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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CENTER OF MARION	6434 A DALE DR MARION, MS 39342

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F 000	INITIAL COMMENTS	F 000		

The State Agency (SA) conducted a COVID-19 Focused Survey for Nursing Homes at the facility from 11/09/2020 to 11/13/2020. During the survey, the SA determined the facility was not in compliance with the requirements of participation for Medicare and Medicaid. The facility was not following Infection Control safety practices in guidance recommended by the Centers for Medicare and Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC) during the COVID-19 pandemic. The SA cited the regulation F880.

The SA identified an Immediate Jeopardy (IJ) on 11/10/2020, and determined the IJ existed on 11/07/2020, with the death of Resident #49, a resident who had not left the building, whose death was due to or as a result of COVID-19. The facility had a total number of 32 positive COVID-19 residents out of a total census of 90 in the building at the time of the survey and has had one (1) positive COVID-19 resident death. The facility has had a total of 32 positive COVID-19 and 25 positive COVID-19 staff members. The facility is licensed for 120 beds.

On 11/10/20, at 3:15 PM, the SA notified the facility of an Immediate Jeopardy (IJ) due to the facilities failure to follow the Centers for Disease Control (CDC) and Centers for Medicare & Medicaid Services (CMS) guidelines for infection control practices during the COVID-19 pandemic. The facility failed to follow infection control guidelines to prevent the spread of COVID-19 due to failure to change Personal Protective Equipment (PPE) gown upon entering and exiting positive and negative COVID-19 resident rooms,

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

Electronically Signed | 12/16/2020

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F 000	Continued From page 1 and failure to provide a biohazard barrel to dispose of doffed Personal Protective Equipment (PPE). The failure to change PPE between entering and exiting positive and negative COVID-19 resident rooms and not providing a biohazard barrel to dispose PPE placed all the residents in the building in a situation to cause serious injury, harm, impairment, or death. The SA determined the Immediate Jeopardy (IJ) existed at: 42CFR(s): 483.80(a)(1)(2)(4)(e)(f) Infection Control(F880) at a scope and severity of a "K". The facility submitted an Acceptable Immediate Jeopardy Removal Plan, on 11/12/2020, in which the facility alleged all corrective actions were completed on 11/11/2020, and IJ removed on 11/12/2020. The SA validated the facility's Immediate Jeopardy Removal Plan on 11/13/2020 and determined the IJ was removed on 11/12/2020 prior to exit on 11/13/2020. Therefore the scope and severity for 42 CFR (s):483.80(a)(1)(2)(4)(e)(f) Infection Control (F880) was lowered from "K" to a scope and severity of a "E", while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements.	F 000		
F 880 SS=K	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	F 880		12/16/20

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F 880	Continued From page 2	F 880		

development and transmission of communicable diseases and infections.

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

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

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

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F 880	Continued From page 3 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to follow COVID-19 infection control guidelines to prevent the spread of the COVID-19 virus which likely led to the death of one (1) resident (Resident #49) who had not been outside the facility and failed to prevent the possible spread of the COVID-19 virus between positive and negative COVID-19 residents for Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12 and #13, as evidenced by the facility's failure to change Person Protective Equipment (PPE) between positive and negative COVID-19 residents rooms. The facility also failed to provide a biohazard barrel to dispose of doffed PPE at the exit door. The facility census at the time of survey was 90 residents.	F 880	F000 - The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies nor the reported conversations and other information cited in support of the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitiutes the centers allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicatied.	

