Electronically delivered
January 11, 2021

Administrator
Avera Morningside Heights Care Center
300 South Bruce Street
Marshall, MN 56258

RE: CCN: 245228
Cycle Start Date: December 1, 2021

Dear Administrator:

On December 15, 2020, we informed you of imposed enforcement remedies.

On December 28, 2020, the Minnesota Department(s) of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the survey findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 1, 2021, will remain in effect.

- Directed plan of correction, Federal regulations at 42 CFR § 488.424 Please see electronically attached documents for the DPOC.

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444).

You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 1, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 1, 2021.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new

admissions.

As we notified you in our letter of December 15, 2020, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 1, 2021.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program

Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, MN 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 1, 2021 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a

hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION/ INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

A Directed Plan of Correction (DPOC) is imposed in accordance with 42 CFR § 488.424. Your facility must include the following in their POC for the deficient practice cited at F880:

DIRECTED PLAN OF CORRECTION - Actively Screening Residents

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

POLICIES/PROCEDURES/SYSTEM CHANGES:

- The facility's Quality Assurance and Performance Improvement Committee must conduct a root cause analysis (RCA) to identify the problem(s) that resulted in this deficiency and develop intervention or corrective action plan to prevent recurrence.

The Infection Preventionist and Director of Nursing shall complete the following:

- Conduct active health screening and surveillance of residents upon admission and twice daily for fever (>100.0oF or subjective) and symptoms of COVID-19 (shortness of breath, new or change in cough, chills, sore throat, muscle aches).
- Develop and implement an infection sign and symptom tracking tool to monitor all residents for communicable, respiratory infection. All nursing leaders will be educated on how to use the tool.
- Group residents, or "cohorting," should be done when possible to separate residents with an infectious disease (positive residents) from residents who are not affected. Plans to cohort should be carefully established in advance and should be centered on implementation of infection control practices.
- Isolate and restrict incoming residents discharged from hospitals, or other facilities, to their room for 14 days and implement TBP when necessary.
- Assess newly admitted residents with respiratory symptoms that include cough, fever or shortness of breath for known exposure to a person with COVID-19 in the 14 days prior to illness onset, or recent admission to facilities with COVID-19 cases. Ask discharging facility whether diagnostic testing has been conducted for COVID-19.

TRAINING/EDUCATION:

- Guidance on the use of pulse oximetry is available from MDH: Pulse Oximetry and COVID-19: https://www.health.state.mn.us/diseases/coronavirus/hcp/pulseoximetry.pdf
- Remind residents to practice social distancing and perform frequent hand hygiene.
- Educate and assist the resident to utilize an appropriate mask to reduce droplet spread.

CDC RESOURCES:

Infection Control Guidance: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html
CDC: Isolation Precautions Guideline:
https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html

CDC: Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007): https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Personal Protective Equipment: https://www.cdc.gov/niosh/ppe/
Healthcare Infection Prevention and Control FAQs for COVID-19: https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control-faq.html

MDH RESOURCES:
Personal Protective Equipment (PPE) for Infection Control: https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/ppe/index.html
MDH Contingency Standards of Care for COVID-19: Personal Protective Equipment for Congregate Care Settings (PDF): https://www.health.state.mn.us/communities/ep/surge/crisis/ppegrid.pdf
Interim Guidance on Facemasks as a Source Control Measure (PDF): https://www.health.state.mn.us/diseases/coronavirus/hcp/maskssource.pdf
Interim Guidance on Alternative Facemasks (PDF): https://www.health.state.mn.us/diseases/coronavirus/hcp/masksalt.pdf
Aerosol-Generating Procedures and Patients with Suspected or Confirmed COVID-19 (PDF): https://www.health.state.mn.us/diseases/coronavirus/hcp/aerosol.pdf
Droplet Precautions: https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html
Airborne Precautions: https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html

MONITORING/AUDITING:
- Chart all clinical measurements and symptoms daily for each resident.
- Use cumulative data to conduct active surveillance. Record daily the number of residents that have been transferred to acute care, even for non-respiratory disease, by using a sheet like that in Appendix E. In some LTC facilities, an increasing number of transferred residents has preceded confirmation of COVID-19 in the facility.
- All residents positive for fever or symptoms should be isolated, placed under transmission-based precautions, and tested for COVID-19. Clinicians are encouraged to test for other causes of respiratory illness in addition to COVID-19.
- Conduct a RCA (root cause analysis) which will be done with assistance from the Infection Preventionist, Quality Assurance and Performance Improvement (QAPI) committee and Governing Body. The RCA should be incorporated into the intervention plan. Information regarding RCAs is available in the Guidance for Performing Root Cause Analysis (RCA) with Performance Improvement Projects (PIPs).

