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PARHAM HEALTH CARE & REHAB CEN	2400 E PARHAM ROAD RICHMOND, VA 23228

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A COVID-19 Focused Emergency Preparedness Survey was conducted on 01/26/2021 through 02/02/2021. The facility was in substantial compliance with 42 CFR Part 483.73 emergency preparedness regulations, and has implemented The Centers for Medicare & Medicaid Services and Centers for Disease Control recommended practices to prepare for COVID-19. The census in this 180 certified bed facility was 124 at the time of the survey.	E 000		
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey and an Abbreviated survey were conducted on 01/26/2021 and continued through 02/02/2021. Significant Corrections are required for compliance with 42 CFR Part 483.80 infection control regulations, for the implementation of The Centers for Medicare & Medicaid Services and Centers for Disease Control recommended practices to prepare for COVID-19. One complaint was investigated during survey. Immediate Jeopardy was identified in the area of Infection Control at a Scope and Severity Level Four, pattern. After removal, it was lowered to a Level Two, pattern. The census in this 180 certified bed facility was 124 at the time of the survey. The survey sample consisted of 32 resident reviews and 5 employee reviews.	F 000		
F 880 SS=K	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880		3/8/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 02/26/2021

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 880	Continued From page 1 The facility must establish and maintain an 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	F 880		

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involved, and
(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, staff interview, facility documentation review, and clinical record review, the facility staff failed to provide infection control measures in accordance with the Center for Medicare and Medicaid Services (CMS) and The Centers for Disease Control and Prevention (CDC) recommendations, to prevent the spread of COVID-19, for 5 Residents (Resident #6, #7, #8, #9 and #10) in a survey sample of 32 Residents and for 5 facility staff (LPN A, LPN B, RN D, CNA D, CNA E)

1. The facility staff permitted employees who had

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The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies nor the reported conversations and other information cited in support of the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility's allegation of compliance. All alleged

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confirmed positive test for COVID-19 to continue to work, without meeting the CDC return to work (RTW) criteria, which exposed Residents #6, #7, #8, #9, and #10, who were all previously negative for COVID-19.

2. The facility staff failed to don (put on) all necessary PPE (personal protective equipment) prior to entering rooms with enhanced droplet precautions.

Immediate Jeopardy was identified on 1/27/2021 at 6:15 PM for finding number 1. After verification, Immediate Jeopardy was removed on 2/2/2021 at 2:00 PM, and the scope and severity was lowered to a Level 2, pattern due to finding number 2.

The findings included:

1. The facility staff permitted employees who had confirmed positive test for COVID-19 to continue to work, without meeting the CDC return to work (RTW) criteria, which exposed Residents #6, #7, #8, #9, and #10, who were all previously negative for COVID-19.

On 1/26/21 at approximately 3:30 PM, during Entrance Conference, a telephone interview was conducted by Surveyor B with the Facility Administrator (Employee A). The Facility Administrator was asked if he ever had to implement emergency staffing strategies during the COVID-19 pandemic, he stated, "No". The Facility Administrator was asked if the facility had experienced any staffing problems, he stated, "No". The Facility Administrator was asked if resident care had been impacted by any staffing

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deficiencies cited have been or will be corrected by the date or dates indicated.

F880

1. What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice;

- Resident #6 remains COVID negative. She is no longer on Enhanced Droplet-Contact Precautions. The Medical Director and patient's Responsible Party (RP) are aware.
- Resident #7 tested positive 1/11/21, remained asymptomatic, and is no longer on Enhanced Droplet-Contact Precautions. The Medical Director and RP are aware.
- Resident #8 no longer resides in Center.
- Resident #9 tested positive 1/11/21, remained asymptomatic, and is no longer on Enhanced Droplet-Contact Precautions. Medical Director and RP are aware.
- Resident #10 tested positive 1/8/21, remained asymptomatic, and is no longer on Enhanced Droplet-Contact Precautions. Medical Director and RP are aware.
- LPN A is currently employed and has met return to work criteria.
- LPN B is no longer employed.
- RN D is currently employed and has met return to work criteria.
- CAN D is no longer employed.
- CNA E is currently employed and has met return to work criteria.

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concerns, he stated, "Not at all".

On 1/26/21 during the afternoon, Surveyor A conducted a tour of the facility. Surveyor A was accompanied by Employee B, the Director of Nursing (DON) during this tour. Surveyor A had asked the DON how the outbreak had affected staffing, the DON stated "what we did was based on the need at that time, if this unit was positive and staff were positive and asymptomatic we allowed them to work on the positive unit".