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F 880	Continued From page 4 On 11/09/2020, the State Agency (SA) surveyor observed facility staff failing to change PPE when between entering positive and negative resident rooms wearing the same PPE. Record review revealed the facility had one resident death due to (1) COVID-19. The facility's failure to follow appropriate COVID-19 infection control guidelines for not changing PPE between positive and negative residents and not providing a biohazard barrel for doffed PPE has caused, or likely to cause serious injury, harm, impairment or death to residents who tested positive for the COVID-19 virus while residing solely in the facility. The Immediate Jeopardy (IJ) was determined to exist at a scope and severity of a "K" on 11/7/2020, at the time of Resident #49's death and affected 32 COVID-19 positive residents. The SA notified the facility of the IJ on 11/10/2020 related to the death of the COVID-19 positive resident and provided the facility the IJ template for Infection Control F880 at 42 CFR(s): 483.80(a)(1)(2)(4)(e)(f). The facility provided a Removal Plan stating the facility completed all actions for removal as of 11/11/2020 and the IJ was removed on 11/12/2020. The SA validated on 11/13/2020 prior to exit that the facility actions were completed and the IJ was removed as of 11/12/2020 and the scope was lowered to an "E" for F880. Findings include: Review of the facility's policy titled, "Coronavirus Disease (COVID-19) - Infection Prevention and	F 880	F880 - 1. On 11/09/2020, Fifty-Five (55) asymptomatic residents were screened, assessd and tested for COVID-19. 3 residents tested positive and were moved to the COVID Unit. On 11/10/2020, Sixty-four (64) asymptomatic staff were screened, assessed, and tested for COVID 19. Six (6) staff tested postive and were sent home to quarantine. On 11/10/2020, at approximately 4:00 PM, biohazard barrels were placed on halls 600, 800, and 500. At approximately 7:30 PM, signage was placed identifying the location of COVID-19 positive residents. On 11/10/2020, training was initiated by the Staff Development Registered Nurse (RN) employed by another facility entitled Donning/Doffing of PPE to include appropriate disposal in biohazard waste bins, appropriate sequencing of PPE, and proper changing of PPE between positive COVID-19 Residents and COVID-19 negative Residents. No staff were allowed to work prior to being trained on Donning/Doffing of PPE to include appropriate disposal in biohazard waste bins, appropriate sequencing of PPE, and proper changing of PPE between positive COVID-19 Residents and COVID-19 negative Residents. 2. All residents could have potential exposure to COVID-19. 3. All employees have been educated on Donning and Doffing PPE correctly by the Staff Development Registered Nurse and the Corporate Training and Development Coordinator.	

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F 880	Continued From page 5 Control Measures", revised 9/20/20, revealed, "Policy Statement: This facility follows recommended standard and transmission-based precautions, environmental cleaning and social distancing practices to prevent the transmission of COVID-19...7. Standard precautions are utilized when caring for all residents...12. For a resident with known or suspected COVID-19: a. Staff wear gloves, isolation gown, eye protection and an N 95 or higher-level respirator if available...and b. Resident is placed in a private room with a dedicated bathroom (if available) and close the door... Contact and droplet precautions are implemented for any residents with symptoms of respiratory infection. Current CDC guidelines will be followed for infection prevention and control of residents diagnosed with COVID-19." Review of the facility's policy titled, "Infection Prevention and Control Program", revised 10/2018, revealed, "An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections." Review of the facility 700 Hall resident list revealed the residents were last tested on 11/5/20. The resident's results were negative. Review electronically of the National Healthcare Safety Network (NHSN) facility report revealed 32 positive residents were housed on 500, 600 and 800 halls. Review of the facility's employee spread sheet revealed 25 positive staff members. Five (5) staff recovered and returned to work.	F 880	11/13/2020 and on-going. Maintenance Director was educated by the Administrator on placing the red biohazzard barrels at exit door of isolation areas. Director of Maintenance educated the Housekeeping and Maintenance staff on placing red biohazard barrels at exit door of isolation areas. 11/10/2020 On December 15, 2020, a Directed In-Service for all staff was conducted by an Infection Preventionist from another facility. The in-service was on prinicples of transmission-based precautions, hand hygiene, standard precautions, and infection prevention and control. Clean Red Barrels will be stored inside the building for after-hours access. Staff has been educated on the location of the Red Barrels and proper use. December 21, 2020. 4. Observation audits have been instituted on November 15, 2020, and are being conducted by the Director of Nursing, Staff Development Registered Nurse, or Resident Care Coordinator to ensure adherence of transmission based precautions are followed with Donning and Doffing PPE by staff and to ensure biohazard barrels are placed at exit doors of isolation areas. These observations will be daily times two (2) weeks, then will continue four (4) times per week for three (3) weeks then weekly for ten (10)weeks or until the outbreak has ended. 12/15/2020 and on-going. The Resident Care Coordinators will bring the results of	

