified four (4) COVID-19 positive residents resided on the 400 hall by highlighting the names with a yellow marker. The positive residents on the 400 Hall resided in rooms (407) Resident #12, (,[DATE]) Resident #14, (,[DATE]) Resident #15 and (412) Resident #19. Further review of the facility's census printed, on [DATE] at 10:05 AM, revealed there was 14 negative COVID-19 residents on the 400 hall. The observation of CNA #1 revealed she entered the COVID-19 negative rooms as follows: Resident #13 (room [ROOM NUMBER]), Resident #18 (room [ROOM NUMBER]) and Resident #20 (room [ROOM NUMBER]), on [DATE] at 12:00 PM to remove the Styrofoam lunch trays from the residents' rooms. During an interview, on [DATE] at 2:00 PM, CNA #1 confirmed she failed to change her gown and gloves when entering positive COVID-19 residents' rooms. CNA #1 said she did not think about it to change her PPE after entering the positive residents' rooms because she was only picking up lunch trays. CNA #1 said she was in-serviced to change PPE when providing care to COVID-19 positive Residents. CNA #1 confirmed by going into positive resident rooms to remove their lunch trays could possibly cause negative residents to become positive. Review of the facility's Training Sign In Sheets revealed CNA #1 attended in-service training that addressed COVID-19 and infection control on [DATE], [DATE] and [DATE]. Review of the facility's Face Sheet for Resident #12 revealed Resident #12 was admitted by the facility on [DATE], with the included [DIAGNOSES REDACTED]. Review of Resident #12's lab reports revealed the resident was tested for COVID-19 on [DATE] and the results returned on [DATE] to be positive. Review of the facility's Face Sheet for Resident #14 revealed Resident #14 was admitted by the facility on [DATE], with the included [DIAGNOSES REDACTED]. Resident #14 was tested for COVID-19 ON [DATE] and the results returned positive on [DATE]. Review of the facility's Face Sheet for Resident #15 revealed Resident #15 was admitted by the facility on [DATE], with the included [DIAGNOSES REDACTED]. Resident #15 was tested for COVID-19 on [DATE] and the results were reported to be positive on [DATE]. Record review of the facility's Face Sheet for Resident #19 revealed the facility admitted Resident #19, on [DATE], with the included [DIAGNOSES REDACTED]. Resident #19 was tested for COVID-19 on [DATE] and the results was reported on [DATE] to be positive. During an interview, [DATE] at 2:50 PM, the DON confirmed as of [DATE], the facility has 18 positive covid-19 residents in the building. The DON said the facility did not have any positive residents until the facility was tested , on [DATE], when the facility was tested by the outbreak team. The DON said 30 out of 70 residents tested positive. The DON said most of the residents that was positive was on the 200 Hall. There were no positive residents on the 100 Hall. The DON also said he believed the residents on the 100 Hall became positive due to an asymptomatic employee. The DON confirmed the facility has had a total of 60 positive residents and 15 positive staff. The DON said there was two (2) staff still on quarantine due testing positive at this time. The DON also confirmed that one (1) resident died in the facility and two (2) residents died at the hospital related to COVID-19. The DON confirmed CNA #1 failed to follow the facility policy by not changing PPE and sanitizing her hands after each positive resident. The DON said all the staff has been in-serviced on donning and doffing PPE. The DON said he would provide more education to CNA #1. The DON also confirmed CNA #2 should have cleaned the oxygen concentrator and placed a bag over it prior to moving it to another room. The DON said he was going to re-in-service the staff. Record review, of the Face Sheet for Resident #25, revealed Resident #25 was admitted by the facility on [DATE] and readmitted on [DATE], with the included [DIAGNOSES REDACTED]. Resident #25 resided on the 100 Hall. Resident #25 tested positive for COVID-19 on [DATE]. Resident #25 expired at the facility on [DATE]. Review of Resident #25's Death Certificate revealed the resident expired, on [DATE] at 1:55 PM, due to [MEDICAL CONDITION] due to COVID-19. Record