STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495174	A. BUILDING _____ B. WING _____	C 08/04/2021

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DULLES HEALTH & REHAB CENTER	2978 CENTREVILLE ROAD HERNDON, VA 20171

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 8/2/21 through 8/4/21. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 8/2/2021 through 8/4/2021. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Three complaints (VA00052074- unsubstantiated, VA00049657-unsubstantiated and VA00048763-unsubstantiated), were investigated during the survey. The census in this 166 certified bed facility was 151 at the time of the survey. The survey sample consisted of 45 Resident reviews.	F 000		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95,	F 607		9/17/21

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

Electronically Signed | 08/20/2021

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 607	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to implement their abuse policy regarding the screening of employees for 12 employees (Employee D, Employee F, Employee G, CNA F, CNA G, LPN H, LPN J, LPN I, RN B, RN C, RN D and RN E) in a sample of 25 employee records reviewed. 1. The facility staff failed to obtain a criminal background check within 30 days of hire for 3 Employees (Employee D, Employee F and RN E). 2. The facility staff failed to perform professional license verification to ensure nursing employees held current licensure or certification and to determine if they had been subject to disciplinary action against their license as a result of abuse, neglect or mistreatment for 3 employees (LPN H, LPN J and RN D). 3. The facility staff failed to check references prior to hire for 9 employees (Employee D, Employee F, Employee G, CNA F, CNA G, RN B, RN C, RN E and LPN I). The findings included: On 8/3/21 during the afternoon, Surveyor E met with Employee A, the facility Administrator to review the above noted employee file findings. Employee A confirmed that the documents were not present as listed above. On 8/4/21 at 10:20 AM, The Administrator was asked about the importance of these verifications and checks prior to or at the time of hire and she stated, "so that that we hire staff that come recommended and in good standing in the	F 607	1. Employee□s D, F, G, CNA-F, CNA-G, LPN-H, LPN-J, LPN-I, RN-B, RN-C, RN-D and RN-E have now all been reviewed and corrected. The facility did obtain criminal background checks for employee D, F, and RN-E. The facility did run a license verifications of licensed staff LPN-H, LPN-J, RN-D. The facility did complete reference checks on employee D, F, G, CNA-F, CNA-G, RN-B, RN-C, RN-E, and LPN-I. All abuse screening has been completed. 2. All other employees in the facility have the potential to be affected if proper screening, back ground checks, license verification, and reference checks are not completed. All other employee files have been reviewed to make sure that screenings, background checks, license verifications, and reference checks have been completed. Any file that wasn□t complete has been corrected. 3. Administrator will educate Human Resources and hiring managers on the proper screening for all newly hired employees prior to their start date. 4. Administrator or designee will Audit 100% of new hire files prior to orientation which is held every other week for twelve weeks. Results will be reviewed and revised by QAPI committee. 5. AOC: September 17, 2021	

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F 607	Continued From page 2 community". On 8/4/21, Surveyor E met with the facility Administrator and reviewed all of the above noted items. The facility Administrator stated no further information was available. On 8/4/21, a review of the facility policy titled, "Abuse Prevention" was conducted. This policy read, "Sccreening: A) Potential associates will be screened during the application process and references will be checked with previous and current employers, and/or professional and personal sources. B) State licensure and certification agencies, and applicable registries will be contacted to ensure current licensure or certification and to determine if the potential associate has been subject to disciplinary action against his professional license as a result of a finding of abuse, neglect, and exploitation, mistreatment of residents or misappropriation of resident property. For purposes of this section a reprimand is considered disciplinary action. C) Potential associates will be subject to a criminal background check and will not be employed if any conviction of abuse, neglect, exploitation, misappropriation, misappropriation of property or mistreatment is found." The Administrator and Director of Nursing (DON) were made aware of the findings on 8/4/21. No further information was received.	F 607		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the	F 676		9/17/21

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F 676	Continued From page 3 resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to ensure necessary services for communication with one	F 676	1. Communication board was placed in resident #86 room on 8/4/2021.	