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F 880	Continued From page 6 During an interview on 11/9/2020, at 10:00 AM, with the Administrator (ADM) confirmed the facility had 32 COVID-19 positive resident cases in the building. The facility also has 25 positive staff cases. The ADM confirmed Dogwood is the designated unit which houses the positive residents. An observation of COVID-19 Unit on 11/9/2020, at 10:45 AM, revealed the unit is closed and is referred to as Dogwood Unit. The unit consisted of four halls; 500, 600 and 800 halls for positive residents and the 700 hall for negative residents. The staff on the Dogwood Unit were dressed in full PPE and were screened upon entrance. The staff donned PPE at the door while entering the unit. Dogwood Unit did not have a red barrel close to the door to doff PPE. Observation revealed staff wearing the same PPE when caring for both positive and negative residents. Record review the electronic NHSN facility report and Admission Record revealed Resident #22 residing in room 606-A tested positive for COVID-19 on 11/1/2020. An observation on 11/9/2020 at 10:30 AM, revealed the Physical Therapist Assistant (PTA) removing PPE in the soiled utility room. The PTA did not put on clean PPE. The PTA then went to an open area of the COVID-19 positive unit documenting on his personal laptop computer without wearing any PPE. There were residents roaming up and down the COVID-19 halls. Resident #22 who tested positive was confused and sitting in the open area rolling around in her wheelchair.	F 880	the Infection Control Round Observations to the monthly Quality Assurance Committee for review, recommendations for any changes and compliance. 12/16/2020 and on-going.	

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During an interview on 11/10/2020, at 1:35 PM, with the PTA confirmed he removed his PPE in the soiled utility room. The PTA confirmed he failed to put on new PPE while he was charting on the computer. The PTA said he did not know he needed to continue to wear his PPE in the open area and confirmed he walk down a hall with positive residents before leaving the building without PPE. The PTA stated he was not in-serviced on when to wear PPE.

Observation on 11/9/2020, at 10:45 AM, revealed Resident #22 continued to be confused and rolled in and out of resident's rooms on the 700 hall which housed negative residents. Registered Nurse (RN) #3 observed the resident and removed the resident from room 704 then assisted Resident #22 to the center of the hall to watch television.

An observation on 11/9/2020, at 11:00 AM, revealed RN #2 answered call light in room 706 (negative room) after passing medications on the 600 halls with positive residents. RN #2 did not change her PPE between rooms.

An observation on 11/9/2020, at 11:00 AM, revealed Resident #22 continued to roam around the 700 Hall containing negative residents. Resident entered rooms #701, #703, #706 and #710. The resident was re-directed by Certified Nurse Assistant (CNA) #1. Resident #22 was again rolled to the open area of the unit to watch the television.

An observation on 11/9/2020 at 12:00 PM revealed CNA #3 and CNA #4 passed out and picked up trays to the residents on the 700 hall which housed negative residents and 800 hall

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which house positive residents without changing their PPE. Observation also revealed CNA #1 passing out trays on the 600 Hall, 700 Hall, and 800 Hall. The SA observed CNA #1 passing out and picking up trays on the negative hall after passing out trays on the positive halls. CNA #1 did not change his PPE.

During an interview on 11/10/2020, at 1:30 PM, CNA #1 revealed he's responsible for providing care to all the men on Dogwood Unit. CNA #1 said he works on all the halls of the unit. CNA #1 said he did not know the residents were negative on the 700 halls. CNA #1 confirmed he wore the same PPE to provide care for the positive and negative residents. CNA #1 confirmed he removed his PPE at the end of his shift in the soil utility room. CNA #1 confirmed he walked down the positive hall without PPE to go out the back door.

An observation on 11/9/2020, at 12:15 PM, revealed CNA #3 feeding resident in room 710-A. CNA #3 did not change her PPE prior to entering the residents' room. CNA #3 had just finish providing care for residents on the positive halls.

