DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 28, 2020

Administrator
Gil-Mor Manor
96 Third Street East
Morgan, MN 56266

RE: CCN: 245594
Survey Start Date: April 28, 2020

Dear Administrator:

On June 16, 2020 the Minnesota Department(s) of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of April 30, 2020. Per the CMS Memo QSO-20-20-All, enforcement remedies were suspended from March 23, 2020 to May 31, 2020 and will be evaluated at a later date.

The CMS Region V Office may notify you of their determination regarding any remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Electronically delivered
May 13, 2020

Administrator
Gil-Mor Manor
96 Third Street East
Morgan, MN 56266

SUBJECT: SURVEY RESULTS
CCN: 245594
Cycle Start Date: April 28, 2020

Dear Administrator:

SUSPENSION OF SURVEY AND ENFORCEMENT ACTIVITIES

The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with Memorandum QSO-20-20-All, CMS is suspending certain Federal and State Survey Agency surveys, and delaying revisit surveys, for all certified provider and supplier types.

During this time, CMS is prioritizing and conducting only the following surveys: focused infection control surveys, investigations of complaints and facility-reported incidents that are triaged at the Immediate Jeopardy (IJ) level, and revisit surveys for unremoved IJ level deficiencies. With the exception of unremoved IJs, CMS will also be exercising enforcement discretion during the suspension period. For additional information on the prioritization of survey activities please visit https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0.

SURVEY RESULTS

On April 28, 2020, the Minnesota Department of Health completed a COVID-19 Focused Survey at Gil-Mor Manor to determine if your facility was in compliance with Federal requirements related to implementing proper infection prevention and control practices to prevent the development and transmission of COVID-19. The survey revealed that your facility was not in substantial compliance. The findings from this survey are documented on the electronically delivered CMS 2567.

PLAN OF CORRECTION

You must submit an acceptable electronic plan of correction (ePOC) for the enclosed deficiencies that were cited during the April 28, 2020 survey. Gil-Mor Manor may choose to delay submission of an ePOC until after the survey and enforcement suspensions have been lifted. The provider will have ten days from the date the suspensions are lifted to submit an ePOC. 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. Please note that if an onsite revisit is required, the revisit will be delayed until after survey and enforcement suspensions are lifted. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation.

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; and
- The date that each deficiency will be corrected.

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

Nicole Osterloh, Unit Supervisor
Minnesota Department of Health
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230 Cell: 218-340-3083

INFORMAL DISPUTE RESOLUTION

You have one opportunity to dispute the deficiencies cited on the April 28, 2020 survey through Informal Dispute Resolution (IDR) in accordance with 42 CFR § 488.331. To receive an IDR, send (1) your written request, (2) the specific deficiencies being disputed, (3) an explanation of why you are disputing those deficiencies, and (4) supporting documentation by fax or email to:

Nicole Osterloh, Unit Supervisor
Minnesota Department of Health
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230 Cell: 218-340-3083

An IDR may not be used to challenge any aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

An IDR, including any face-to-face meetings, constitutes an informal administrative process that in no way is to be construed as a formal evidentiary hearing. If you wish to be accompanied by counsel for your IDR, then you must indicate that in your written request for informal dispute resolution.

Gil-Mor Manor may choose to delay a request for an IDR until after the survey and enforcement suspensions have been lifted. The provider will have ten days from the date the suspensions are lifted to submit a request for an IDR in accordance with the instructions above.

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES

The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at https://qioprogram.org/. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at https://qioprogram.org/locate-your-qio.

Sincerely,

Kamala Fiske-Downing

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Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING _____ B. WING _____	04/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIL-MOR MANOR	96 THIRD STREET EAST MORGAN, MN 56266

(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 A COVID-19 Focused Infection Control survey was conducted on 4/28/20, 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	F 000		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §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	F 880		4/30/20

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

Electronically Signed | 05/21/2020

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 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 (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.	F 880		

