STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125058	A. BUILDING _____ B. WING _____	10/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YUKIO OKUTSU STATE VETERANS HOME	1180 WAIANUENUE AVENUE HILO, HI 96720

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F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was conducted by the State Survey Agency (SA) Office of Health Care Assurance (OHCA) from 09/09/20 to 10/16/20. The facility was found not to be in substantial compliance with 42 CFR 483.80 Infection Control regulations and has not implemented the Centers for Medicare and Medicaid Services (CMS) and Centers for Disease and Prevention (CDC) recommended practices to prepare for COVID-19. Survey dates: 09/10/20 to 10/16/20 Census: 72 On 10/16/20 a teleconference exit with the facility's Administrator, Director of Nursing (DON), and Regional Nurse Consultant (RNC)2 were notified of an Immediate Jeopardy at F880 Infection Control. The IJ was identified on 08/20/20. The IJ is ongoing. The facility failed to control/manage a spread of COVID 19 among residents and staff in the facility as evidenced by the following: 1. The facility failed to adequately screen employees for exposure to COVID-19. 2. The facility failed to respond timely to an outbreak when they failed to implement precautions for 2 days after becoming aware of the outbreak for Residents (R)2, 3, 4, 5, 6, 7, and 8. Additionally, they failed to adequately contact trace residents and staff exposed to suspected and COVID-19 positive cases, and failed to implement work restrictions for Maintenance Staff (MS)3.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/19/2020

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 SS=J	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 and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		10/19/20

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F 880	Continued From page 2 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to help identify and prevent the transmission of COVID-19. Additionally, the facility failed to follow the Centers for Medicare and Medicaid Services (CMS) and the Center for Disease Control and Prevention (CDC) recommendations and guidelines for COVID-19. These deficient practices are evidenced by the following: 1.The facility failed to adequately screen	F 880	Yukio Okutsu State Veterans Home. This plan of correction constitutes the facility's allegation of compliance for the deficiencies cited in the CMS 2567. However, the submission of this plan is not an admission that a deficiency exists. The plan of correction is prepared solely because it is required by federal and state law. This response and plan of correction does not constitute and admission or agreement by the provider of the facts	

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F 880	Continued From page 3 employees for exposure to COVID-19. 2.The facility failed to respond timely to an outbreak when they failed to implement precautions for 2 days after becoming aware of the outbreak for Residents (R)2, 3, 4, 5, 6, 7, and 8. Additionally, they failed to adequately contact trace residents and staff exposed to suspected and COVID-19 positive cases, and failed to implement work restrictions for Maintenance Staff (MS)3. 3.Medical Doctor (MD)2 and Licensed Practical Nurse (LPN)2 failed to adhere to national standards for Personal Protective Equipment (PPE) usage and hand hygiene. These failed practices contributed to the outbreak in the facility. As of 9/4/20, this included 51 residents and 17 employees testing positive for COVID-19. As of 09/30/20 there were 19 deaths in the facility, seven (7) resident deaths in the hospital, for a total of 26 deaths, and the outbreak was on-going. Findings include: 1) Upon initial arrival at the facility on 09/09/20 at 08:45 AM and on subsequent onsite visits on 09/10/20, 09/15/20, 09/24/20 and 09/25/20, surveyor was screened for the COVID-19 virus before entering the facility. The screener asked the surveyor if she washed her hands, then proceeded to ask questions listed on the facility's "COVID-19 Screening Tool." The tool is used to consistently screen all visitors entering the facility and each employee prior to the start of their shift. Surveyor was not asked if she had contact with someone positive or under investigation for COVID-19. During the entrance conference with the facility's	F 880	alleged or the conclusions set forth in the Statement of Deficiencies. F880 Corrective actions: Finding 1- Employee Screening a.COVID-19 staff screening tool was updated on 10/17/20 to re-include question asking if staff member had been exposed to any person infected with COVID-19 or a person under investigation for COVID-19. Finding 2- Responding Timely to an Outbreak a.Maintenance staff were reeducated on 10/16/20 by Infection Preventionist/designee on work restrictions for staff who were exposed to COVID-19 and self-isolation (quarantine) protocols. b.The NHA, DON, and IP were reeducated on 10/16/20 by RNC/designee on work restrictions for staff who were exposed to COVID-19 and self-isolation (quarantine) protocols for individuals who do not pass screening process. c.The Nursing Home Administrator (NHA) Director of Nursing (DON), Infection Preventionist (IP) were reeducated by RNC/designee on 10/16/20 on the principles of prompt response to a COVID-19 outbreak. Currently there are no residents with active COVID-19 in the facility. d.The NHA, DON, and IP were	