During an interview on 11/10/2020 at 2:15 PM with CNA #3 confirmed she did not know the residents on the 700 Hall is negative. She was told all the residents on the Dogwood unit were positive. CNA #3 also confirmed she wore her same PPE for the whole day except if she got it soiled or when she left the building. CNA #3 confirmed she assisted a resident in room 710A with her lunch and did not change her PPE. CNA #3 acknowledged that due to her not changing her PPE, a resident could become COVID-19 positive.

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On 11/9/2020, at 1:00 PM, upon the State Agency (SA) asking RN #1 where the staff normally removed and placed soiled PPE, RN #1 tied a red biohazard bag on the handrail in the hall. The facility did not have a red barrel for dirty PPE.

On 11/10/2020, at 12:00 PM, observation revealed CNA #6 passing out trays to positive and negative residents without changing her PPE. CNA #6 also picked up trays from positive and negative rooms without changing PPE.

During an interview on 11/10/2020, at 2:30 PM, with CNA #6, the CNA confirmed she did not know the residents on the 700 halls were negative residents. CNA #6 said she was told all the residents on Dogwood Unit were positive. CNA #6 also confirmed she wore the same PPE the whole day except when it got soiled or when she left the building. CNA #6 confirmed she doffed her PPE in the soiled utility room and walked down the positive hall with positive residents to go out the back door of the facility. CNA #6 said she don't' know what happened to the red barrel.

Observation on 11/10/2020, at 12:00 PM, revealed CNA #5 passing out trays to the positive and negative residents without changing her PPE. CNA #5 also picked up trays from positive and negative rooms without changing PPE.

During an interview on 11/10/2020, at 2:45 PM, with CNA #5 confirmed she did not know the resident on the 700 halls were negative residents. CNA #5 said she was confused. She thought all the residents on Dogwood Unit were positive. CNA #5 confirmed she wore the same PPE to

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take care of positive and negative residents. CNA #5 said she took off PPE and placed it in a garbage can that was available. She doesn't know what happen to the red barrels.

Observation on 11/10/2020, at 12:20 PM, of RN #3's medication cart garbage can revealed several soiled gowns and shoe covers.

During an interview on 11/10/2020, at 12:30 PM, with RN #3 confirmed she takes her PPE off and puts it in her garbage can on her cart. She doesn't know what happened to the red barrels that the facility had at one time.

During an interview on 11/10/2020, at 2:00 PM with RN #2, the Infection Preventionist, revealed the nurse had done the Infection Preventionist training. RN #2 confirmed 32 positive residents and 25 positive staff for the facility. RN #2 said because a lot of staff has tested positive for COVID-19, she has had to work the floor passing medication. RN #2 confirmed the staff was not in-serviced on the negative and positive residents. RN #2 said she thought the staff knew which residents were positive and negative. RN #2 also confirmed she failed to change her PPE after giving medication to residents on the 600 halls (positive residents) and before answering a call light for room # 706 (a negative resident). RN #2 said she did not know what she was thinking. RN #2 said at one time the 700 hall doors were closed to separate the negative residents from the positive residents. RN #2 said she did not know why the doors were opened. RN #2 also confirmed the facility failed to have red barrels at the back door to doff their PPE. RN #2 said she don't know what happened to the barrels. RN #2 confirmed it is not the facility's policy to tie the red

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biohazard bags on the handrails in the hallway. RN #2 said she did not know where the barrels were, so she tied the biohazard bag on the handrail.

During an interview, on 11/10/2020, at 3:00 PM, the Medical Director (MD) confirmed the facility had an outbreak of COVID-19 positive residents in October 2020. The MD said he did not know how the outbreak started. The MD said he believed it started with an employee. The MD said he did not know the facility staff were not observing standard precautions and were wearing the same PPE to take care of positive and negative residents. The MD confirmed that practice could cause the negative residents to test positive. The MD said he believed that because so many staff members had tested positive, this required the staff to work extra days which caused them to make poor decisions.