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F 880	Continued From page 2 §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, and document review the facility failed to actively screening staff prior to entry and appropriately remove personal protective equipment (PPE) prior to exiting 1 of 1 resident (R1) room in accordance with Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control (CDC) guidelines for COVID-19. This had the potential to effect all 28 residents. Findings include: SCREENING Observation and interview on 4/28/20 at 8:40 a.m., with social services designee (SSD)-A and registered nurse (RN)-B identified SSD-A arrived for her shift that day. SSD-A entered through the first door wearing a source mask and proceeded to take her own temperature and complete her own risk assessment tool screening. SSD-A walked into the facility to her office and dropped her personal items off. SSD-A proceeded through a sittiing area and the dining room to the nurse's station. SSD-A handed her self-completed risk assessment to RN-B who reviewed her answers and placed the completed tool in a folder. RN-B would review the risk assessment tool for staff who brought it to the nurses' station to ensure	F 880	On April 28, 2020, Gil-Mor Manor initiated active screening for all employees and contract agency staff by those trained employees prior to entering the facility to prevent the spread of infection. Employees received education, training and demonstrated competency beginning on April 28 and completed on April 30, how to screen employees and contracted essential agency staff for signs and symptoms of COVID-19. In addition, education, training and competency demonstration was conducted for nursing and activities employees on how to screen, document and review resident screenings. All employees were notified of the change in actively screening of employees prior to entrance to the building in person, via email, posted at the front entrance, posted on employee information board, as well as put on the Gil-Mor Employee Facebook private site stating that employees can no longer screen themselves in the front entrance. Each employee will need to ring the doorbell and wait for the charge nurse, or a trained employee to come to	

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F 880	Continued From page 3 nothing was "concerning" and no further screening was required. SSD-A and RN-B identify that was the facility's usual practice. No staff were actively screened at the point of entry. Review of the undated Risk Assessment tool identified staff were to answer all questions: 1) What is your temperature? 2) Have you had a temperature 100 degrees Farenhight (F) or greater in last 24 hours. 3) Do you have a new cough? 4) Do you have new shortness of breath (SOB) and or chest tightness? 5) Do you have new respiratory symptoms that are not related to a previous diagnoses? 6) Have you had close contact with a person with suspected or confirmed COVID-19 within the last 14 days? 7) Have you visited an area with high incidence of COVID-19 within the last 14 days? 8) Have you traveled to a CDC restricted country within the last 14 days? 9) Have you had close contact with a person who has traveled to a CDC restricted country in the last 14 days? If you reply YES to any of the above risk factors or your temperature is greater than 99 degrees F, use the radio to be further assessed by staff prior to entry. Please turn into nurses station for evaluation when completed. Observation on 4/28/20 at 9:19 a.m., of the administrator-(A) identified after entering, The A completed her own risk assessment form, took her temperature, and walked through a sitting area by the entry on her way to her office to drop off her personal items. A proceeded through the sitting area and dining room to the nurse's station. The A handed RN-C her self-screening	F 880	the door to ACTIVELY SCREEN for temperature, signs and symptoms. There is NO EXCEPTION! On April 30, 2020, the facility Safety and Infection Control and Prevention Meeting was help and newly updated Active Screening Policy and Procedures were reviewed. Education and training has been completed for all staff to actively screen staff as well as the nursing and activity department were training to screen, document and review resident for signs and symptoms of COVID-19. Reviewed the updated don and doffing of PPE for the isolated resident which will be donned prior to entering the resident□s room and doffed in the room next to the bathroom that is attached to the isolated room. Signs were posted on April 28, 2020 to identify the proper areas and process. Auditing will be done weekly by the Director of Nursing or designee. Focus will be on 2 staff per shift each week, selected randomly. Director of Nursing will review audit results and information will be presented and reviewed at quarterly QAPI meetings to determine compliance and the need for further monitoring to ensure compliance. Plan of correction completion date is April 30, 2020 placing the facility in compliance. Updated policy and procedures are as follows;	

