STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495185	A. BUILDING ______ B. WING ______	C 01/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAVERLY REHABILITATION AND HEALTHCARE CENTER	456 E MAIN ST WAVERLY, VA 23890

(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
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 01/05/22 through 01/06/22. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Five complaints, (VA00053894--Unsubstantiated, VA00053699--Substantiated with Deficiency, VA00052882--Substantiated with Deficiency, VA00052816--Substantiated with Deficiency, and VA00052474--Substantiated with Deficiency), were investigated during the survey. The census in this 120 certified bed facility was 97 at the time of the survey. The survey sample consisted of 12 resident reviews.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review, facility record review, and in the course of an investigation, the facility staff failed to meet professional standards of quality for 3 Residents (#'s 1, 5, and 7) in a survey sample of 12 Residents. The findings include: For Resident #1 the facility staff failed to report a change in patient condition to the charge nurse, wound nurse, physician and family.	F 658	F658: Services Provided Meet Professional Standards CFR(s): 483:21(b)(3)(i) Comprehensive Care Plans. (i)Meets professional standards of quality. (residents #s 1,5, and 7) 1. The condition change notification to family representative, attending physician and IDT for resident # 1 cannot be retroactively corrected as was identified on 7/5/2021.	2/4/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 01/24/2022

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 658 Continued From page 1

Resident #1 was admitted to the facility on April 18, 2018, with the following diagnoses: COPD, hypertension, repeated falls, difficulty walking, Venus insufficiency, dementia, adult failure to thrive, spinal stenosis, vitamin D deficiency, and anemia.

On 1/6/22 review of the clinical record revealed and FRI investigation revealed two LPN's employed through a staffing agency, were found to have had knowledge of maggots on Resident #1's foot prior to a nurse finding them on 7/5/21. The results of the investigation revealed the two nurse's contracts were subsequently terminated for failing to report these findings to a charge nurse, wound nurse, supervisor or physician.

A review of the investigation revealed the Administrator did conduct interviews and found that two nurses were heard discussing the fact that they had seen the maggots days before. NOTE: It is important to note that the maggots were not seen in a wound.

On the morning of 1/6/22 an interview was conducted with LPN C who stated that "Nurses should report changes in condition to the Nurse Practitioner, or the Physician and the family and it should be documented in the 24 hour report."

The nurses were unable to be reached for interview.

Per the Agency for Healthcare Research and Quality [ahrq.gov]

https://www.ahrq.gov/patient-safety/settings/long-term-care/resource/facilities/ltc/gdmod1.html#:~:te

F 658

2. Current 24-hour report notes and documentations have been reviewed by the VP of Clinical Services and found no missed notification opportunity.

3. Licensed nurses will be re-educated on facility policy and procedure on Condition Changes and Notification by the Director of Nursing or Designee by 1/28/22. The Director of Nursing or Designee will review five times a week 24-hour reports and other clinical documentations relating to condition changes to verify that residents� family and attending physicians/advanced nurse practitioners are duly notified of condition changes within a reasonable time.

4. The Director of Nursing or Designee shall immediately address any missed notification opportunity, and initiate investigation to ascertain reason(s) for such failure. The Director of Nursing or Designee shall report such missed notification opportunities to QAPI committee meetings monthly for three months.

5. Compliance date of completion February 4, 2022.

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F 658	Continued From page 2 xt=A%20change%20in%20a%20resident%27s%20condition%20may%20mean,complications%2C%20transfer%20to%20a%20hospital%2C%20or%20even%20death "A change in a resident's condition may mean that he or she is at risk. Action can be taken only if changes are noticed and reported, the earlier the better. Changes that are not reported can lead to serious outcomes, including medical complications, transfer to a hospital, or even death." On 1/6/22 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on Resident interview, staff interviews, facility documentation review, clinical record review and during the course of a complaint investigation, the facility staff failed to provide ADL assistance with regards to showering, for a Resident who was dependent upon staff to maintain personal hygiene, for one Resident (Resident #5) in a survey sample of 12 Residents. The findings included: On 1/5/22 at approximately 12:30 PM, Surveyor C	F 677	F677: ADL Care Provided for Dependent Residents CFR(s): 483.224(a)(2) 1. The resident # 5 received shower on 1/6/2022 as scheduled and stipulated. 2. Shower schedules and preferences been reviewed by the Unit Managers, and preferences are being honored. 3. The Director of Nursing or Designee will re-educate the certified aides on shower schedules and preferences by	2/4/22