During an interview on 11/10/2020, at 3:10 PM, the Director of Nurses (DON) confirmed as of 11/9/2020, the facility had 32 positive COVID-19 residents in the building. The DON said the facility also had 25 COVID-19 positive staff. On October 22, 2020 when the facility tested the staff, three staff members tested positive. The residents were tested on 10/26/20, one resident tested positive. The DON said all the staff has been in-serviced on donning and doffing PPE. The DON confirmed the staff failed to follow the facility policy by not doffing PPE in a red biohazard barrel. The DON also said the double doors to the 700 Hall that housed negative residents should have been closed. The DON confirmed the staff failed to follow the facility policy by wearing the same PPE in positive and negative residents' rooms. The DON said the negative residents

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could become positive because the staff failed to change their PPE from positive to negative residents.

During an interview on 11/11/20, at 4:00 PM, the Administrator (ADM) confirmed as of 11/9/2020, the facility has 32 positive COVID-19 residents and 25 positive staff. The ADM said the residents and staff are tested every 3 to 7 days. The ADM said she documents the positive residents and staff members on her calendar. The ADM confirmed the facility did not have red barrels in the building. The ADM revealed the maintenance personnel was out with COVID-19. The ADM said she did not know the red biohazard barrels were not in the building because she had not been on the COVID-19 unit. The ADM also said she did not know that staff were wearing the same PPE for negative and positive residents. The ADM confirmed one (1) resident died at the hospital related to COVID-19. The Administrator also confirmed on 11/11/2020 two (2) of 13 residents converted from negative to positive status Resident #12 and Resident #13.

Record review of the facility's Admission Record for Resident #49, revealed he was admitted to the facility on 10/17/2013, with the included diagnoses of Diabetes Mellitus, Hypertension and Osteomyelitis. Resident #49 resided on the 800 halls. Resident #49 tested positive for COVID-19 on 10/28/2020. Resident #49 transferred to the hospital on 10/28/2020, where he expired on 11/7/2020.

Record review of the facility's Admission Record for Resident # 12, revealed Resident #12 was admitted 1/20/2010 with the included diagnoses of psychosis, diabetes Mellitus and Atrial

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Fibrillation. Resident #12 resides on the 700 halls. Resident #12 converted to positive status on 11/11/2020. Resident was removed to the positive hall.

Record review of the facility's Admission Record for Resident # 13, revealed Resident #13 was admitted 5/19/2015 with the included diagnoses of Kidney Failure, Hypertension and Chronic Obstructive Pulmonary Disease. Resident #13 resides on the 700 halls. Resident #13 converted to positive status on 11/11/2020. Resident was removed to the positive hall.

The facility submitted an acceptable Immediate Jeopardy (IJ) Removal Plan on 11/12/2020. Review of the Removal Plan revealed the facility took the following actions to remove the immediate Jeopardy:

1. The facility was informed by the State Agency of the Immediate Jeopardy (IJ) at 3:15 PM on 11/10/2020, related to the facility's failure to follow infection control practices per the Centers for Disease Control and Prevention (CDC) guidelines. The facility failed to provide a biohazard barrel to dispose of doffed Personal Protective Equipment (PPE), and failed to change PPE from a positive COVID-19 Resident to a COVID-19 negative Resident, (going from room to room). The facility is licensed for 120 beds and had a census of 91 on 11/9/2020. Census breakdown is:

Dogwood Unit:
Hall 700 - total Residents 13 /13 COVID-19 negative Residents
Hall 600 - total Residents 20/18 COVID-19

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F 880	Continued From page 14 positive Residents and 2 COVID-19 negative Residents Hall 800 - total Residents 14/14 COVID-19 positive Residents Hall 500 - total Residents 4/1 COVID-19 negative Resident, 2 COVID-19 recovered Residents, 1 COVID-19 positive Resident Magnolia Unit - total Residents 40/40 COVID-19 negative Residents 2. A Quality Assurance (QA) meeting was conducted on 11/10/20, at approximately 4:40 PM. Attendees included the Medical Director, Administrator, Director of Nursing, Nurse Practitioner, Resident Care Coordinator/Registered Nurse/Infection Preventionist, Activities Director, Social Service Director, Corporate Registered Nurse, Director of Long Term Care Operations, Corporate Training and Development Coordinator to discuss the following findings: a.) The failure of employees to change Personal Protective Equipment (PPE) when going from a positive COVID-19 resident care area to a negative COVID-19 resident care area and b.) The failure of the facility to maintain the appropriate placement of biohazard waste bins at the exits of the COVID-19 units. The committee recommended training for all staff related to CDC Guidelines for COVID-19 regarding Donning and Doffing of PPE to include disposal in designated biohazard waste bins, appropriate sequencing of PPE, and proper changing of PPE between positive COVID-19 Residents and COVID-19 negative Residents. Recommendations were made to follow the policies and procedures of Donning/Doffing PPE.	F 880		