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F 880	Continued From page 4 management team on 09/09/20 at 09:15 AM, Regional Vice President (RVP) speculated there were possibly two index individuals for the COVID-19 outbreak that ensued on 08/20/20, which included a maintenance staff and a resident. In an interview with MS1 on 09/24/20 at 10:08 AM, he stated that he was screened with the "COVID-19 Screening Tool" with the screener prior to his shift on 08/20/20 and was allowed to work. The "COVID-19 Screening Tool" was used to screen the Maintenance Staff (MS)1, 2, and 3 prior to their shift on 08/20/20. On 08/21/20 MS3 was screened before he started his shift. The facility's "COVID 19 Screening Tool," did not include an inquiry about possible exposure with someone positive or under investigation for COVID-19. MS1 worked with MS2 and MS3 on 08/20/20. MS3 ate lunch with MS1 on 08/20/20. Both MS1 and MS2 were sent home on 08/20/20 due to possible exposure and having symptom for the COVID-19 virus. On 09/24/20 at 09:00 AM, surveyor interviewed the DON/IP regarding the facility's "COVID-19 Screening Tool." She mentioned that it was revised as guidelines changed. The facility's "COVID-19 Screening Tool" has gone through several updates - 03/31/2020; 04/29/2020; 07/16/2020; 09/08/2020; and 09/23/2020. A follow up interview with the DON/IP and RVP was done on 10/06/20 at 11:46 AM. Surveyor inquired about the "COVID-19 Screening Tool" and its numerous changes not including the prompt for the visitor or employee to be screened for possible exposure to the COVID-19 virus. The DON/IP and RVP stated, "It should have been	F 880	reeducated by RNC/designee on 10/17/20 on contact tracing. Finding 3- PPE Use and Hand Hygiene a.MD2 was reeducated to hand hygiene and PPE use by infection preventionist/designee on 9/9/20, and LPN2 was reeducated to hand hygiene and PPE use by infection preventionist/designee on 9/16/20. Identification of others at risk: Finding 1- Employee Screening a.A baseline audit was completed on 10/15/20 to review completed screening tools from the past 7 days. No new instance of current exposure was identified. No staff were identified as needing to be excluded from work. Finding 2- Responding Timely to an Outbreak a.As of 10/15/20, there is 1 staff member who was identified as COVID-19 positive. Contact tracing has been completed in collaboration with Department of Health. This person is currently excluded from work. It was identified that no residents were exposed by this staff member, and that 1 staff member was exposed. The exposed staff member was excluded from work and obtained two negative COVID-19 tests prior to returning to work as directed by the local health department. b.The residents who had COVID-19 are recovered. As of 10/15/20 there are 2	

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F 880	Continued From page 5 there and don't know why it's not there." The facility's "COVID-19 Screening Tool," version date 07/16/20 was reviewed on 09/24/20 at 09:30 AM. The tool does not include screening for possible contact with persons who are positive or under investigation for COVID-19. A review of the facility's policy "Infection Prevention & Control Process for Screening Employees During the COVID-19 Pandemic" dated 05/2020 was done. It did not specify the screening criteria. The Centers for Medicare and Medicaid Services (CMS) guidance memo QSO-20-14-NH, dated March 4, 2020, stated that screening of visitors and health care staff should include "contact with someone with or under investigation for COVID-19." CMS memo QSO-20-20-ALL dated March 23, 2020, stated that screening should include "contact with someone with known or suspected COVID-19." 2) Upon arrival at the facility on 09/09/20 at 08:30 AM, observed a screening station for visitors and employees posted at the entrance of the facility. After being greeted by the Regional Nurse Consultant (RNC) at 08:45 AM, she stated a private company was at the facility conducting COVID-19 testing for employees due to the COVID-19 outbreak. She also stated that the dedicated COVID-19 resident care unit was located on the first floor of the facility. In a tour of the facility at 1:09 PM, the RNC stated that residents negative for and residents recovered from COVID-19 were housed on two hallways of the second floor. The third hallway of the second floor housed the persons under investigation (PUI; residents who have not yet been confirmed	F 880	residents on contact/droplet precaution isolation after leaving the facility for an appointment. Observation of contact/droplet isolation precautions in place for both residents on 10/15/20 revealed no new concerns. Finding 3- PPE use and Hand Hygiene a.Current residents and staff are at risk. Systemic Changes: Finding 1- Employee Screening a.The Screening Tool has been remodified to include exposure to confirmed or suspected COVID-19. b.Current staff members were educated on COVID-19 screening and exclusion to work by requiring them to view (Keep COVID-19 Out https://youtu.be/7srwrF9MGdw) video by 10/19/20. Finding 2- Responding Timely to an Outbreak a.Current staff members were educated on prompt response to a COVID-19 outbreak by requiring them to review QSO 19-10 NH dated 03/11/2019 Module 5 titled Outbreaks by 10/19/20. b.Facility obtained the Sofia 2 antigen test on 9/16/20 to have access to more immediate COVID-19 results, as needed. Finding 3- PPE use and Hand Hygiene a.Current staff members were educated on hand hygiene and PPE use	