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F 676	Continued From page 4 non English speaking Resident (Resident # 86) in a survey sample of 45 Residents. Findings included: For Resident # 86, the facility staff failed to ensure an effective means of communication for an a non English speaking resident. Resident # 86, a 81 year old female was admitted to the facility on 3/4/2019. Diagnoses included but were not limited to: Dementia, Anemia, Anxiety Disorder, Insomnia, and Adjustment Disorder. Resident # 86's most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 6/16/2019. The MDS coded Resident # 86 with a BIMS (Brief Interview for Mental Status) score of "00" out of 15, indicating severe cognitive impairment. Resident # 86 was coded as requiring extensive to total assistance of one to two staff persons for ADLs (Activities of Daily Living). Resident # 86 was coded as always incontinent of bowel and bladder. During the initial tour on 8/02/21 07:38 PM, Resident # 86 was observed lying in bed watching TV. Resident # 86 did not answer questions asked by the surveyor and did not make eye contact with the surveyor. Resident # 86's roommate stated "She (Resident # 68) does not speak English. Her daughter usually translates for her but she's gone for a few weeks. I'm looking out for her." Review of the clinical record was conducted on 8/3/2021.	F 676	2. All residents have been reviewed for need of communication boards and all residents were given appropriate communication boards. 3. DON or designee will educate all staff on how to access alternative means of communication to be able to communicate with residents effectively. 4. DON or Designee will audit 100% of patients with communication boards to ensure that patient has them and that they are being utilized while communicating with that patient. Audit will occur daily times five days, weekly times three weeks, and monthly times two months. Results will be reviewed and revised by QAPI committee. 5. AOC: September 17, 2021	

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Review of the care plan revealed documentation about communication deficits (Resident # 86 spoke Mandarin) and interventions to use a communication board and the translation line.

Problem: "has a communication problem r/t (related to) dementia, speak only Mandarin"
.
Goal: "will be able to make basic needs known by on a daily basis through the review date.

Interventions included:
"Encourage resident to continue stating thoughts even if resident is having difficulty. Focus on a word or phrase that makes sense, or responds to the feeling resident is trying to express.
Mandarin speaking. Communication binder given to patient.
Monitor/document residents ability to express and comprehend language, memory, reasoning ability, problem solving ability and ability to attend.
Monitor/document/report to MD(medical doctor) PRN (as needed) changes in: Ability to communicate,
Potential contributing factors for communication problems, Potential for improvement.
Observe for effectiveness of communication strategies and assistive devices
Observe for / document physical/ nonverbal indicators of discomfort or distress, and follow-up as needed.
Observe for / record confounding problems: decline in cognitive status, mood, decline in ADL, deterioration in respiratory status, oral motor function, hearing impairment (ear discharge and cerumen (wax) accumulation, poor fitting/missing dental appliances etc.
OT/PT(Occupational Therapy/Physical

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Therapy)/Nurse to evaluate resident dexterity/ability to use communication board, writing, use computer or use of sign language as alternate communication to speech."

On 8/3/2021 at 9:45 AM, Resident # 86 was observed lying in bed with her eyes closed. Resident # 86 did not answer when Surveyor C called her name. Resident # 86 opened her eyes and looked around the room when Surveyor C was leaving the room.

On 8/3/2021 at approximately 11:55 AM, a CNA (Certified Nursing Assistant) was observed in the room with Resident # 86. The CNA (CNA H) asked Resident # 86 how she was doing. Resident # 86 did not respond. CNA H stated the staff used the translation line to communicate with Resident # 86 if they could not communicate with her, CNA H stated Resident # 86's daughter translated for them often.

On 8/04/21 at 10:15 AM, an interview was conducted with the Activities Director (Employee M) and Activities Assistant (Employee N) who both stated they used the translation line to communicate with Resident # 68.

On 8/04/21 at 10:20 AM, an interview with the Unit Manager (Employee J) was conducted. Employee J stated the staff used the translation line and a communication board to communicate with Resident # 86. Employee J stated the staff would call the resident's daughter to translate too. Employee J stated Resident # 86 understood some English and was able to say hello and a few words. Employee J went with Surveyor C to Resident # 86's room and looked for a communication board. None was seen in the

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room. Employee J stated the clinical staff did not speak the same language as Resident # 86.

Surveyor C asked Resident # 86 if she had eaten breakfast. Resident #86 looked at the surveyor with a blank stare and did not respond. Employee J asked the Resident if she had eaten breakfast. Resident # 86 eventually looked at Employee J and did not respond. A few moments later, Resident # 86 smiled but did not speak. Employee J looked in the night stand, on the dresser and on the wall near the bed for the communication board. Employee J stated she did not see a communication board. Employee J stated she would contact Physical Therapy to get a communication board. There was no Mandarin speaking Communication binder noted at the bedside.

