STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035296	A. BUILDING _____ B. WING _____	06/03/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ASPIRE TRANSITIONAL CARE	1521 NORTH PINE CLIFF DRIVE FLAGSTAFF, AZ 86001

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** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, facility documentation, review of the Centers for Disease Control (CDC) recommendations and the Arizona Department of Health Services (ADHS) guidelines and policies and procedures, the facility failed to ensure that infection control standards were followed, by failing to ensure that one Certified Nursing Assistant (CNA) did not work while exhibiting signs and symptoms of possible COVID-19, by failing to thoroughly screen staff and visitors, by failing to ensure full use of Personal Protective Equipment (PPE) was used on the COVID suspected/unknown status/new admissions unit, including two resident rooms that were on isolation droplet precautions, and by failing to ensure that staff were social distancing at the nurse's station. The deficient practices could result in the spread of COVID-19 to residents and staff. Findings include: -Regarding the staff member who exhibited symptoms of COVID-19: The survey team entered the facility on June 3, 2020 at 8:05 a.m. In an interview, the Infection Control Preventionist (ICP/Registered Nurse/staff #40) stated there were no residents with suspected or confirmed COVID-19 infection. However, she stated that there was one staff member, a CNA (staff #34) who was tested on [DATE] and they were notified that the CNA had tested positive on June 2. The ICP stated the CNA was not feeling well on Saturday May 30, 2020, and worked on Sunday May 31. She stated that all residents and staff who had worked closely with the CNA were to be tested today. An interview was conducted with a CNA (staff #22) on June 3, 2020 at 9:33 a.m. She stated that she enters the facility through the designated side entrance and she takes her temperature, puts on her mask, answers the yes and no questions on the form about signs and symptoms of COVID and travel, and then signs the form. She stated that you should not come into the building if you have any signs or symptoms of illness. She said if your temperature is above 99 degrees, you should notify your charge nurse. She stated the charge nurse would talk to the Director of Nursing (DON/staff #66) and the staff would be tested if they had signs or symptoms. She stated that she had been educated on the signs and symptoms of COVID-19. An interview was conducted with a Licensed Practical Nurse (LPN/staff #10) on June 3, 2020 at 10:10 a.m. She stated that staff enter the building from the side door and masks are to be in place at entry. She said that she takes her temperature and if it is over 99.8, the DON or ICP would be notified and would give directions on how to proceed. She said that she would also sign the form if she had no signs or symptoms. She said that she had received a sheet that listed the signs and symptoms to be watching for. She stated that if she had signs or symptoms or an elevated temperature at home, she should stay home and call the DON. An interview was conducted with the ICP (staff #40) on June 3, 2020 at 11:51 a.m. She stated they are following the CDC guidelines for staff and residents that exhibit signs and symptoms of COVID-19. She stated that if staff become ill during their shift, they should let the DON know, and if a staff member had an elevated temperature or signs and symptoms of COVID-19, the staff member would be sent home with a packet of instructions. The ICP said if a staff member is symptomatic and was not tested , they would not return to work for 10 days since the onset of symptoms and be free of symptoms for at least three days without medication. The ICP further stated that the CNA (#34) was ill on May 30, 2020 but went home early, and then got tested for COVID-19. She said that staff #34 should have notified the DON that she was ill on Saturday, May 30. She stated that staff #34 had worked a full shift on May 31, as she had no elevated temperature or signs and symptoms that day. She stated that staff #34 did not check in with her or the DON on May 31, before coming to work. She said staff #34 called on June 2, 2020, and notified the facility that her test from May 30 was positive for the COVID-19 virus. She said that staff #34 put all staff and residents in the building at risk for COVID-19, as she did not follow the facility's policy for staff illness, since she returned to work the day after she was exhibiting signs and symptoms. An interview was conducted with the CNA (staff #34) on June 3, 2020 at 1:01 p.m. She stated that she woke up on May 30, 2020 at 4:00 a.m., and was not feeling well and had muscle aches. She stated that she took [MEDICATION NAME] before reporting to work. She said when she came in to work she also had a sore throat. She said the laser gun thermometer showed a temperature of 99.3. She stated that she marked that she did not have any symptoms, because when she had a sore throat in March, she was told that she should not mark it as they were only to mark COVID symptoms. At this time, the questionnaire for staff/visitors regarding signs and symptoms of COVID-19 was reviewed with staff #34. The questions included if a sore throat was present. Staff #34 responded by saying We do not read those. Staff #34 said