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F 880	Continued From page 6 with having the COVID-19 virus) unit. Four residents from here, tested positive for the COVID-19 virus and was transferred to the first floor "in the middle of the night" last night. On 09/09/2020 surveyor requested the facility's line listing of the COVID-19 positive residents and staff. A review of the facility's staff "COVID19 Positive Cases" date of onset 8/20/2020 revealed that the first staff who tested positive for the COVID-19 virus was from the maintenance department. A tour to the maintenance department was conducted on 09/15/20 at 09:30 AM. During the tour, an interview with MS1 was conducted in the hallway outside of the maintenance office and the maintenance staff break room. An inquiry was made with MS1 regarding social distancing inside their break room. MS1 stated there were four (4) people in the breakroom at a time starting in the beginning of March 2020 and it was changed to two (2) people in late August 2020 when facility staff and residents started to become infected with the COVID-19 virus. MS1 stated that he tested positive for COVID-19 on 09/05/20. An interview was conducted with the Maintenance Staff Supervisor (MSS) on 09/25/20 at 10:10 AM. He informed the surveyor that on 08/20/20 a random testing was scheduled on some of his staff. Later that day, MS1 and MS3 were in the break room for lunch. The MSS claimed he was informed by MS1 that he had just received a call from his daughter that her friend tested positive and that they may have been exposed to the COVID-19 virus. The MSS called the Administrator and informed him about MS1. MS1 was sent home on 08/20/20 at 11:42 AM. His time	F 880	by requiring them to view (Using Clean Hands https://youtu.be/xmYMUly7qiE and PPE Lessons https://youtu.be/YYTATw9yav4) video by 10/19/20. b.Additional signage was posted at facility exit to remind staff to remove PPE and perform hand hygiene upon exiting the facility on 10/19/20. Directed Plan of Correction Current staff members viewed the following training videos by 10/19/20: •Sparkling Surfaces - https://youtu.be/t7OH8ORr5Ig •Clean Hands - https://youtu.be/xmYMUly7qiE •Keep COVID-19 Out! - https://youtu.be/7srwrF9MGdw •Lessons - https://youtu.be/YYTATw9yav4 Current staff were educated on hand hygiene and glove use using Module 5, Module 6B and Module 7 of QSO 19-10 NH by 10/19/20. RCA was conducted by QAPI members on 10/19/20. RNC/Designee validated credential of facility infection preventionist on 10/16/20 and credentials are being submitted to OCHA with DPOC. Infection Prevention Consultation services have been arranged with Hilo Medical	