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F 677	Continued From page 3 conducted an interview with Resident #5. When asked if he receives showers, Resident #5 stated, "Rarely". On 1/6/22, a clinical record review was conducted. This review revealed from 12/8/21 through 1/6/22, Resident #5 only received bed baths. The clinical record revealed no indication that Resident #5 had refused a shower during this time frame. On 1/6/22, the facility staff provided the survey team with additional ADL (activities of daily living) records from 11/1/21 through 1/6/22. These records were reviewed and revealed that Resident #5 had not received a shower during this time, only bed baths were provided. Review of Resident #5's care plan revealed the following entry, "BATHING/SHOWERING: The resident requires max assist". There was no indication in the care plan that Resident #5 refused showers. On 1/6/22, interviews were conducted with CNA B and CNA D. Both reported that Residents are showered based upon a shower schedule. CNA's B and D stated that if Residents refused a shower it is documented in the ADL record. On 1/6/22, the shower schedule was received. This revealed that Resident #5 was scheduled to receive showers on the 3-11 PM, shift on Monday and Thursday of each week. Review of the facility policy titled, "Activities of Daily Living (ADLs), Supporting" read, "Appropriate care and services will be provided for residents who are unable to carry out ADLs	F 677	1/28/22. The unit manager shall review five shower schedules on wing 1, five on wing 2, weekly randomly to ensure showers are provided as scheduled/stipulated. The Unit managers will immediately address non-compliant issues as soon as possible. 4. Findings from the weekly reviews/audits shall be reported to QAPI committee meetings monthly for three months. 5. Completion date February 4. 2022	

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F 677	Continued From page 4 independently....including appropriate support and assistance with: a. Hygiene (bathing, dressing, grooming, and oral care)". A review of the facility policy titled "Bath, Shower/Tub" was conducted. This policy read, "The purposes of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin.....Documentation 1. The date and time the shower/tub bath was performed. 2. The name and title of the individual(s) who assisted the resident with the shower/tub bath....5. If the resident refused the shower/tub bath, the reason(s) why and the intervention taken". On 1/6/22, the facility Administrator was made aware of the concern that Resident #5 was not provided showers. No further information was received. Complaint related deficiency.	F 677		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving,	F 755		2/4/22

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F 755	Continued From page 5 dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on staff interviews, facility documentation review, clinical record review and in the course of a complaint investigation, the facility staff failed to administer medications due to a lack of availability, to one Resident (Resident #6) in a survey sample of 12 Residents. The findings included: On 1/5/22, Surveyor C conducted a clinical record review for Resident #6. This review revealed a physician order dated 12/24/21, that read, "Benztropine Mesylate Tablet 0.5 MG Give 1 tablet by mouth at bedtime for EPS" [extrapyramidal signs/muscle stiffness and rigidity]. Review of the MAR (medication administration	F 755	F 755: Pharmacy Services/Procedures/Pharmacist/Records 1. The unadministered medication Benztropine Mesylate tablet 0.5mg for resident # 6 cannot be corrected retroactively. 2. Current review of eMARS indicate no missed medication administration for all residents. 3. The Director of Nursing or Designee will re-educate licensed nurses on facility policy and procedures on medication administration by 1/28/22. The licensed nurse shall immediately notify the prescribing practitioner immediately for	

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F 755	Continued From page 6 record) revealed that Resident #6 did not receive this medication as prescribed until 12/27/21. Review of the nursing notes revealed no entries as to why Resident #6 did not receive the medication Benztropine tablets for 3 days. On 1/5/22 at approximately 3PM, Surveyor C accompanied by LPN F, conducted an observation of the medication availability for Resident #6. This review revealed that Resident #6's Benztropine was present in the medication cart and had 21 tablets remaining. The medication card indicated a pharmacy dispense date of 12/27/21. LPN F was unable to give any details as to when this medication had been ordered. On 1/5/22 in the afternoon, an interview was conducted with LPN B. LPN B indicated that medications can be ordered several ways and the pharmacy delivers daily. On 1/5/22, during an end of day meeting, the facility staff were made aware that Resident #6 had a delay in receiving medications as ordered. On 1/6/22 at 10:55 AM, an interview was conducted with LPN D. LPN D stated when orders are received the pharmacy delivers medications within 24 hours. When asked what is the process if a medication is not available she stated, "I would see if it is available in the Pyxis [emergency stock of medications], if not, I would call the provider and see if they want to hold it or give an order for something else". When asked why it is important for Residents to receive medications as ordered, LPN D said, "They have conditions that need it".	F 755	further directives when she or he realizes that a medication is not readily accessible/available. 4. The Director of Nursing or designee shall audit, randomly, electronic medication records (eMARs) of three residents per week for 3 months or until substantial compliance is achieved. Findings from the weekly eMARs audits shall be presented to QAPI committee meetings monthly for three months or until three consecutive months of no missed medication is achieve 5. Completion date February 4, 2022	