review, of the Face Sheet for Resident #26, revealed Resident #26 was admitted by the facility, on [DATE], with the included [DIAGNOSES REDACTED]. Resident #26 resided on the 200 Hall. Resident #26 tested positive for COVID-19 on [DATE] at the facility. Resident #26 was sent to the emergency room (ER), on [DATE]. The Departmental Notes dated [DATE] at 3:42 PM, revealed Resident #26 was exhibiting hypoxemia and lethargy. The resident would not keep his oxygen (O2) on even with the nurse continuing to apply the O2, Resident #26's oxygen saturation (O2 sat) was low as 70 to 78 percent (%) with O2 at five liters per minute (5L/M). An order was received from the physician to send Resident #26 to the emergency room (ER). Emergency Response Services (EMS) arrived at 3:10 PM and the resident was transferred out to the hospital at 3:20 PM per the EMS. Previous Departmental Notes documented by Social Services (SS) at 2:33 PM and 2:34 PM, revealed the SS staff was performing a Minimal Data Set (MDS) evaluation for the resident's mood and memory. Resident #26 expired, on [DATE], at the hospital. Review of the hospital's Discharge Summary, for Resident #26, with a date of service [DATE], and signed by the physician on [DATE], revealed Resident #26 was admitted on [DATE] and discharged on [DATE] due to the resident expired on [DATE] at 11:36 PM. The discharge [DIAGNOSES REDACTED]. Record review, of the Face Sheet, for Resident #27, revealed Resident #27 was admitted by the facility, on [DATE], with the included [DIAGNOSES REDACTED]. Resident #27 resided on the 300 Hall. Resident #27 tested positive for COVID-19 on [DATE]. Resident #27 was sent to the emergency room (ER) on [DATE]. Review of the Departmental Notes with a late entry at [DATE] at 1:18 AM, revealed on [DATE] at 10:45 PM, Resident #27 was noted to be coughing with congestion and wheezing. Vital Signs (V/S) was blood pressure (B/P) ,[DATE], Pulse (P)-100, O2 sat 90%, Respirations (R)-18 and a temp of 101.3 degrees Fahrenheit (F). The physician was notified and a new order to transfer the resident to the ER was received. Resident #27 was transferred to the ER per (Name of Transport) at 11:00 PM. The Resident #27 was noted to be coughing with congestion and wheezing, oxygen saturation (O2 sat) 90%, temperature 101.3 degrees Fahrenheit. Review of the hospital's Discharge Summary, for Resident #27, revealed the resident was admitted , on [DATE], with the [DIAGNOSES REDACTED]. The Discharge Summary stated Resident #27 expired, on [DATE] at 8:45 PM, and the Primary [DIAGNOSES REDACTED]. The summary was signed by the physician on [DATE] at 8:54 PM. On [DATE] at 10:48 AM, an observation revealed the Registered Occupational Therapist (ROT) and Physical Therapist Assistant (PTA) entered Resident #23's room wearing masks/shields and gloves, but no gowns on. Further observation revealed the ROT and PTA assisted Resident #23 to drink water from a cup and then the ROT and PTA both left the room. On [DATE] at 10:52 AM, an interview with the ROT and PTA as they were exiting Resident #23's room revealed they did not have PPE gowns on during their visit to Resident #23 because they were only helping the resident do drink some water. Review of Resident #23's lab reports revealed she tested positive for COVID-19 on [DATE]. On [DATE] at 11:36 AM, an interview with the Medical Doctor (MD) revealed if a resident in the facility is COVID-19 positive then that resident would be required to be on contact/droplet precautions and whoever enters the room should wear full PPE with gowns, if they are 6 (six) feet or closer proximity to the resident. On [DATE] at 1:45 PM, an interview with the ROT revealed she did not have to wear a PPE gown while she was in Resident #23's room because she was not providing care for Resident #23, she was only giving her water to drink. She stated since she was not providing direct resident care, she only had to wear gloves and mask/shield that she did not have to wear a gown. This surveyor asked if she was 6 (six) feet in proximity to Resident #23, and she replied yes, she was within 6 (six) feet of Resident #23. On [DATE] at 1:55 PM, an interview with the PTA revealed she did not have to wear a PPE gown when entering Resident #23's room because she was not providing care, only giving her water to drink. This surveyor asked if she was closer than 6 (six) feet to Resident #23, and she replied she was at Resident #23's bedside. The PTA stated since she was not providing Resident #23 direct patient care, she did not have to don a gown before entering Resident #23's room. The facility submitted an acceptable Immediate Jeopardy (IJ) Removal Plan, on [DATE]. Review of the Removal Plan revealed the facility took the following actions to remove the Immediate Jeopardy. 