On 8/04/21 at 10:30 AM, an interview with CNA (Certified Nursing Assistant) M was conducted. She stated that the Certified Nursing Assistants used gestures to communicate with the resident and called the daughter to translate. CNA M stated the resident's daughter visited the facility often. CNA M also stated the staff used the translation line to communicate with Resident # 86. CNA M also stated the staff looked at the resident for nonverbal communication like staff would look for frowning if the resident was in pain. CNA M stated she did not see a communication board in Resident # 86's room.

On 8/3/2021 at 11:15 AM, an interview was conducted with the Director of Nursing who stated the facility staff used the translation line and a communication board to communicate with Resident # 86. The Director of Nursing stated communication was important to make sure the

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F 676	Continued From page 8 resident's needs were met. On 8/04/2021 at 12:08 PM, an interview was conducted with Employee J who stated she obtained a Communication board from the Physical Therapy Department. During the end of day debriefing, the facility Administrator, Director of Nursing and other administrative staff were informed of the findings. The Administrator and Director of Nursing stated the facility staff should have an effective means of communicating with Resident # 86. They stated a communication board should be used by staff to help with communication. No further information was provided.	F 676		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for	F 761		9/17/21

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F 761	Continued From page 9 storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility documentation review, the facility staff failed to properly label medications in 2 out of 6 medication carts. Specifically, there were vials of insulin and one bottle of ophthalmic solution observed opened and undated on 08/03/2021. The names of the Residents on the medication containers were identified and placed in the sample as Resident #3, Resident #106, Resident #19, and Resident #356. The findings included: Resident #3, a 60-year-old male, was admitted to the facility on 04/12/2021. Diagnoses included but were not limited to renal insufficiency and hypertension. Resident #3's most recent Minimum Data Set with an Assessment Reference Date of 04/26/2021 was coded as a quarterly assessment. The Brief Interview for Mental Status was coded as "15" out of possible "15" indicative of intact cognition. Resident #106, a 63-year old female, was admitted to the facility 05/14/2019. Diagnoses included but were not limited to hypertension and renal insufficiency. Resident #106's most recent Minimum Data Set with an Assessment Reference Date of 07/06/2021 was coded as a	F 761	1. Medication for patient 3, 106, 19, 356 was labeled with the date it was opened on the vial/bottle. 2. Any resident on the insulin bottles or ophthalmology drop bottle medications could be at risk if the bottle is not dated upon opening it. All med-carts were audited and any corrections have been made. 3. DON or Designee will educate all RN's and LPN's utilizing our policy for medication storage. 4 DON or Designee will audit medications in vials/bottles will be done. Two med-carts will be audited each day for 5 days, 5 carts weekly times 3 weeks, and All med-carts will be checked monthly time two months to ensure proper med storage. Results will be reviewed and revised by QAPI committee. 5. AOC: September 17, 2021	

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quarterly assessment. The Brief Interview for Mental Status was coded as "15" out of possible "15" indicative of intact cognition.

Resident #19, a 75-year-old female, was admitted to the facility on 12/22/2016. Diagnoses included but were not limited to coronary artery disease, hypertension, and diabetes mellitus. Resident #19's most recent Minimum Data Set with an Assessment Reference Date of 05/12/2021 was coded as a quarterly assessment. The Brief Interview for Mental Status was coded as "6" out of possible "15" indicative of severe cognitive impairment.

Resident #356, a 91-year-old female, was admitted to the facility on 07/18/2021. Diagnoses included but were not limited to diabetes mellitus type 2 and end stage renal disease. Resident #356's most recent Minimum Data Set assessment was not completed.

On 08/03/2021 at 3:15 P.M., this surveyor and Licensed Practical Nurse E (LPN E) observed the contents of Medicine Cart #2 on the 300 unit. A bottle of ophthalmic solution was stored inside a small, clear plastic bag with Resident #3's name on both the bag and the bottle. The bag had a handwritten date of 07/30/21. The top of ophthalmic solution was not sealed indicating it had been opened. LPN E verified that the handwritten date of 07/30/21 on the bag was the date the bottle was opened. The bottle of ophthalmic solution was undated. When asked about the process for labeling medications, LPN E indicated when a medication is opened, both the bottle and the bag should be dated.