that she knew to report a fever or shortness of breath, but thought she just had a cold. She stated that she knew the temperature reading was wrong, because the laser gun thermometers had a history of [REDACTED]. She said the readings were 100.8 and 100.3, so she went to the nurses that were working (one of which was staff #60) and reported it to them. She stated they told her that she should go home if she did not feel well and should not be in the facility, and was told to call the DON. She stated that she called the DON at approximately 5:35 a.m. on May 30, and reported the elevated temperatures and was told to take Tylenol, wait an hour to see if the fever broke, check her temperature every 1-2 hours, and to stay at work and keep the DON updated. She stated that she texted the ICP at 5:41 a.m. on May 30, and told her that she did not feel well, had a fever and a sore throat and that the DON was not sending her home. She stated that the ICP told her to wait the hour as directed by the DON. She stated that after her fever and sore throat were identified on May 30, she did vital signs on nine or more patients, updated the boards in the patient rooms, and passed water to patients. The CNA said at approximately 6:45 a.m., she called the DON and told her that her temperature was still 100.3 and the fever had not broken, and the DON told her to go home. She said that she got tested for COVID-19 on Saturday, May 30, 2020. She stated the DON and ICP knew that she was scheduled to work on May 31, 2020, but they were super short staffed and you can only stay home for an elevated temperature, difficulty breathing or obvious COVID-19 symptoms. She stated that she came in on May 31, 2020, because she had no fever and did not know that a sore throat was a symptom of COVID-19. She stated that she worked with nurses, CNA's, and 8-9 residents that day. The CNA said that she saw the ICP during her shift, and the ICP asked her how she was feeling. She said that she told the ICP that she was feeling better than yesterday, but had a sore throat. She stated that she was not instructed to go home. She stated that she was still scheduled to work on June 1, 2020, but called off for a family emergency. She said when she got the positive test results on June 2, 2020, she called the facility to notify them. Another interview was conducted with the ICP on June 3, 2020 at 1:38 p.m. She stated that she provided education to the staff in the beginning of the pandemic on the signs and symptoms of COVID-19 which included cough, shortness of breath, fever and sore throat. She stated that staff were directed to report any signs or symptoms to the DON, and the DON would follow up. She stated that on May 30, 2020, the CNA (staff #34) texted her at 5:37 a.m. and told her that she (staff #34) had come to work with an elevated temperature of 99.7 and 100 degrees, and that she had called the DON. She said staff #34 reported that the DON told her to take [MEDICATION NAME] and re-take her temperature in an hour. The ICP said that she texted staff #34 at 5:40 a.m. and asked her what her symptoms were and the CNA texted back and said a sore throat, shivers and an elevated temperature. She stated that she did not discuss when the CNA was scheduled next to work and that she did not give the CNA direction on what to do next. She stated that she saw staff #34 working on May 31, 2020 and asked how she was feeling, and that the staff #34 stated that she was fine and her temperature was normal. She acknowledged that staff #34 returning to work on May 31, after exhibiting signs and symptoms of illness and being sent home ill from work on May 30,

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** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) 2020, did not coincide with the recommendations the facility was following, and that by having staff #34 work while ill placed residents and staff at risk for the spread of COVID-19 infection. An interview was conducted with a LPN (staff #60) on June 3, 2020 at 2:16 p.m. She stated that on May 30, 2020, the CNA (staff #34) told her that she was really tired and had an elevated temperature when she got to work, around 100.7 degrees. She stated the CNA told her that she called the DON and was told to relax for about an hour and then re-take her temperature. She said the CNA, after reporting that she had a fever did vital signs on her residents. She stated the CNA should not have worked on May 30, as she knew she was ill and that she increased the risk of transmitting the infection to residents and staff. She said that about an hour later she saw the CNA at the station and the CNA told her that she had re-checked her temperature and it was still elevated, so the DON was sending her home. She stated that she was shocked to see the CNA back at work on May 31. She stated that staff had received education on the signs and symptoms of COVID-19, which included sore throat, fever, body aches, diarrhea, vomiting, cough and stuffiness. She said if staff have any signs or symptoms, they have been told to call off from work. She said it was her understanding that if any staff had a fever, they were to immediately contact the DON or ICP and follow their instructions. An interview was conducted with the DON on June 3, 2020 at 2:30 p.m. She stated that on the morning of May 30, 2020, the CNA (staff #34) called her and told her that she had taken her temperature three times and