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F 880	Continued From page 7 sheet revealed that he worked for 5.75 hours on that day. The MSS further revealed that as he was walking back to his office, he came across MS2. He heard MS2's "hoarse" voice and suspected that he was sick. MSS sent MS2 home at 11:38 AM on 08/20/20. Review of MS2's time sheet shows that he worked for 5.75 hours on that day. On 09/25/20 at 11:00 AM, a phone interview was conducted with MS2. He explained that on 08/19/20, MS1, MS3 and himself (MS2) ate together in the break room. On 08/20/20, the three of them worked together to demolish a wall in room 172, the facility's designated as the COVID unit. MS2 stated that during lunch, he ate his lunch outside while MS1 and MS3 ate in the breakroom. MS2 tested positive for COVID-19 on 08/22/20. On 09/25/20 at 11:37 AM, a concurrent interview and record review was conducted with MS3. MS3 stated, "After working together on the first floor on 08/20/20, I had lunch with MS1 for about 15 minutes and then MS1was sent home." The maintenance work order log was reviewed with MS3. The log showed a request to fix a broken staff bathroom handle on the first floor, and someone attempted to fix the handle. MS3 confirmed that he attempted to fix the handle on 08/20/20. Surveyor asked why he was not sent home on 08/20/20 and why he came to work the next day, 08/21/20. MS3 said, "No one talked to me and I was scheduled to work." He mentioned that his supervisor knew that he was working on 08/21/20 and he was told to stay in the office. MS3 informed surveyor that he came to the facility on 08/23/20 for another testing. He was screened and tested and as he began to leave	F 880	Center. An updated LTC infection control self-assessment was completed on 10/19/20. LTC infection control self-assessment was reviewed by Infection Preventionist, Medical Director, Regional Nurse Consultant (RNC), and Regional Vice President (RVP). LCT infection control self-assessment is being submitted to OCHA with DPOC. Monitoring: Finding 1- Employee Screening a.Infection Preventionist/Designee will audit screening tools representing 10% of completed staff screening tools on a weekly basis to verify compliance with CDC work exclusion guidelines. This audit will be conducted weekly X 4 weeks, then monthly X 2 months. Finding 2- Responding Timely to an Outbreak a.Infection preventionist/designee will audit any residents who are COVID-19 positive or persons under investigation (PUI) weekly to verify contact/droplet isolation precautions are in place per CDC guidelines. This audit will be completed weekly X4 weeks, then monthly X 2 months. Finding 3- PPE Use and Hand Hygiene a.Infection preventionist/designee will audit 10% of staff members for doffing or donning PPE and performing hand	

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F 880	Continued From page 8 the facility, Human Resources Staff (HR) informed him that his test on 08/20/20 was positive for COVID-19. MS3 informed surveyor that on 08/31/20 he was in the emergency room for 2-3 hours due to shortness of breath. On 09/25/20 at 10:15 AM, review of the maintenance work order log was done with the assistance of MSS. He stated, "My staff are constantly everywhere. Some of their work/job are not always documented because I communicate with them using walkie talkie." Surveyor asked why MS3 was not sent home since all his staff worked together and had lunch together on 08/20/20. The MSS responded, "It's not my call but if I have to do it all over again, I would have sent them home." The MSS informed surveyor that he instructed MS3 on 08/21/20 to "stay in the office and not go outside unless the building is on fire." On 09/24/20 at 3:12 PM, the DON was interviewed. Surveyor asked the DON the reason why MS1 and MS2 were sent home on 08/20/20, but MS3 continued to work despite exposure to MS1 and MS2. MS1, MS2, and MS3 worked on demolishing a wall in room 172 located in the nursing facility. In addition, MS1 and MS3 ate lunch together on 08/20/20 for about fifteen minutes without their mask on. Surveyor further inquired about MS3's continuation to work on 08/21/20 and she responded, "He was asymptomatic, so he can come to work." The DON also stated that MS3 had no symptoms per the "COVID-19 Screening Tool." On 09/25/20 at 09:00 AM, a copy of the facility's contact tracing of the maintenance staff was requested from the DON/IP. The DON claimed,	F 880	hygiene to verify compliance with CDC PPE and hand hygiene guidelines. This audit will be conducted weekly X4 weeks, then monthly X2 months. Audits will be reviewed and monitored monthly through the facility's Quality Assurance and Performance Improvement Process. Infection preventionist/designee will report trends to the QAPI committee monthly for review and further direction. Date of COMPLIANCE: 10/19/20 Person Responsible for Implementation of this Plan of Correction: Nursing Home Administrator	

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F 880	Continued From page 9 "They have it and it will take only few minutes to pull from the system." In addition, the DON said, "It's in my head, it should be fast for me to write." There was no document received by the end of the workday. The contact tracing sent by the RNC was received via email as an attachment on 09/26/20 at 12:11 PM. The attachment revealed an undated and untitled summary of what was discussed when surveyor requested the contact tracing. The summary failed to identify that MS3 was exposed to MS1 and MS2 who were possibly exposed to the COVID-19 virus on 08/20/20. On 09/09/20 10:30 AM, a record review of the resident "COVID19 Positive Cases" with the onset date of 08/23/20 was done. This document identified the facility's COVID-19 positive residents with their COVID-19 test date and results, date the resident was placed on droplet/contact precautions (an infection control measure of isolation and PPE use to prevent transmission of germs that cause illness), symptoms and their expiration date, if applicable, and it revealed: a) Resident (R)2 experienced symptoms of fever and cough and tested positive on 08/23/20 but was not placed on droplet/contact precautions until 08/25/20. b) R3 experienced symptoms of fever and cough and tested positive on 08/23/20 but was not placed on droplet/contact precautions until 08/25/20. c) R4 experienced symptoms of fever and cough and tested positive on 08/23/20 but not placed on droplet/contact precautions until 08/25/2020. He expired on 09/02/20.	F 880		