On 1/26/21, the facility staff provided the survey team with a staff surveillance log. On 1/27/21, this log was reviewed and revealed that employees were listed with a "COVID positive date, first back to work date, and actual" column. The facility Administrator was asked to explain the form. The Administrator stated, the "first back to work date is the first day after a 10 day quarantine they could return and the actual date is the date they actually returned". Surveyor A identified that there were multiple staff listed who had a COVID positive test date of 12/22/20-12/29/20, who did not have actual return to work dates listed and there was no indication of the position the employees held. The facility Administrator indicated he would review the form and provide a revised copy.

On 1/27/21, the facility Administrator provided the survey team with a revised Employee Surveillance log which included employee's position. This log included green, yellow and red highlighting. The Administrator explained that "red, these people are still sick, yellow, they could return but have not, green, they have recovered". This log was reviewed and revealed the following:

1. LPN A tested positive for COVID-19 on

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- Center Staff are currently using all appropriate PPE as per guidelines.

2. How you will identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken;

- All residents are at risk to be affected by alleged deficient practice related employees not meeting CDC return to work criteria and failure to utilize appropriate PPE.

3. What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur.

- Staff Development Coordinator or Designee will educate all center staff on appropriate return to work criteria and appropriate PPE upon entering Enhanced Droplet-Contact Precaution areas.

4. How the corrective action will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place.

- Unless in staffing crisis, asymptomatic COVID-19 positive employees will be sent home to quarantine until they have met all CDC return to work criteria. Audits will be completed 3 times a week for 2 weeks, once a week for 2 weeks, monthly for 2 months and then be reviewed in QAPI meeting that involves reviewing screening tool for staff on entry to work. The Clinical Report will be reviewed for residents with potential signs and symptoms of COVID-19. This audit will be completed 3

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1/8/21, with a return to work date of 1/8/21.
2. RN D tested positive for COVID-19 on 1/11/21, with a return to work date of 1/11/21.
3. LPN B tested positive for COVID-19 on 1/19/21, with a return to work date of 1/24/21.
4. CNA D tested positive for COVID-19 on 1/5/21, with a return to work date of 1/8/21.
5. CNA E tested positive for COVID-19 on 1/5/21, with a return to work date of 1/5/21.

The facility census on 1/5/21 indicated 119 beds of 180 beds total were occupied. There were 56 vacant beds within the facility on units located outside of the designated COVID positive unit.

The facility census on 1/8/21 indicated 121 beds of 180 beds total were occupied. There were 51 vacant beds within the facility on units located outside of the designated COVID positive unit.

The facility census on 1/29/21 indicated 130 beds of 180 beds total were occupied. There were 33 vacant beds within the facility on units located outside of the designated COVID positive unit.

Review of the clinical records revealed the following:

1. Resident #6, who has a trach and had never tested positive for COVID-19. Resident #6 remained on the COVID positive unit and received trach care as well as medication administration by COVID positive staff who had not met the CDC RTW criteria on 1/8/21, 1/11/21, 1/12/21, 1/13/21, 1/16/21, and 1/17/21 per the MAR (Medication Administration Record) and Treatment Administration Record, therefore exposing Resident #6 to the COVID-19 virus.

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times a week for 2 weeks, 3 times a week for 2 weeks, once a week for 2 weeks, monthly for 2 months, and then be reviewed in QAPI meeting.

- SDC or designee will audit 10% staff to observe PPE donning prior to entering Enhanced Droplet-Contact Precautions rooms to ensure appropriate PPE is utilized. This audit will be completed 3 times weekly for 2 weeks, weekly times 2 weeks, monthly for 2 weeks, and then be reviewed in QAPI meeting.

5. Date of compliance: 3/8/21

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2. Resident #7, who was COVID negative until 1/11/21, was a Resident of the COVID positive unit and was cared for on 1/11/21, by 2 COVID positive staff (LPN A and RN D) who had not met the RTW criteria.

3. Resident #8, was COVID negative and was housed on the COVID positive unit, when other beds were available within the facility. Per the MAR for Resident #8, he was cared for by COVID positive staff (LPN A and RN D) who had not met the CDC RTW criteria on 1/8, 1/11, 1/12, 1/13, 1/16, 1/17. Subsequently Resident #8 tested positive for COVID-19 on 1/26/21.

4. Resident #9, who was COVID negative until 1/11/21, was a Resident of the COVID positive unit and was cared for on 1/8/21 and 1/11/21 by a COVID positive staff (LPN A) who had not met the RTW criteria.