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F 880	Continued From page 4 form. RN-C then placed those results into a folder. The A was not actively screened at the point of entry. Observation on 4/28/20 at 9:35 a.m., of the North exit door identified signage was posted designating the entrance for contracted physical therapy (PT) and occupational therapy (OT) staff. A small platform stand was placed directly inside of the doorway. A thermometer, ear probes, pen, blank Risk Assessment tools, and two completed Risk Assessment tools sat on the platform. Of the two completed risk assessments, neither had been signed off by a witness. Interview on 4/28/20 at 9:41 a.m., with housekeeping staff (H)-A identified staff were to come into the facility wearing a source control mask. Once inside, staff were to take their own temperature, and fill out the COVID risk assessment tool questionnaire. They would then bring the tool to the nurse's station for the nurse on duty to review. If staff had a temperature above 99.5 or said yes to any of the questions, they were not to enter the facility. Staff were to use the walkie-talkie to call the nurse to the entrance for physical assessment of symptoms and or further examination of any questions answered yes. Review of the Resident Symptom Screeing for COVID-19 identified the forms had prefilled resident room and name, followed by slots to record tempurature, oxygen level, and the presence or absence of cough, SOB, sore throat, diarrhea and included a spot to ensure staff reminded residents to perform hand hygiene.The forms had been filled out twice per day for 4/21/20, 4/22/20, 4/23/20, 4/24/20 and 4/25/20 by	F 880	Active Screening Policy and Procedure All staff members and any contract agencies will be screened for signs/symptoms prior to entering the facility to prevent the spread of infection. 1. Staff members and contract agencies (hospice, clergy, therapy, etc.) will ring the doorbell outside the facility. They can then enter into the porch area and WAIT for the charge nurse, a trained CNA, or other trained staff to come to the door. 2. The staff member or contract agency staff□s temperature will be taken by the charge nurse, trained CNA, or other trained staff and all questions on the Staff Assessment tool will be completed. 3. If the staff member or contract agency staff has a temperature greater than 100.0 or has answered yes to any of the questions on the screening form, they will be sent home immediately and should be tested for COVID-19 prior to returning back to work. 4. If the staff member or contract agency staff is clear to work, they should clean all equipment in the porch area, sanitize their hands, ensure that their mask is worn appropriately, and report to work. 5. The charge nurse, CNA or trained staff should sign the form at the bottom indicating that they actively screened the staff member for s/s of COVID-19. The form should be brought to the nurse□s station and reviewed by the charge nurse. 6. Therapy staff entering the end of the west wing will call the facility prior to entering the facility. The charge nurse, a trained CNA, or other trained staff will actively screen the therapy staff and	

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F 880	Continued From page 5 activies staff. Those forms were not filled out in the same manner each time.Some staff placed check marks each of the boxes, some staff wrote "ok" at the top and drew a line down the page, connecting each resident. It was unclear if check marks identified the presence or absence of symptoms or what signs and symptoms would be abnormal and cause to immediately inform the nurse. Of those screenings, on: 1) 4/21/20, 4/22/20, and the 4/24/20 screenings were not signed off by the nurse until 4/27/20. 2) 4/26/20, no resident screening occurred and there was no mention licensed nursing staff ensured screeing occured that day. If any of the symptoms were present, licensed nursing staff were to be made aware immediately. The nurse would then evaluate if symptoms were explainable or suspicious for COVID. If symptoms were suspicious staff were to isolate the resident to their room, close the door, wear a mask, and call administration immediately for further instructions. Interview and docuement review on 4/28/20 at 10:00 a.m,, with RN-B identified resident screenings were completed by activities staff using the Screening for COVID-19 log and return to the nurse. Nurseing staff were to review and sign off to review each resident screening was completed. Nursing staff were to complete the resident screening if the activities staff had not. RN-B confirmed nursing had not always evaluated the forms that same day. On 4/26/20, resident screening had not been completed. RN-B was unaware who was to oversee the completion of the forms by activities or nursing staff. Interview on 4/28/20 at 10:00 a.m., with activities	F 880	follow steps 2-5 above. 7. This process will be audited daily by staff development, the director of nursing, MDS coordinator, or infection nurse to ensure that it is be completed correctly. Resident Screening Policy and Procedure Purpose: " To screen resident□s for signs and symptoms of COVID-19 " To identify signs and symptoms of COVID-19 " To keep the population safe Equipment: " Resident screening form " O2 saturation monitor " Thermometer " Disinfecting wipes Procedure 1. Each resident will be screened three times daily on each shift 2. Staff members that are completing the screening will be trained on how to accurately take a temperature, accurately take oxygen saturations, know what parameters are normal for temperature and O2 saturations and when to report abnormal reading to the charge nurse, and will be trained to identify symptoms in residents and report symptoms or abnormal findings to the charge nurse 3. The staff member will gather the following data in regards to symptoms. They will put yes or no in each to the symptom boxes	