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F 755	Continued From page 7 On 1/6/22, Employee F, the Vice President of Operations confirmed that Resident #6 had a delay in medication administration due to the unavailability of medications. Employee F went on to state that the facility had ongoing issues with the pharmacy and were in the process of changing pharmacy providers in the near future. Review of the facility policy titled, "Administering Medications" was reviewed. This policy read, "...4. Medications are administered in accordance with prescriber orders, including any required time frame". No further information was received. Complaint related deficiency.	F 755		
F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility staff failed to obtain lab services for 1 Resident (Residents #3) in a survey sample of 12 residents.	F 770	F 770: Laboratory Services 1. The laboratory order for resident # 3 on 11-6-2021 for basic metabolic panel (BMP) cannot be retroactively corrected. The resident discharged to home on	2/4/22

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F 770	Continued From page 8 Findings included: For Resident #3, the facility staff failed to obtain a physician ordered BMP (Basic Metabolic Profile) blood specimen. Review of the clinical record revealed a physician's progress note ordering a BMP lab on 11-6-21. However, no specimen was ever obtained. Review of facility lab policy revealed the following; "1. The physician will identify and order...lab testing based on the resident's diagnostic and monitoring needs. 2. The staff will process requisitions and arrange for tests. 3. The laboratory ....or other testing source, will report test results to the facility." On 1-6-21 at approximately 2:31 p.m., the Administrator was asked for the BMP results for Resident #3, and she responded "We have no BMP for (name) this Resident." The Administrator and DON were notified of the staff failure to obtain a lab test ordered by a physician at the end of day meeting on 1-6-21. The Administrator stated that the expectation was that nurses would obtain labs as ordered by the physician. No further information was provided. COMPLAINT DEFICIENCY	F 770	11/9/21 before lab was obtained. 2. Current laboratory orders have been reviewed and processed accordingly. 3. The Director of Nursing or Designee will re-educate licensed nurses and unit managers to review laboratory order process from point of order to completion when results are obtained and communicated to the prescribing practitioner by 1/28/22. Unit managers shall audit laboratory requisition log five times a week from point of order to completion for three months. Any issues identified shall be corrected as soon as possible. 4. The Director of Nursing or Designee shall report their weekly summary reports to QAPI committee meetings monthly for three months. 5. Date of completion and compliance February 4, 2022.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		2/4/22

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F 880	Continued From page 9 §483.80 Infection Control 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:	F 880		

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F 880	Continued From page 10 (A) The type and duration of the isolation, depending upon the infectious agent or organism 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 observations, staff interviews, clinical record reviews and in the course of a complaint investigation the facility staff failed to implement infection control measures to prevent the spread of COVID-19 for 2 Residents (Resident #6, #7) in a survey sample of 12 Residents. The facility staff failed to provide signage to notify facility staff and any visitors of the identified Residents being on transmission based precautions, this lack of signage resulted in	F 880	F880: Infection Prevention & Control 1. On 1/6/2022 Signs were immediately posted on door of residents # 6 and & 7 to show type of infection and precautionary measures that must be adhered to upon entering and existing room. Isolation bins also placed near exit door of room to dispose of used gowns and gloves 2. The Infection Preventionist and team	

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F 880 Continued From page 11

facility staff providing direct Resident care without donning proper PPE to minimize the risk of exposure and/or spread of infection, specifically COVID-19.

The findings included:

On 1/5/22 at approximately 12:45 PM, Surveyor C conducted tour of the facility. During this tour no signage to indicate Residents #6 and #7 were on transmission based precautions was noted, nor was any PPE (personal protective equipment) located outside of the rooms. Surveyor C proceed to make direct observations and interactions with Resident #6 and Resident #7.

On 1/5/22 at approximately 3PM, Surveyor C again entered the room of Resident #7 to make additional observations. No signage was observed and no PPE (personal protective equipment) station was outside of the room. CNA B was in the room providing direct patient care to Resident #7. CNA B was observed to have on an N-95 mask (medical respirator) and eye protection.

On 1/6/22 at approximately 10 AM, Surveyor C again made observations and interviewed Resident #6 in her room. There was no signage to indicate Resident #6 was on isolation and no PPE was available outside of the room. Surveyor C exited the room and notified LPN F of a request Resident #6 had.

On 1/6/22 at 10 AM, LPN F was observed passing medications on the hall to Resident #7. LPN F was observed to have only an N-95 mask and eye protection on.

F 880

reviewed and verified all other residents on isolation precautions have proper signage in place.