On 08/03/2021 at approximately 3:25 P.M., this

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surveyor and LPN F observed the contents of Medication Cart #1 on the 300 unit. The following observations were made:

1) For Resident #106, a vial of insulin (insulin glargine) was stored inside a small, clear plastic bag with Resident #106's name on both the bag and the vial. The bag had a handwritten date of 07/03/21. The protective cap was not on the vial indicating it had been opened. LPN F verified that the handwritten date of 07/03/21 on the bag was the date the vial was opened. The vial was a little more than half full. The vial of insulin glargine was undated. Also, a vial of insulin (Insulin Aspart) was stored inside a small, clear plastic bag with Resident #106's name on both the bag and the vial. The bag had a handwritten date of 07/03/21. The protective cap was not on the vial indicating it had been opened. LPN F verified that the handwritten date of 07/03/21 on the bag was the date the vial was opened. The vial was more than half full. The vial of Insulin Aspart was undated.

2) For Resident #19, a vial of insulin (insulin glargine) was stored inside a small, clear plastic bag with Resident #19's name on both the bag and the vial. The bag had a handwritten date of 07/03/21. The protective cap was not on the vial indicating it had been opened. LPN F verified that the handwritten date of 07/03/21 on the bag was the date the vial was opened. The vial was a little more than half full. The vial of insulin glargine was undated. Also, a vial of insulin (insulin regular human) was stored inside a small, clear plastic bag with Resident #19's name on both the bag and the vial. The bag had a handwritten date of 07/03/21. The protective cap was not on the vial indicating it had been opened. The vial was less

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DULLES HEALTH & REHAB CENTER	2978 CENTREVILLE ROAD HERNDON, VA 20171

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F 761	Continued From page 12	F 761		

than half full. LPN F verified that the handwritten date of 07/03/21 on the bag was the date the vial was opened. When asked about the process for labeling medications, LPN F indicated when a medication is opened, both the vial and the bag should be dated.

3) For Resident #356, a vial of insulin (Insulin Aspart) was stored inside a small, clear plastic bag with Resident #356's name on both the bag and the vial. The bag had a handwritten date of 07/20/21. The protective cap was not on the vial indicating it had been opened. LPN F verified that the handwritten date of 07/20/21 on the bag was the date the vial was opened. The vial was more than half full. The vial of Insulin Aspart was undated. When asked about the process for labeling medications, LPN F indicated when a medication is opened, both the vial and the bag should be dated. When asked how long insulin could be stored after it was opened, LPN F stated, "30 days."

On 08/03/2021 at 3:45 P.M., the unit manager, LPN G, was notified of findings. When asked about the expectation for labeling medications, LPN G stated that both the vial and the bag should be labeled with the date it was opened. When asked why, LPN G stated so staff will know exactly when the vial was opened in case it got separated from the bag.

On 08/03/2021 at 5:40 P.M., the administrator and the Director of Nursing (DON) were notified of findings. When asked about the expectation for labeling medications, the DON stated the expectation is for staff to label the vial at the time it is opened. A copy of their policy for medication storage and the manufacturer's information for

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F 761	Continued From page 13 each unlabeled medication were requested. On 08/04/2021, the facility staff provided a copy of the manufacturer's information for the medications. The manufacturer's information for insulin glargine under the header "Storage" documented that vials "in-use" may be stored for "28 days refrigerated or room temperature." The manufacturer's information for insulin regular human under the header "Storage and Handling" and sub-header "After the vial has been opened" an excerpt documented "Throw away the opened vial after 40 days, even if there is still insulin left in the vial." The manufacturer's information for insulin regular human under the header "After the vials have been opened" an excerpt documented "Throw away all opened vials after 28 days, even if they still have insulin left in them." On 08/04/2021, the facility staff provided a copy of their policy entitled, "Medication Storage." An excerpt under the header entitled, "Policy", it was documented, "Medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations or those of the supplier." On 08/05/2021 by the end of survey, the administrator stated they had no further documentation to submit.	F 761		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an	F 880		9/17/21