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F 880	Continued From page 6 aide (AA)-B identified nursing staff had instructed her how to take resident temperature and oxygen saturations. Activities staff were to complete the resident assessments by taking the temperature and oxygen saturations and asking the residents the questions of cough, shortness of breath, sore throat, or diarrhea. She was to remind them to wash their hands and document on the Resident Symptom Screening for COVID-19 form and give to the nurse when completed. AA-B was to notify the nurse of any temp higher than 99.0 degrees F or oxygen saturations lower than 90%. Activities staff do not work every other sunday and failed to complete the screening on 4/26/20. There was no mention how the activities aide, although trained to take temperatures and oxygen levels, was able to assess residents for other potential signs and symptoms of COVID with no health background in assessment. Interview on 4/28/20 at 12:38 p.m., with AA-A identified activites staff were to complete the resident screenings. She had been trained how to take temperature and oxygen saturations at another facility. She completed the Resident Symptom Screening for COVID-19 form by taking the residnets temperature, oxygen saturations and asked the questions on the form. After completion of the form it was given to the licensed nurses. There was no mention how the activities aide, although trained to take temperatures and oxygen levels, was able to assess residents for other potential signs and symptoms of COVID with no health background in assessment. Interview on 4/28/20 at 1:28 p.m., with the DON identified she was unaware of what training had been provided to the activities staff regarding	F 880	" Temperature (anything greater than 100 will be reported to the Charge Nurse immediately) " O2 saturations " Cough " Shortness of breath " Sore throat " Diarrhea " Chills " Shaking " Muscle pain " Headache " New loss of taste or smell " Residents will be reminded to complete hand hygiene 4. The staff member will report any abnormal findings to the charge nurse immediately. Licensed nurse is to evaluate whether symptom(s) are explainable or are suspicious of COVID-19. If suspicious of COVID-19, isolate resident to room with closed door and mask on when around others in their room until directions are established. Call administration immediately for further guidance and directions. 5. If it is found that the resident has s/s of COVID-19, they will be tested within the facility. COVID-19 testing supplies are available at the Sleepy Eye Medical Center and once testing is complete can be delivered to Sleepy Medical Center lab for results. 6. It is the CHARGE NURSES responsibility to ensure completion of the form and to review all information. The	

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F 880	Continued From page 7 completion of the resident screening and was unaware of those staff holding any healthcare assessment background. The DON indicated activities staff knew how to take a resident's temperature or oxygen level and give the daily screening sheet to the nurses when completed. The DON was unaware there was no resident screening completed on 4/26/20 nor the 4/21/20, 4/22/20 and 4/24/20 screenings were not reviewed by a nurse until 4/27/20. Her expectation was resident screenings were to be completed by nursing staff if activities staff were unavailable to complete the screening. Nursing staff should have reviewed the screenings in a timely manner. She was unaware of a policy regarding the screening of the residents. Interview on 4/28/20 with RN-B infection preventionist identified she had trained the activities staff how to take a temperature and check oxygen saturations. This included waht temperatures and oxygen levels to report to the nurse. what symptoms to ask the residnets and remind the resident to perform hand hygiene. Licensed nurses were to review the forms right away and make sure the information was accurate and further assess if indicated. Nursing staff were to complete the resident screenings in the abcense of activities staff. Interview on 4/28/20 at 3:06 p.m., with the administrator identified she was unaware that no screening was completed on 4/26/20 or that the 4/21/20, 4/22/20 and 4/24/20 screenings were not reviewed by a nurse until 4/27/20. Her expectation was that it would be completed by nursing staff if activities staff were unavailable to complete the screening and licensed nurses would review the screenings in a timely manner.	F 880	charge nurse will sign the form after it is completed and reviewed. 7. Tasks can be delegated to other TRAINED staff but the NURSE MUST REVIEW AND SIGN THE FORM indicating that they have reviewed the form.	