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/GuidanceforRCA.pdf

In accordance with 42 CFR § 488.402(f), the DPOC remedy is effective 15 calendar days from the date of the enforcement letter. The DPOC may be completed before or after that date. A revisit will not be approved prior to receipt of documentation confirming the DPOC was completed. To successfully complete the DPOC, the facility must provide all of the following documentation identified in the chart below.

Documentation must be uploaded as attachments through ePOC to ensure you have completed this remedy.

Imposition of this DPOC does not replace the requirement that the facility must submit a complete POC for all cited deficiencies (including F880) within 10 days after receipt of the Form CMS 2567.

Use this for IJ

Item	Checklist: Documents Required for Successful Completion of the Directed Plan
1	Consultant name and credentials meeting the criteria outlined above
2	Executed contract with the consultant
3	Documentation demonstrating that the RCA was completed as described above
4	List of facility policies and procedures reviewed by the consultant.
5	Infection control self-assessment
6	Summary of all changes as a result of the RCA and consultant review – to include a summary of how staff were notified and trained on the changes
7	Content of the trainings provided to staff to include a Syllabus, outline, or agenda as well as any training materials used and provided to staff during the training
8	Names and positions of all staff to be trained
9	Staff training sign-in sheets
10	Summary of staff training post-test results, to include facility actions in response to any failed post-tests
11	Summary of follow-up employee supervision and work performance appraisal to include when employees were observed, what actions were observed, and an evaluation of the effectiveness of any new policies and procedures.

Use this for Non-IJ

Item	Checklist: Documents Required for Successful Completion of the Directed Plan
1	Documentation of the RCA and intervention or corrective action plan based on the results with signatures of the QAA Committee members and members of the Governing Body
2	Documentation that the interventions or corrective action plan that resulted from the RCA was fully implemented
3	Content of the training provided to staff, including a syllabus, outline, or agenda, as well as any other materials used or provided to staff for the training
4	Names and positions of all staff that attended and took the trainings
5	Staff training sign-in sheets
6	Summary of staff training post-test results, to include facility actions in response to any failed post-tests
7	Documentation of efforts to monitor and track progress of the interventions or

	corrective action plan

In order to speed up our review, identify all submitted documents with the number in the “Item” column.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245228	A. BUILDING _____ B. WING _____	12/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MORNINGSIDE HEIGHTS CARE CENTER	**300 SOUTH BRUCE STREET MARSHALL, MN 56258**

(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 Infection Control survey was conducted on 12/28/20, at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.73(b)(6). The facility was IN full compliance Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control survey was conducted on 12/28/20, at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was determined NOT to be in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, a revisit of your facility will be conducted to validate substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		2/9/21

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

Electronically Signed | 01/21/2021

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 §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: (A) The type and duration of the isolation,	F 880		

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F 880	Continued From page 2 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 interview and document review, the facility failed to follow Centers for Disease Control (CDC) and Centers for Medicare and Medicaid Services (CMS) guidance for COVID-19 by implementing transmission based-precautions (TBP) when signs and symptoms of potential COVID or like illness were identified for 1 of 5 resident (R1). Findings include: R1's 12/28/20, face sheet identified an admission	F 880	On January 21th 2021 the QAPI team members met to conduct a RCA. The team reviewed residents' nursing notes and noted there continued to be gaps in documentation regarding symptoms, and the need to initiate and document the utilization of the appropriate level of PPE. The LTC COVID-19 policies and procedures for isolation were reviewed. Education for all nursing on documentation which occurred on a nursing staff meeting on January 20th,	