that it was elevated. She stated that she told the CNA to go home, to call her before she came back to work, and to keep a temperature log. She said the CNA did not call her before coming to work on May 31, 2020, nor did she tell her that she had been tested for COVID-19 on May 30, 2020. An interview was conducted with the Administrator (staff #26) on June 3, 2020 at 2:39 p.m. He stated that when staff marks yes/no on the staff screening form they are supposed to have reviewed the accompanying sheet, which listed the signs and symptoms of COVID-19. Another interview was conducted with the DON on June 3, 2020 at 2:51 p.m. She stated that staff #34 called her early in the morning on May 30, and told her that she had taken her temperature 2-3 times and was running 99 to 100 degrees. She said staff #34 did not report any further symptoms other than being tired. She said the CNA asked if she could take [MEDICATION NAME] and she told her she could take Tylenol, after she re-took her temperature. She said that she did not tell her to wait an hour before re-taking her temperature. She said that she called the ICP to let her know of the situation so that she could handle it, as the concern was related to infection control. She said the CNA called her back at 6:50 a.m. and told her that the ICP had told her to go home, at which time the DON also told the CNA not to come in on May 31, 2020. She stated that she would have expected the ICP to question the CNA further on May 31, when the ICP saw that the CNA had returned to work after being ill and sent home the day before. The DON further stated that the ICP had since reported to her that she knew that the CNA had been tested for COVID-19 on May 30, and that the CNA had reported on May 31, to the ICP that she had another elevated temperature during her shift, but still worked the full day. The DON said that she did not know what the CNA's temperature had been on May 31. She stated that if the CNA woke up sick on May 30, she was expected to call off work and if she did not, the CNA did not follow policy and that she put staff and residents who she had contact with at risk for the transmission of infection. She stated that when the CNA reported to the nurses that she had an elevated temperature, she would have expected the nurses to remove the CNA from the floor, call the ICP, and if unable to reach the ICP to call her. She stated that when the ill CNA cared for residents, she put them at risk of exposure to illness. She stated that if staff has an elevated temperature they follow the guidance for the staff member to stay out of work for three days, without an elevated temperature and without medication use, as it could reduce a temperature. She stated when the CNA returned to work on May 31, 2020, the CNA did not follow their policy and placed staff and residents at risk for infection transmission. A follow up interview was conducted with the ICP (staff #40) on June 3, 2020 at 3:27 p.m. She stated that the CNA (staff #34) came to her on May 31, 2020 and told her that she had an elevated temperature she thinks around late morning, and her temperature was 99 point something but not over 100 degrees. She said the CNA denied having any other symptoms and that the CNA said she had been running around on the unit. She stated that she told the CNA to keep an eye on it and did not tell the CNA to leave work, and she did not notify anyone else. She stated that since our last interview she had looked again at her phone and saw that the CNA had called her at 5:41 a.m. on May 30, 2020 and told her that she had talked to the DON about her elevated temperature and what the DON had said, and that she told the CNA to go home and take the prepared packet home. She stated that staff should know the signs and symptoms of COVID-19, because she covered it at the time of the creation of the COVID-19 unit. A later interview with the ICP was conducted on June 3, 2020 at 4:08 p.m. She stated that all education documentation had been provided. However, she was unable to locate any documentation of the staff education regarding signs and symptoms of COVID-19, and what staff are to do if they become ill. Per the DON on June 3, 2020 at 4:13 p.m., there were no further policies or procedures addressing the signs and symptoms of COVID-19, and what staff are to do if they become ill beyond what had been provided. The DON referred to the flu pandemic plan. An interview was conducted with the Administrator (staff #26) on June 3, 2020 at 4:27 p.m. He stated that they are following CDC guidelines for their pandemic plan. Review of the daily staff screening forms which were in a binder included the following: Employees are expected to be screened daily prior to reporting to your work unit and read, sign, attest and have temperature taken and recorded. At any time during the day, if you become ill, you will need to report to the Infection Control Nurse or designated charge nurse in your building for evaluation and review. The daily staff screening forms also included to review and attest to the following: In the past 24 hours have you developed a fever, cough, sore throat, shortness of breath, loss of smell. Mark below as yes (you have) or No (you have not). Further review of the daily staff screening forms revealed that staff #34 signed in on May 30, 2020, with a temperature of 99.3 F and marked no to the above question regarding any symptoms. Staff #34 also