1. On [DATE] at 11:55 AM, the state agency notified the facility of an Immediate Jeopardy due to facility failure to follow Centers for Disease Control (CDC) and Centers for Medicare & Medicaid Services (CMS) guidelines for infection control practices during the COVID-19 pandemic. The facility failed to follow infection control guidelines to prevent the spread of COVID-19. Certified Nursing Assistant (C.N.A.) #1 failed to change her Personal Protective Equipment (PPE) gown while entering COVID positive and negative resident rooms from rooms 401 to 414 with four (4) positive COVID-19 residents. Certified Nursing Assistant (C.N.A.) #2 failed to clean oxygen concentrator between contaminated resident's room [ROOM NUMBER] to a non-contaminated room [ROOM NUMBER] across the hallway. On [DATE],

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 2) the Occupational Therapist (OTR) and the Physical Therapy Assistant (PTA) entered a positive resident's room [ROOM NUMBER] without Personal Protective Equipment (PPE). As of [DATE], the facility had a total of 60 residents who had tested positive for COVID-19. The facility has 120 licensed beds with a census of 68. As of [DATE], the facility had a total of 18 out of 68 residents who had tested positive for COVID- 19 with 2 COVID deaths in the facility. 2. The facility held a Quality Assurance and Assessment Committee meeting at 12:45 PM, on [DATE], with the Medical Director, Infection Preventionist, Administrator, Director of Nursing, Director of Rehab, Social Services Director, Director of Housekeeping & Laundry, Dietary Service Manager, Business Office Manager, and Minimum Data Set Coordinator to discuss the findings of: 1. Failure to change Personal Protective Equipment (PPE), specifically gowns, from a positive COVID resident room to a negative COVID resident room and 2. Failure to clean equipment transferred from a positive COVID resident room to a negative COVID resident room. Additionally discussed was in-service training for all staff related to CDC Guidelines for COVID-19 regarding use of Personal Protective Equipment (PPE) and in-service training for all staff related to disinfecting equipment from contaminated area to uncontaminated area. Policy revisions for Personal Protective Equipment- Using Gowns and Cleaning and Disinfection of Resident-Care Items and Equipment were discussed and revisions approved: o Droplet precautions were changed to include gloves, gowns, and goggles in addition to masks when entering from gloves, gown, and goggles if there is a risk of spraying secretions. o Durable Medical Equipment (DME) was changed to durable medical equipment (DME) such as oxygen concentrators must be cleaned and disinfected before removing from a contaminated area and moved to a non-contaminated area for reuse by another resident or same resident from Durable medical equipment (DME) must be cleaned and disinfected before reuse by another resident. 3. As of [DATE], all 60 Covid-19 positive residents care plans were updated by Registered Nurse(RN) #1 and Licensed Practical Nurse(LPN) #2 on [DATE]. Daily temperature checks and oxygen levels are being done on 8 negative residents. Care plans for risk of exposure to COVID- 19 by negative residents have been addressed by the Director of Nursing (DON). 4. On [DATE], the facility Director of Nursing (DON) initiated in-service training on revised policy and procedures on CDC Guidelines for COVID-19 use of Personal Protective Equipment (PPE) of when to use, when to remove, and when to dispose properly. The following staff received this in-service: 1 of 5 RN 9 of 16 LPN 12 of 26 CNA 5 of 8 Dietary 1 of 2 Laundries 4 of 4 Housekeeping 5 of 5 Therapies 1 of 1 Business Office Manager 1 of 1 Admissions liaison 1 of 1 Receptionist 1 of 1 Marketing 1 of 2 Activities 1 of 1 Administrator 1 of 1 Social Worker No staff will be allowed to work until participation of in-service CDC Guidelines for COVID-19 use of Personal Protective Equipment of when to use, when to remove, and when to dispose properly. 