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3. As of 11/11/2020, Care Plans of 33 COVID-19 positive Residents were reviewed and updated by Licensed Practical Nurse/MDS Nurse #1 related to COVID-19 problems and interventions.

4. On 11/10/2020, at approximately 4:00 PM, biohazard barrels were placed on halls 600, 800 and 500. At approximately 7:30 PM, signage was placed identifying the location of COVID-19 positive residents. On 11/10/2020, training was initiated by the Staff Development Registered Nurse (RN) employed by another facility entitled Donning/Doffing of PPE to include appropriate disposal in biohazard waste bins, appropriate sequencing of PPE, and proper changing of PPE between positive COVID-19 Residents and COVID-19 negative Residents. The following employees received this in-service:
one (1) of one (1) Administrator
one (1) of one (1) Central Supply
nineteen (19) of forty-three (43) Certified Nursing Assistants
eight (8) of twelve (12) Dietary
five (5) of thirty-five (35) Licensed Practical Nurses
five (5) of fifteen (15) Registered Nurse
one (1) of one (1) Resident Care Coordinator/Registered Nurse/Infection Preventionist
two (2) of three (3) Social Service
one (1) of one (1) Director of Nursing
one (1) of one (1) Medical Records
two (2) of three (3) Activity
two (2) of four (4) Clerical
one (1) of three (3) Laundry
two (2) of eight (8) Housekeeping
No staff members will be allowed to work until they have been trained on Donning/Doffing of

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PPE to include appropriate disposal in biohazard waste bins, appropriate sequencing of PPE, and proper changing of PPE between positive COVID-19 Residents and COVID-19 negative Residents.

5. Fifty-five (55) asymptomatic Residents were screened, assessed, and tested for COVID-19 on 11/09/2020. Fifty-two (52) Residents were negative. Resident #23, Resident #40, and Resident #24 were positive and moved to the COVID-19 Unit. Sixty-four (64) asymptomatic staff were screened, assessed, and tested for COVID-19 on 11/10/2020. Fifty-eight (58) staff were negative. Six (6) staff were positive and sent home to quarantine. Thirteen (13) asymptomatic Residents residing on 700 Hall were screened, assessed, and tested for COVID-19 on 11/11/2020. Results were ten (10) out of twelve (12) Residents were negative for COVID-19. One (1) 700 Hall Resident, Resident #10, was at the hospital at the time of testing and tested negative at the hospital. Resident #13 and Resident #12 were moved to the COVID-19 Unit.

6. The facility alleges that the Immediate Jeopardy was removed on 11/12/2020.

The State Agency (SA) validated the facility's Immediate Jeopardy Removal Plan through observation, interview, record review and review of sign-in-sheets 11/13/2020.

1. The SA validated through observations that no further issues were observed regarding staff not changing PPE when exiting COVID-19 positive residents' rooms on the 700 Hall.

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2. The SA validated through interviews and review of the facility's in-service sign-in sheets that in-service education was provided by the facility to all the staff in the form of lectures and films.

3. The SA validated through Observation and interviews the facility placed red biohazard barrels at the exit doors to doff PPE.

4. The SA validated through record review that all residents in the facility were assessed for signs and symptoms of COVID-19.

5. The SA validated a Quality Assessment and Assurance Committee meeting was held on Tuesday, November 10, 2020 by interview of persons who attended and review of sign in sheets.

6. The SA validated facility wide testing for staff and residents was done on 10/22/2020, 10/28/2020, 11/05/2020 and 11/11/2020.

7. The SA validated that all the facility's IJ Removal Plan's corrective actions were completed and the IJ was removed as of 11/12/2020, and validated by the SA's exit on 11/13/2020.