5. Resident #10, who was COVID negative until 1/18/21, was a Resident of the COVID positive unit and was cared for on 1/11, 1/12, 1/13, 1/14, 1/16, and 1/18 by 2 COVID positive staff (LPN B and RN D) who had not met the RTW criteria.

On 1/27/21 at 10:19 AM, when the facility Administrator was asked again about staffing and if they had implemented their emergency staffing plan, the Administrator stated, "I guess based on this, we were because it is a transition from the normal process". When asked what strategies they implemented based on their emergency staffing plan, he stated, "we contracted with agency staffing and called 3 other sister facilities".

On 1/27/21 at 11:12 AM, Surveyor B received an email from the Facility Administrator which read,

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"I wanted to follow-up on the discussion for staffing usage for the center. We have initiated staffing agency contracts with [name redacted] Healthcare staffing since the second week in December. This was due to the first week COVID out break and the need to have assistance with staffing. The account manager that we discuss needs and go through is [name and phone number redacted]. We continue to use the RTW [Return to Work] strategies within the CDC [Center for Disease Control and Prevention] recommendations and Guidance as attached. Also, as mentioned discussions regarding staffing strategies have been had with our public health nurses and epidemiology teams. The frequent contact is listed below. This is to include contingent and crisis staffing. Henrico Public Health Contact: [name and phone number redacted, assigned 'Other A' on survey identifier]
Thanks
[name redacted, Facility Administrator]".

On 1/27/21 at approximately 11:40 AM, Surveyor B conducted a telephone interview with Henrico Health Department Public Health Nurse (Other A) who confirmed that she was a point of contact for the facility as previously identified by the Facility Administrator. The Public Health Nurse stated she was unaware of any recent staffing shortages at the facility and has regular contact with facility staff, including the Facility Administrator. The Public Health Nurse stated, "In the middle of December, [name redacted, Henrico Health Department Infection Control Specialist, assigned 'Other B' on survey identifier] conducted a site visit to [the facility] in response to an [COVID-19] outbreak and [the Facility Administrator] was advised at that time that it was not recommended to have [COVID] positive staff that have not

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completed a quarantine work with [COVID] negative staff because they [the facility] could not properly and safely accommodate this staffing arrangement".

On 1/27/21 Surveyor A had a conversation with the facility contact person for the nursing staffing agency. The nursing staffing agency representative did confirm that the facility had initiated a contract with them the second week of December and due to being a new contract and the upcoming Christmas and New Year Holidays staffing had been challenging. The nurse staffing agency representative did provide details of how many nursing shifts, to include nurses and CNA's they had been able to cover on a weekly basis since the inception of the contract. The agency had provided as few as 2 shifts in a week to as many as 20 shifts within a week.

The facility Administrator did not provide any evidence of communication with local healthcare coalitions, federal, state and other public health partners nor any development of regional plans to identify designated healthcare facilities or alternate care sites with adequate staffing to care for patients with SARS-CoV-2 infection, as CDC guidance suggests to mitigate staffing shortages. The facility Administrator also failed to provide any evidence of reaching out to sister facilities for staffing assistance, as the Administrator indicated in their Emergency Staffing plan.

On 1/27/2021 at 6:15 PM, Immediate Jeopardy (IJ)was called , due to the facility allowing COVID-19 positive staff to work, prior to meeting the CDC return to work criteria care for COVID-19 negative Residents. By allowing this, it created the likelihood that serious harm or

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death could occur if the Resident's contracted COVID-19. The facility staff, which included the Administrator and the Director of Nursing (DON) were made aware of IJ.

On 1/28/21, the Facility Administrator submitted an IJ abatement plan, which the survey team accepted. The abatement plan stated:

A. All staff working today will be tested for COVID-19 and all staff not tested today will be tested prior to their next shift. All COVID-19 positive staff members will be sent home to quarantine until they have met CDC return to work criteria. Any previous positive staff members that have not met return to work criteria will be sent home to quarantine.

B. All residents that are eligible for testing have been tested and no new positive cases were identified. All residents that are negative but exposed will be placed on enhanced droplet precautions for 14 days. Any residents that test positive will be placed on a hot unit on enhanced droplet precautions. Two negative residents from the hot unit have been moved to a separate unit and placed on enhanced droplet precautions for 14 days.

The Center will ensure that positive and negative patients will not be cohorted in the same room.

C. The DON or designee will continue COVID-19 testing on staff and residents for COVID-19 based on current CDC guidelines.

D. The DON or designee will educate all staff that are currently working and all other staff prior their next shift on CDC return to work criteria.