3. The Infection Preventionist or Designee will re-educate licensed nurses to identify residents on infection precautions and process of obtaining and posting appropriate signs by 1/28/22. On a daily basis, the infection control practitioner (ICP) and or designee will review new and existing infections in the facility, and ensure that required infection control and precautionary signs are posted at strategic locations to educate and alert general staff and visitors

4. The Infection Preventionist or designee shall report findings from daily observations and reviews to QAPI committee meetings on monthly bases for three months.

5. Date of completion February 4, 2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495185	A. BUILDING ______ B. WING ______	C 01/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAVERLY REHABILITATION AND HEALTHCARE CENTER	456 E MAIN ST WAVERLY, VA 23890

(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
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On 1/6/22 at approximately 4:30 PM, during the course of a complaint investigation the facility staff identified and provided the survey team with physician orders for Resident #6 and Resident #7 stating they were on quarantine/TBP (transmission based precautions) due to a recent direct exposure to a COVID positive staff member. The physician orders read as follows:

* Resident #6 had an order dated 12/27/21, that read, "Maintain resident on enhanced droplet precautions d/t [due to] partial vaccinated status and potential exposure every shift for 14 days maintain resident on enhanced droplet precautions".

* Resident #7 had an order dated 12/27/21, that read, "Maintain resident on enhanced droplet precautions d/t partial vaccinated status and potential exposure every shift for 14 days maintain resident on enhanced droplet precautions".

On 1/6/22 at approximately 4:35 PM, Surveyors C and D again observed the rooms of Residents #6 and #7. There was no signage on the unit doors, which were open, no signs on the Resident room entry and no PPE observed outside of the rooms.

On 1/6/22 at approximately 4:40 PM, Surveyor D notified LPN C, the unit manager concerning Resident #6. LPN C then responded to Resident #6's room wearing an N-95 mask and eye protection. LPN C entered without donning any additional PPE, approached the bedside of Resident #6, interacted with the Resident and made adjustments to her bed. When LPN C exited the room she confirmed that the Residents on the hall were all on TBP. When asked why

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she had not donned [put on] an isolation gown and gloves, she said, "That's on me". When asked how staff would know the Residents were on TBP, LPN C said, "It's in the computer". LPN C confirmed that there was no signage present that would notify staff.

On 1/6/22 at approximately 4:40 PM, Surveyor C & D interviewed LPN F and CNA B. Both LPN F and CNA B confirmed they had been responsible for Residents #6 and #7 for the entire shift (since 7 AM) and had been providing direct Resident care to the Residents. Both staff stated that the Residents were not on TBP (transmission based precautions) that they were aware of and no one had told them otherwise.

On 1/6/22 at approximately 5 PM, the facility Administrator, VPO (Vice President of Operations) and LPN C were made aware of the concerns. The facility Administrator stated she knew signs had previously been in place and was unaware of why or when they were removed. LPN C, who is also the facility infection preventionist confirmed the facility follows CDC (Centers for Disease Control and Prevention) guidance.

Review of the facility policy titled "Isolation-Categories of Transmission-Based Precautions" read, "Transmission-Based Precautions are initiated when a resident develops signs and symptoms of a transmissible infection;... and is at risk of transmitting the infection to other residents...Droplet Precautions. 1. Droplet Precautions may be implemented for an individual documented or suspected to be infected with microorganisms transmitted by droplets that can be generated by the individual

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coughing, sneezing, talking, or by the performance of procedures such as suctioning....Gloves, gown and goggles should be worn if there is risk of spraying respiratory secretions".

The facility policy titled, "COVID Guidance for [company name redacted]" with a creation date of 9/14/21, was reviewed. It read, "Management of Residents with Close Contract of Higher Risk exposure: Unvaccinated residents with exposure will be placed on TBP/quarantine for 14 days following the exposure, regardless of test result...HCP [healthcare personnel] will wear full PPE when providing care for the resident (gown, gloves, eye protection, N95)".

CDC guidance titled "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes" read, "Manage Residents who had Close Contact with Someone with SARS-CoV-2 Infection. Unvaccinated residents who have had close contact with someone with SARS-CoV-2 infection should be placed in quarantine for 14 days after their exposure, even if viral testing is negative. HCP caring for them should use full PPE (gowns, gloves, eye protection, and N95 or higher-level respirator)". Accessed online at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html#anchor_1631030997450

CDC guidance titled, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic" was reviewed. It read, "1. Recommended routine infection prevention and control (IPC) practices during the COVID-19 pandemic...Ensure everyone is aware of

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F 880	Continued From page 15 recommended IPC practices in the facility. -Post visual alerts (e.g., signs, posters) at the entrance and in strategic places (e.g., waiting areas, elevators, cafeterias) with instructions about current IPC recommendations (e.g., when to use source control and perform hand hygiene). Dating these alerts can help ensure people know that they reflect current recommendations". Accessed online at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html No further information was provided.	F 880		