signed in on the daily staff screening form on May 31, 2020, with a temperature of 98 and marked no to the questions regarding having any symptoms. The daily staff screening forms also included that further screening will be reviewed with you to evaluate risk of exposure if you have said yes to any of these symptoms or exposure risk. You will then be advised of needed precautions to follow based on individual needs and facility status. Temperature of over 100 will need further review. Review of the staff sign in sheets for May 30 and May 31, 2020 revealed that staff #34 was assigned to work the A and B Halls. Review of the time card report for May 30, 2020 for staff #34 revealed that she clocked in at 5:33 a.m. and clocked out at 7:04 a.m. Review of the time card report for May 31, 2020 for staff #34 revealed she clocked in at 5:37 a.m. and clocked out at 2:11 p.m. Further review of the binder revealed additional information for staff to review which included the following questions: 1) Do you have any signs or symptoms of a respiratory infection, such as a fever, cough, shortness of breath or sore throat? 2) In the last 14 days, have you had contact with a confirmed case of COVID-19 or under investigation for COVID-19, or have had a respiratory illness? 3) Have you had any international travel within the last 14 days to countries with sustained community COVID-19 transmission? 4) Do you reside in a community where community-based spread of COVID-19 is occurring? If yes to any of these questions, please contact DON or ICP with numbers provided. Administrative staff provided documentation which is posted in the employee break room titled, Steps we are taking to protect the resident and staff. The steps included implement active screening of residents and health care personnel for respiratory symptoms including actively checking temperatures for a fever, and document absence of symptoms. Those with symptoms of respiratory infection (fever, cough, shortness of breath or sore throat) should not be permitted to enter the facility at any time. The posting stated to enforce sick leave policies for ill health care personnel that are non-punitive, flexible, and consistent with public health policies, allowing ill health care personnel to stay home. The facility's Infection Prevention and Control Program (IPCP) policy included under Monitoring Employee Health and Safety that the facility has established policies and procedures regarding infection control among employees, contractors, vendors, visitors and volunteers, including situations when these individuals should report their infections or avoid the facility. Review of the ADHS guidance dated April 10, 2020, provided by the facility revealed that common symptoms of COVID-19 include: fever, cough, sore throat, shortness of breath, muscle aches and fatigue. The guidance included that those at high-risk for severe illness from COVID-19 were people who live in a long-term care facility (LTCF), people [AGE] years of age and older, and people of all ages who have underlying medical conditions. The information included COVID-19 spreads easily in the LTCF population and outcomes can be severe. Rates of pneumonia and death are increased in this population as compared to the general population. COVID-19 infected staff and visitors are the most likely sources of introduction into a facility. It is critical for your facility to take immediate action to reduce the risk of your residents and staff getting sick with the disease. Strict adherence to visitor restrictions and enforcement of sick leave policies for ill staff are recommended. The recommendations also included the following: Actively screen all staff for fever and respiratory symptoms before they start each shift; Perform a temperature check; ask staff to report and assess for symptoms (feeling feverish, new or changed cough, sore throat, difficulty breathing or shortness of breath); Instruct staff that if they become ill while working, they should immediately stop working, notify their supervisor and go home; and implement a tracking system for clearing staff to return to work

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) after illness. The guidance included to exclude staff from work if they are symptomatic with respiratory illness and if staff have not been tested and have compatible symptoms (fever, cough, and shortness of breath) they should stay home away from others until three days (72 hours) after all symptoms of acute infection resolve. Review of the Employee Infection and Vaccination Status policy revealed that employees must report a temperature greater than 100 degrees Fahrenheit and acute upper respiratory infection to the Infection Preventionist (IP) or designee. The policy included the Medical Director and IP will collaborate to determine the significance of any employee health condition in relation to job responsibility and the employees' restrictions regarding direct resident contact. A policy regarding Infected Healthcare Workers revealed the IP and/or designee will monitor and manage ill healthcare personnel and staff, who develop fever and respiratory symptoms and will be instructed not to report to work, or if at work to stop resident-care activities, don a facemask, promptly notify their supervisor and the IP and/or designee before leaving work and be excluded from work until at least 24 hours after they no longer have a fever (without the