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E. Date of completion 01/28/2021

On 1/29/21, the survey team was onsite to verify the IJ removal plan had been implemented as follows:

1. On 1/29/21 the survey team conducted a review of all staff working 1/28/21 and 1/29/21. This review revealed that LPN C worked 1/28/21 and on the testing log "hx" was noted beside her name to indicate she had a history of testing positive for COVID-19. Review of the staff surveillance log revealed LPN C was not listed as having tested positive. CNA G was noted on the staff working list for 1/28/21. Review of the testing log for 1/28/21 revealed CNA G with a "hx" to indicate she had a history of a previous positive COVID-19 test and was not eligible to be re-tested. However, the surveillance log did not list CNA G as having had a positive COVID test.

2. During staff interviews on 1/29/21, CNA H indicated she had not been tested for COVID-19 since 1/21/21. CNA H was noted on the staff testing log for 1/28/21 with no indication of being tested.

3. On 1/29/21, staff interviews were conducted with 7 staff members regarding the CDC return to work criteria and education they received. Of the 7 staff, they all consistently reported that the facility Administrator or DON would let them know how long they would have to be out of work, depending upon their symptoms. When asked what the minimum time for the quarantine period was, only 1 staff member was able to state "I think it is 10 or 14 days, I'm not sure".

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The survey team determined that the facility had not removed IJ at this time, for the reasons noted above and notified the facility of these findings on 1/29/21 at 1:15 PM.

The facility Administrator submitted a revised Abatement Plan to the survey team on 1/29/21, with a revision to the completion date, which now stated 2/1/21.

The survey team then returned to the facility on 2/2/21.

The survey team verified that all Residents who had not tested positive for COVID-19 within the last 90 days were re-tested on 1/27/21.

The survey team verified that any Resident who resided on the COVID hot unit and had never tested positive had been moved off of the Hot unit and placed on enhanced droplet pre-cautions.

The survey team verified the COVID status of all Residents and ensured that Residents were cohorted with Residents of the same COVID status (COVID negative with COVID negative, recovered with other recovered and COVID positive with COVID positive).

The survey team conducted observations on 1/29/21 and verified that all Residents exposed to COVID-19 positive staff that had not met the CDC return to work criteria, were placed on enhanced droplet precautions due to exposure.

The survey team reviewed staff testing logs for the past 10 days and identified all staff that had tested positive for COVID-19. The as-worked schedule was then reviewed for 1/28 and 1/29 to

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ensure those staff had been removed from the schedule and were not currently working.

The survey team reviewed all staff currently working and ensured they had been tested for COVID-19 on 2/1/21 or prior to their shift on 2/2/21. If they were not eligible for testing due to a previous positive COVID-19 test they had met the CDC RTW criteria for a 10 day quarantine period.

The survey team verified that any Resident admissions since the review conducted on 1/29/21, were properly cohorted with a Resident of the same COVID-19 status. The facility census was reviewed to ensure no room changes had been performed since 1/29/21, that may have caused cohorting concerns.

The survey team conducted staff interviews to verify that staff were aware of the CDC RTW criteria and need for a quarantine period if they test positive for COVID-19.

IJ was then removed at 2:00 PM on 2/2/21.

Review of the facility policy titled, "COVID-19" stated, "11. Containment/Management c. cohort like patients in a designated area (i.e. a close group of rooms on a certain hall)".

Per the CDC "Return to Work Criteria for HCP with SARS-CoV-2 Infection. Symptom-based strategy for determining when HCP can return to work.
HCP with mild to moderate illness who are not severely immunocompromised: At least 10 days have passed since symptoms first appeared and at least 24 hours have passed since last fever

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without the use of fever-reducing medications and symptoms (e.g., cough, shortness of breath) have improved. Note: HCP who are not severely immunocompromised and were asymptomatic throughout their infection may return to work when at least 10 days have passed since the date of their first positive viral diagnostic test". Accessed online 1/27/2021: https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html

Per the "CDC Strategies to Mitigate Healthcare Personnel Staffing Shortages" the following guidance is provided to healthcare facilities: "Maintaining appropriate staffing in healthcare facilities is essential to providing a safe work environment for healthcare personnel (HCP) and safe patient care. As the COVID-19 pandemic progresses, staffing shortages will likely occur due to HCP exposures, illness, or need to care for family members at home. Healthcare facilities must be prepared for potential staffing shortages and have plans and processes in place to mitigate these.... There are Contingency and Crisis Capacity Strategies that healthcare facilities should consider in these situations:
When staffing shortages are anticipated, healthcare facilities and employers, in collaboration with human resources and occupational health services, should use contingency capacity strategies to plan and prepare for mitigating this problem. At baseline, healthcare facilities must:
Be in communication with local healthcare coalitions, federal, state, and local public health partners (e.g., public health emergency preparedness and response staff) to identify additional HCP (e.g., hiring additional HCP, recruiting retired HCP, using students or

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volunteers), when needed".