5. On [DATE], the facility Director of Nursing(DON) initiated in-service training on updated policy and procedures based on CDC Guidelines for COVID-19 on when to disinfect equipment from a contaminated area to an uncontaminated area. The following staff received this in-service: 1 of 5 RN 9 of 16 LPN 12 of 26 CNA 5 of 8 Dietary 1 of 2 Laundries 4 of 4 Housekeeping 5 of 5 Therapies 1 of 1 Business Office Manager 1 of 1 Admissions Liaison 1 of 1 Receptionist 1 of 1 Marketing 1 of 2 Activities 1 of 1 Administrator 1 of 1 Social Worker No staff will be allowed to work until participation of in-service CDC Guidelines for COVID-19 on when to disinfect equipment from a contaminated area to an uncontaminated area. 6. On [DATE], the facility Administrator was in-serviced by the Director of Nursing (DON) on CDC Guidelines for COVID-19 use of Personal Protective Equipment {PPE) of when to use, when to remove, and when to dispose properly and CDC guidelines for COVID-19 on when to disinfect equipment from a contaminated area to an uncontaminated area. The Director of Nursing (DON) was in-serviced by the Administrator on CDC Guidelines for COVID-19 use of Personal Protective Equipment (PPE) of when to use, when to remove, and when to dispose properly and CDC Guidelines for COVID-19 on when to disinfect equipment from a contaminated area to an uncontaminated area. The Infection Preventionist, MD, in-serviced the Administrator and the Director of Nursing (DON) on [DATE] at 5:45 PM. on CDC Guidelines for COVID-19 use of Personal Protective Equipment (PPE) of when to use, when to remove, and when to dispose properly and CDC Guidelines for COVID-19 on when to disinfect equipment from a contaminated area to an uncontaminated area. 7. The facility Director of Nursing (DON) will monitor daily adherence to infection prevention practices and infection control requirements through daily monitoring of staff for hand hygiene, environmental cleaning and disinfection, injection and medication safety, use of appropriate personal protective equipment (e.g. gloves, gowns, and facemasks), respiratory hygiene and cough etiquette, and reprocessing of re-usable medical equipment between each patient. The Director of Nursing (DON) and Administrator will continue to track and report new cases of COVID-19. The facility Director of Nursing(DON) and Administrator will communicate status of COVID-19 positive cases and COVID-19 negative cases to staff daily in order to mitigate infection risk and stop transmission of infections. 8. The facility alleges that the Immediate Jeopardy was removed on [DATE]. The State Agency (SA) validated the facility's Immediate Jeopardy Removal Plan through observation, interview, record review and review of sign-in-sheets. 1. The SA validated through observations that no further issues were observed regarding staff not changing PPE when exiting COVID-19 positive residents rooms on the 400 Hall. 2. The SA validated through interviews and review of the facility's in-service sign-in sheets that in-service education was provided by the facility to all of the staff in the form of lectures and films. 3. The SA validated through interviews and review of monitoring tools the facility utilized to perform visual inspections of nursing staff for proper hand hygiene and PPE use, and cleaning Durable Medical Equipment. 4. The SA validated through record review that all residents in the facility was assessed for signs and symptoms of COVID-19. 5. The SA validated a Quality Assessment and Assurance Committee meeting was held on Tuesday, [DATE] by interview of persons who attended and review of sign in sheets. 6. The SA validated facility wide testing for staff and residents was done on [DATE], [DATE], [DATE]. 7. The SA validated that all of the facility's IJ Removal Plan's corrective actions were completed and the IJ was removed as of [DATE] and validated by the SA's exit on [DATE].