use of fever-reducing medicines). Review of the CDC guidance for Return to Work Criteria dated May 2, 2020 revealed that for Health Care Personnel (HCP) with confirmed COVID-19 or who have suspected COVID-19 (e.g. developed symptoms such as cough, sore throat, shortness of breath, fever) included a symptom-based strategy as follows: exclude from work until at least three days (72 hours) have passed since recovery, defined as resolution of fever without the use of fever-reducing medications and improvement in respiratory symptoms, and at least 10 days have passed since symptoms first appeared. The CDC guidance to Long Term Care facilities dated May 18, 2020 included that nursing home residents are at high risk for infection, serious illness and death from COVID-19. Under the heading Keeping COVID-19 out, it stated to actively screen all HCP for fever and COVID-19 symptoms at the start of their shift; test any who screen positive; and any HCP who have fever or symptoms should be excluded from work pending results of the test. Review of the CDC guidance to Long Term Care facilities dated May 19, 2020 revealed that given their congregate nature and resident population, nursing home populations are at high risk of being effected by respiratory pathogens like COVID-19. As demonstrated by the COVID-19 pandemic, a strong infection prevention and control (IPC) program is critical to protect both residents and HCP. The guidance stated to educate and train HCP to include: Reinforcing sick leave policies, and remind HCP not to report to work when ill. Under the heading for evaluate and manage health care personnel the guidance stated to implement sick leave policies that are non-punitive, flexible, and consistent with public health policies that support HCP to stay home when ill. As part of routine practice, ask HCP to regularly monitor themselves for fever and symptoms consistent with COVID-19; remind HCP to stay home when they are ill; If HCP develop a fever (over 100 degrees Fahrenheit) or symptoms consistent with COVID-19 while at work they should inform their supervisor and leave the workplace; Screen all HCP at the beginning of their shift for fever and symptoms of 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 by a temperature over 100 degrees Fahrenheit or subjective fever. -Regarding the screening of visitors: Upon entering the building on June 3, 2020 at 8:05 a.m., a staff member took the surveyors temperature. The staff member asked the surveyors if they had any symptoms, however, did not ask about any specific symptoms (i.e. cough, fever, sore throat, shortness of breath, loss of smell, respiratory illness). The staff member also did not screen the surveyors further to include if they had any contact with a confirmed case of COVID-19 or under investigation for COVID-19 in the last 14 days, or had any international travel in the last 14 days. An interview was conducted with the ICP (staff #40) on June 3, 2020 at 11:51 a.m. She stated that the screening process should include specific signs and symptoms of COVID-19, any travel, and exposure questions. She said that the screening of the surveyors did not follow facility expectations. -Regarding staff not using full PPE on the suspected/unknown COVID status/new admissions unit: An entrance conference was conducted with the ICP (staff #40) on June 3, 2020 at 8:30 a.m. She stated the residents on A-Hall had been in the facility for over 14 days and that the residents on the B-Hall were admitted from the hospital and would remain on that unit for at least 14 days for observation of COVID-19 symptoms, as their status was considered unknown/suspected. She also stated that all staff members are to wear N95 masks. Observations on the B-Hall (residents with unknown/suspected for COVID) were conducted on June 3, 2020 from 9:00 a.m. to 9:30 a.m. During this time, there were approximately 13 observations of staff either entering resident rooms without gowns or eye protection or were observed already in a resident's room, without a gown or eye protection in place. An interview was conducted with a CNA (staff #22) on June 3, 2020 at 9:33 a.m. She stated that all residents from the hospital come to B-Hall. She stated that they keep an eye on them for two weeks for any symptoms of COVID-19, like cough or temperature. She stated that for the rooms on B-Hall she wears a mask and gloves but no gown or eye protection, unless it was an isolation room. An interview was conducted with a LPN (staff #10) on June 3, 2020 at 10:10 a.m. She stated that B-Hall was the Landing Zone and all fresh admissions from the hospital were placed there. She stated the new residents stay on B-Hall for 14 days to isolate them from residents on A-Hall. She stated that most had tested negative at the hospital but they did not want COVID-19 transmission, so they watch them for signs and symptoms and a temperature. She stated that staff wear gloves and a mask for the non-isolation rooms and would not wear eye protection, unless a resident had an active cough. During an interview on June 3, 2020 at 4:27 p.m., the Administrator stated that they were not using eye protection or gowns on the new admissions unit, in an attempt to conserve their supply but not related to a shortage of PPE. He stated that they are following CDC guidelines for their pandemic plan. Review of the CDC guidance to Long Term Care facilities dated April 30, 2020 under the heading, Considerations