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F 880	Continued From page 8	F 880		

Review of 4/9/20, About Coronavirus 2019 Update memo identified all staff were to monitor and be aware of COVID-19 symptoms. Those symptoms were fever, cough, SOB, muscle aches, headaches, sore throat, diarrhea and loss of taste or smell. All staff were to monitor and be aware of COVID-19 symptoms. Those symptoms were fever, cough, SOB, muscle aches, headaches, sore throat, diarrhea and loss of taste or smell. If staff had any of those symptoms, they were to notify the charge nurse or administrator immediately. A licensed nurse was to evaluate those symptoms. There was no indication those symptoms were updated on the above Risk Assessment Tool to potentially restrict staff and visitors who had those symptoms in accordance with CDC guidelines or have a licensed nurse evaluate for active screening as mentioned above.

Review of 4/20/20, Therapy Changes Policy and Procedure During COVID-19 identified PT and OT were to be actively screened by nursing staff prior to entrance to the facility. There was no mention how that process was to be audited for compliance.

PPE
Observation and interview on 4/28/20 at 10:00 a.m., of R1's room with PT-B identified PT-B had provided therapy to R1. R1 was on isolation precautions. Directly outside the room were bins for contaminated linen and trash. Without removing her PPE, (PT)-B exited R1's room wearing face mask, face shield, gown and gloves and the electronic stimulation machine (ESM). PT-B identified she had disinfected the ESM prior to removing it from the room. R1 was placed on

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	245594	A. BUILDING _____ B. WING _____	04/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIL-MOR MANOR	96 THIRD STREET EAST MORGAN, MN 56266

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quarantine status due to recent admission on 4/21/20. PPE was to be removed outside the room in the hallway and contaminated PPE placed in either the waste paper basket or bin marked "gowns". PT-A would enter the facility to begin her shift through the North door. PT-A performed her own self-assessment and laid the paper on the desk at that entrance. No facility staff actively screened PT-A.

R1's 4/27/20, admission Minimum Data Set (MDS) identified R1 was admitted to the facility on 4/21/20 after a hospital stay. R1 was placed on a 14 day isolation for potential exposure to COVID-19 in the hospital. R1 had no signs or symptoms of COVID-19 at that time.

Interview on 4/28/20 at 11:15 a.m., with registered nurse (RN)-B identified staff were to don PPE before entering R1's room and doff PPE outside of R1's doorway. A waste paper basket and a bin marked soiled gowns set right outside of R1's doorway in the hallway. RN-B identified she was responsible for training staff. She used CDC guidelines to train staff. RN-B was unaware CDC guidelines required PPE to be removed inside of the resident's room prior to exit. RN-B agreed removing PPE outside of an isolation room was not within CDC guidance.

Interview on 4/28/20 at 11:30 a.m., with nurse aide (NA)-A identified all facility staff entered through the front door. All other doors were to be locked from the outside. R1's room was located close to the North door. PT and OT entered the facility through the North entrance located close to R1's room. PT and OT are the only persons allowed to enter through a separate door as R1 was quarantined in that area of the facility.

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F 880	Continued From page 10 Interview on 4/28/20 at 1:27 p.m., with director of nursing (DON) identified designated entrance for OT and PT was the North entrance. OT and PT were instructed to take their own temperatures and complete a Risk Assessment form. The DON agreed PT and OT were not actively screened prior to entering the building. All staff were expected to self-assess signs and symptoms of COVID-19. If staff answered yes to any questions on the Risk Assessment Tool, they were to call the nurse via walkie-talkie to actively assess them at that time. The DON agreed self-assessment was not active screening. Interview on 4/28/20 at 3:06 p.m., with the A identified her expectation was when therapy arrived at the facility they were to be screened prior to entrance by facility staff. PT and OT were to notify staff to screen them upon arrival. She was unaware PPE was removed inappropriately outside of R1's room. The A explained R1 was in a secluded hallway, therefore, removing PPE in the hallway was not of concern. The A was unaware active screening for all staff or visitors was required by CDC and CMS to occur prior to entrance to the facility. Review of undated, How to Safely Remove PPE equipment identified all PPE was to be removed prior to exiting the patient room. Review of 4/9/20, About Coronavirus 2019 Update memo Staff were to take time to familiarize themselves with proper donning and doffing of PPE. That was noted to be a "critical aspect of infection control and prevention". There was no mention in the update staff were to receive hands on training to ensure they donned	F 880		

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F 880	Continued From page 11 or doffed PPE appropriately, or had followed CDC guidance with placement of waste receptacles for PPE and linen to be inside the patient room.	F 880		