The CDC article continues to state "Developing regional plans to identify designated healthcare facilities or alternate care sites with adequate staffing to care for patients with SARS-CoV-2 infection.
Developing plans to allow asymptomatic HCP who have had high risk unprotected exposure to SARS-CoV-2 (the virus that causes COVID-19) but are not known to be infected to continue to work onsite during their 14-day post-exposure period. CDC has provided Options to Reduce Quarantine for Contacts of Persons with SARS-CoV-2 Infection Using Symptom Monitoring and Diagnostic Testing. These options could be considered as a measure to mitigate staffing shortages and not as a preferred option. Healthcare facilities should understand that shortening the duration of work restriction might result in additional transmission risks. Healthcare facilities management that elect to implement approaches other than those described in the CDC scientific brief should understand that there might be additional transmission risks posed by their approach".
Accessed online 1/27/2021:
https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html

No further information was received.

2. The facility staff failed to don (put on) all necessary PPE (personal protective equipment) prior to entering rooms with enhanced droplet

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F 880	Continued From page 15 precautions. On 1/29/21 at approximately 9:45 AM, Surveyor A observed Employee E enter room 75. Employee E had on an N-95 mask, isolation gown and gloves. The room door had signage that read, "Enhanced droplet-contact precautions. Perform hand hygiene, surgical mask when entering the room, eye protection when entering the room, gown when entering the room, gloves when entering the room". Employee E was observed with no eye protection on, when asked about eye protection and the sign was pointed to, Employee E was asked if her prescription eye glasses are considered eye protection. Employee E stated, "they said I could use them as eye protection because the goggles keep falling off my face". On 1/29/21 at 10:05 AM, Surveyor A enters the Central Wing. The hall-way housing rooms 46-58 were all noted to be on enhanced droplet precautions with signage on each door as well as PPE stations throughout. RN F, the unit manager was asked to identify the unit and she stated, "these rooms are all on precautions because we had a staff member test positive yesterday and was sent home so they have all been exposed". Surveyor A proceeded onto the hall and observed RN E was passing medications. RN E was observed with an N-95 mask on, hair covering, isolation gown which was only tied at the neck. She prepared medications for the Resident in room 54 and then entered the room with no gloves on. She touched the bedside table and administered medications. She did use hand sanitizer prior to exit. She had on prescription eye glasses and prior to entering the room failed to don eye protection to include a faceshield or goggles and failed to put on gloves.	F 880		

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On 1/29/21 at 10:17 AM, Surveyor A returned to the nursing station to question RN F, the unit manager again. RN F stated prior to entering a room she expects staff to put on "gown, gloves, goggles and N-95". When asked if prescription eye glasses are considered eye protection she stated, "no, you should have goggles over them".

Surveyor A then returned back to the unit and then observed CNA I enter a Resident room with enhanced droplet precaution signage on the door. CNA I had on an isolation gown, N-95 mask and gloves. She failed to put on eye protection. CNA I was asked what PPE was required to enter the room and she stated, "gloves, gown, goggles or faceshield". When asked why she didn't have goggles or a faceshield on she stated, "I had them during COVID but when we went off of precautions I didn't need them so I quit bringing them. We just went on precautions yesterday and I didn't bring them". RN F then entered the unit and proceeded to hand CNA I and RN E a pair of goggles and asked them to wear them.

Review of the facility policy titled, "Transmission Based Precautions-General Practice" read, "4. e. The health care team and visitors will be instructed on the importance and necessity of maintaining TBPs [transmission based precautions] before entering the patient's room".

The CDC gives the following guidance to nursing facilities regarding how to don PPE: "How to Put On (Don) PPE Gear. More than one donning method may be acceptable. Training and practice using your healthcare facility's procedure is critical. Below is one example of donning.
1. Identify and gather the proper PPE to don.

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F 880	Continued From page 17 2. Perform hand hygiene using hand sanitizer. 3. Put on isolation gown. Tie all of the ties on the gown. Assistance may be needed by other healthcare personnel. 4. Put on NIOSH-approved N95 filtering facepiece respirator or higher (use a facemask if a respirator is not available). 5. Put on face shield or goggles. 6. Put on gloves. 7. Healthcare personnel may now enter patient room". Accessed online at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html The facility Administrator and Director of Nursing were made aware of the findings during an end of day meeting held on 1/29/21. No further information was provided. Complaint related deficiency.	F 880		