for New Admissions or Readmissions to the facility revealed that for residents whose COVID-19 status was unknown, All recommended COVID-19 PPE should be worn during care of residents under observation, which 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 gown. Testing residents upon admission could identify those who are infected but otherwise without symptoms. However, a single negative test upon admission does not mean that the resident was not exposed or will not become infected in the future. Newly admitted or readmitted residents should still be monitored for evidence of COVID-19 for 14 days after admission and cared for using all recommended COVID-19 PPE. -Regarding the resident rooms that were on droplet precautions: During the entrance conference on June 3, 2020 at 8:30 a.m., the ICP stated that there were two rooms on B-Hall that were designated as droplet precautions due to resident's who had coughs. She stated that for the droplet isolation rooms, staff were required to wear a gown, gloves, N95 mask and a face shield or goggles. She said these rooms would also have a supply cart outside of the room for PPE. An observation of one of the rooms on droplet precautions on the B-Hall was conducted on June 3, 2020 starting at 9:00 a.m. On the supply PPE cart outside of the room, there was a sign which stated that droplet precautions were in use and included a list to use gloves, mask, goggles/face shield and gown. An observation was conducted on June 3, 2020 at 9:10 a.m., of the second isolation room on the B-Hall which was identified as being on droplet precautions. There was a sign on the door which stated Stop and identified that droplet precautions were in place. At this time, the resident was observed walking towards the door with a walker. A CNA (staff #22) entered the room wearing only a mask and gloves. Once inside, the CNA was speaking to the resident while donning a gown and eye protection. Another observation of this same room was conducted on June 3, 2020 at 9:18 a.m. A CNA (staff #22) entered the room wearing a mask, gloves and eye protection. Once inside of the room, she donned a gown, however, she did not secure the gown at the waist before rendering patient care. During this observation, the CNA also handed bagged used dining supplies to a LPN (staff #10) who was standing in the hall. The LPN did not have any gloves on. The LPN then placed the bagged items on a food cart outside of the room, with bare hands. An interview was conducted with staff #22 on June 3, 2020 at 9:33 a.m. She stated that the two rooms marked as droplet isolation would require a gown, mask, eye shield and gloves. An interview was conducted with a LPN (staff #10) on June 3, 2020 at 10:10 a.m. She stated that for droplet isolation rooms, she wears goggles, gloves, mask and a gown. An interview was conducted with the ICP on June 3, 2020 at 11:51 a.m. She stated there were two rooms on B-Hall which had been designated as on droplet precautions and require additional PPE of gowns and eye protection. She stated that staff should follow the CDC direction for donning and doffing gowns and that the gown should be tied at the back. An interview was conducted with the ICP and the Administrator (#26) on June 3, 2020 at 4:27 p.m. The ICP stated that the observation of a staff member taking an item from a droplet isolation room with bare hands could pose a risk for infection transmission. He stated that they are following the CDC guidelines for their pandemic plan. Review of the CDC guidance for donning a gown included to fully cover torso from neck to knees, arms to end of wrists, wrap around the back, and to fasten at the back of the neck and waist. Review of the CDC Coronavirus Disease 2019 recommendations on Responding to Coronavirus in Nursing Homes revealed the guidance is intended to assist nursing homes and public health authorities with response and cohorting decisions in nursing homes. The guidance stated that for residents with new-onset suspected or confirmed COVID-19, healthcare personnel should use all recommended COVID-19 PPE to care for residents who are symptomatic and asymptomatic. If

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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 -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 3) PPE supply is limited, implement strategies to optimize PPE supply. Review of the CDC Interim Additional Guidance for Infection Prevention and Control for Patients with Suspected or Confirmed COVID-19 in Nursing Homes dated May 18, 2020 revealed key concepts to reduce facility risk, which included to manage visitors and screen everyone entering the facility for COVID-19 symptoms, and implement source control for everyone entering the facility, regardless of symptoms. The current data suggested person-to-person transmission most commonly happens during close exposure to a person infected with [MEDICAL CONDITION] that causes COVID-19, primarily via respiratory droplets produced when the infected person speaks, coughs or sneezes and that droplets can land in the mouths, noses or eyes of people who are nearby or possibly be inhaled into the lungs of those within close proximity. Under the section, Adhere to Standard and Transmission-Based Precautions the guidance stated that Health Care Providers 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) a gown, gloves and eye protection. -Regarding social distan