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F 880	Continued From page 14	F 880		

infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and

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F 880	Continued From page 15 (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, facility documentation and clinical record review the facility staff failed to maintain infection control program to help prevent the development of communicable diseases and infections. For facility staff, 3 of the 5 CNA's working on the Chesapeake Unit did not don appropriate PPE prior to entering the room of a Resident on contact precautions. The findings included: Resident # 20, 61-year-old male admitted to the facility on five 721 diagnoses of but not limited to	F 880	1. Employees K, CNA-H, CNA-I, have been educated on appropriate PPE wearing and appropriate donning and doffing of PPE. 2. Any resident can be affected if the proper PPE is not worn by staff while providing care. 3. Department managers or designee will educate all staff about proper PPE wearing, Donning, and Doffing of PPE correctly	

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F 880	Continued From page 16 hypertension renal insufficiency diabetes wound infection septicemia hyper hypertension and stage renal disease dependent on dialysis. The resident's most recent MDS (minimum data set) with an ARD assessment reference date of 5/7/21 was reviewed. It coded the resident as having a BIMS (brief interview of mental status) score of 12 - indicating mild cognitive impairment. The resident was coded as requiring the extensive physical assistance of two persons for bed mobility, transfers, dressing, toilet use, and personal hygiene. He required the assistance of one person for bathing, and for meals he only required supervision and set up. He The resident had functional limitations in range of motion impairment on one side for the upper extremities, as well as the lower extremities. He used the wheelchair, and was unable to stand, bear weight, or walk. On 8/3/21 at approximately 8:15 AM Surveyor D was observing Med Pass on the Great Falls Unit, and observed Employee K (housekeeping staff) walk across the barrier set up to separate the "Covid Observation Unit" without donning a face shield. The nurse working on that unit stopped her and redirected her back off of the unit. At 8:30 AM the housekeeping supervisor brought a translator down to explain the Covid guidelines and PPE in Employee K's native language. On 8/3/21 at approximately 8:45 AM Surveyor D observed CNA H go into a Resident's room without donning PPE. The plastic bin containing PPE was full, and there was a sign on the door in English and Spanish explaining how to put on the PPE correctly, and which items were required (gown, gloves, mask and face shield). Surveyor D asked CNA H why the Resident is on	F 880	4. DON or Designee will audit 10 staff that are working with patients who have isolation needs to ensure proper wear of PPE, and correct Donning and Doffing. This will be completed daily times 5 days, weekly times three weeks and monthly times two months. Results will be reviewed and revised by QAPI committee. 5. AOC: September 17, 2021	

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Precautions. She stated that she did not know. When asked if she should be wearing the PPE when caring for the Resident. She stated I just went in for a minute."

On 8/3/21 at approximately 9:45 AM, an interview was conducted with the unit manager who stated that the expectation is that anyone going into the room of an isolation patient, Covid or not, they should obey the signs outside the door. The signs and the PPE are there for them.

On 8/4/21 at 9:20 AM, Surveyor A observed CNA I in a room on isolation precautions on the Chesapeake Unit. CNA I was observed to have only a procedure mask on, and was at the bedside of the Resident in D bed. CNA I then went over to the roommate, in W bed, and within 2 feet of each of the Residents. Upon CNA I's exit from the room, Surveyor A asked her why the signage was outside the room indicating that PPE (Personal Protective Equipment) of eye protection, isolation gown and gloves was required for entry into the room. CNA I stated, "I was supposed to put it on."

On 8/4/21 at approximately 11:30 AM an interview was conducted with the Infection Preventionist who stated that it was her expectation that when the CNA's see a PPE bin outside the door, and signage, they should go ask the nurse if they have any questions about the PPE or the reason for precautions.

A review of the CDC guidelines revealed:
https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html#new-admissions
1. "New Admissions and Residents who leave the Facility"

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F 880	Continued From page 18 2. "Create a Plan for Managing New Admissions and Readmissions" 3. "In general, all other new admissions and readmissions should be placed in a 14-day quarantine, even if they have a negative test upon admission." 4. "Guidance addressing placement, duration, and recommended PPE when caring for residents in quarantine is described in Section: Manage Residents who have had Close Contact with Someone with SARS-CoV-2 Infection." 5. "Managing Residents with Close Contact" 6. "Manage Residents who had Close Contact with Someone with SARS-CoV-2 Infection" https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html#residents-close-contact 1. "HCP should wear an N95 or higher-level respirator, eye protection (i.e., goggles or a face shield that covers the front and sides of the face), gloves, and gown when caring for these residents." On 8/4/21 during the end of day conference the Administrator was made aware of the concerns and no further information was provided.	F 880		