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F 880	Continued From page 3 date of 12/22/20, with diagnosis of subarachnoid hemorrhage (bleeding between brain and tissue covering brain), hypertension, stroke, pain, atrial fibrillation, rheumatoid arthritis, type 2 diabetes mellitus, history of pulmonary embolism, and repeated falls. R1 was on quarantine with no TBP identified. R1's progress notes and bowel records identified on 12/23/20 through 12/27/20, R1 had diarrhea daily. R1's 12/26/20, progress note dated identified licensed practical nurse (LPN)-A documented R1 had been having moderate to large amounts of mucus-like stools with odor and 4 diarrhea stools in the past 24 hours. LPN-A confirmed R1 was not on any bowel medications nor had been on any antibiotics. A notification was sent to the provider with orders received to obtain a stool sample for clostridium difficile colitis (C-Diff) toxin. The note lacked identification that TBP had been implemented upon identification of the bowel symptoms of COVID. Review of COVID screening record identified staff are to screen residents for sings and symptoms of cough, sore throat, new loss of taste/smell, shortness of breath, temperature over 100 or 2 temperatures over 99.0, nausea and vomiting, muscle aches, chills, diarrhea, headache, congestion, runny nose, and new onset of fatigue. R1's COVID screenings completed every 12 hours dated 12/23/20 through 12/26/20, and lacked identification of diarrhea or any TBP having been implemented. Observation on 12/28/20 at 9:40 a.m., of R1's room identified R1 had a small red stop sign on the door with the date 1/5/20, written on it. There	F 880	2021. A post education quiz was taken by nursing staff to review the comprehension of the subject matter. Going forward there will be additional education provided and audit results will be presented at the nursing staff meetings. The QA Committee developed a LTC Symptom Monitoring flow chart which will be used as guidance when a resident exhibits any symptoms possibly related to Covid-19 or any other infectious disease. There has been notation on the white board of any Covid-19 (+) residents and/or staff. Resident initials the date of the diagnosis as well as the isolation end date are kept on the white board. The IP nurse and the DON will meet weekly to review any infections and contact tracing to view if there are infections, and analyze data to see if there are any trends, such as cluster in one hall. Clusters are noted, there will be additional training and observation to ensure appropriate infection prevention practices are being performed. The nurses conduct active health screening and surveillance of residents upon admission and 2x daily following CDC's current guidance for Covid-19, as well as other infectious diseases. The nurses review the vitals every 12 hours to assess for any signs or symptoms which may be indicative of an infection. The MDS nurse audits – Covid-19 symptoms on the worklist; they are done Q12, to determine if they have s/s and if they triggered precautions. If they triggered precautions, documentation is reviewed and initiation of PPE signage	

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F 880	Continued From page 4 was no personal protective equipment (PPE) located outside R1's room or any other signs identifying TBP were implemented. Interview on 12/28/20 at 12:44 with the director of nursing (DON) identified the small red stop sign with the date indicated when R1's 14 day quarantine ended as a new admission. She confirmed there had been no documentation staff acted on the identified symptom of diarrhea and implemented TBP. She revealed that R1 had been positive for COVID-19 in November while at another facility so she would not be retested again for 90 days. The DON confirmed staff should have implemented TBP as a precautionary measure, until the cause of the symptoms were identified. Interview on 12/28/20 at 1:56 p.m. with infection preventionist (IP) identified staff should have implemented TBP when R1 was identified with loose stools, even though R1 had a previous history of COVID. Her expectation was if R1 had any suspected C-Diff or COVID-19 symptoms, TBP would be implemented immediately to prevent the spread of infection, that information documented, and sent to the IP for surveillance. Review of the 2020, COVID-19 Infection Prevention and Control policy made no mention of precautionary measures of TBP to be used when a resident had a history of the disease but was showing symptoms of potential infection.	F 880	and appropriate equipment is in place. There are random audits conducted 5 times a week on all four units. All new admissions are audited for stop signs on their doors, indicating, entrance is restricted and specified PPE must be in place before having contact with the resident. The end date of the quarantine is posted on the stop sign. The same auditing is done for all residents that test positive for Covid-19 as well. The start and end date will be noted as part of the auditing process.	