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(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 880	Continued From page 10 d) R5 experienced symptoms of fever and tested positive on 08/23/20 but was not placed on droplet/contact precautions until 08/25/20. He expired on 08/31/20. e) R6 experienced symptoms of cough, shortness of breath and body aches and tested positive on 08/23/20 but was not placed on droplet/contact precautions until 08/25/20. f) R7 tested positive on 08/23/2020 but was not placed on droplet/contact precautions until 08/25/20. g) R8 tested positive for COVID-19 on 08/23/20 but was not placed on droplet/contact precautions until 08/25/20. He expired on 08/29/20. The facility's COVID-19 policy, undated, was received on 09/10/20 at 09:15 AM. A request for an updated policy was made on 09/24/20, but not received. The policy revealed "Contact/droplet precautions are implemented as soon as able, once a resident is suspected to have COVID 19." The CDC guidance, "Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to COVID-19 Potential Exposure at Work, dated June 2020 stated, "exposures can also occur from a suspected case of COVID-19 or a person under investigation (PUI) if testing has not yet occurred or if results are pending. Work restrictions might be applied to healthcare personnel exposed to a PUI if test results for the PUI are not expected to return within 48-72 hours."	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125058	A. BUILDING _____ B. WING _____	10/16/2020

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F 880	Continued From page 11 In the CDC's guidance, "Responding to Coronavirus (COVID-19) in Nursing Homes" updated Apr. 30, 2020, it stated "If the resident is confirmed to have COVID-19, regardless of symptoms, they should be transferred to the designated COVID-19 care unit." 3) On 09/09/20 at 1:15 PM, upon entry into the COVID-19 resident care unit, the ward clerk supplied a gown to the surveyor and instructed the surveyor to use the same N95 mask, face shield and gown throughout the unit. Gloves would need to be changed in between residents and there is to be no glove use at the nursing station and in the hallways. On 09/09/20 at 2:00 PM, surveyor observed MD2 entering the designated COVID-19 resident care unit wearing a face shield and N95 respirator mask. LPN1 noticed MD2 enter the unit without a gown and immediately retrieved a gown by the screening table and gave a gown to MD2. MD2 donned the gown and tied the straps behind his neck and proceeded to walk past the central nursing station. LPN1 helped MD2 to tie the straps at the back of his gown. At 3:20 PM, MD2 was seen walking out wearing all his PPE. He proceeded to take off his gown and placed it into the trash receptacle. MD2 did not remove his contaminated face shield and N95 respirator mask. MD2 did not wash his hands at the sink stationed next to the trash receptacle nor use alcohol-based hand rub (ABHR). MD2 walked out of the facility into his private vehicle while wearing his contaminated face shield and N95 respirator mask. On 09/15/20 at 08:00 AM, LPN2 was exiting the main entrance of the facility where the screening	F 880		

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F 880	Continued From page 12 area is located. There is a sink, soap dispenser and paper towel dispenser in this area. LPN2 was observed to remove her N95 mask and discard it in an open trash receptacle. Then proceeded towards the parking lot without hand hygiene. On 09/09/20 at 3:30 PM interviewed RN1 in the COVID-19 positive resident care unit and verified MD2 was attending to his residents in the unit. The surveyor informed RN1 that MD2 was observed wearing his contaminated face shield, N95 mask, and did not perform hand hygiene prior to going to his personal vehicle. RN1 confirmed that upon exiting the COVID-19 positive resident care unit, MD2 was supposed to remove all contaminated PPE and perform hand hygiene. On 09/10/20 at 1:10 PM, during a conference with the facility's management team, the team was informed of MD2 leaving the COVID-19 resident care unit without removing his PPE and failed to perform hand hygiene before leaving the facility. The facility management acknowledged the failed practice and conducted an in-service with MD2 in the evening of 09/09/20. On 09/15/20 at 08:10 AM, an interview was conducted with the DON. She acknowledged that LPN2 should have washed her hands. In addition, the RVP, employed by the facility's managing agency, mentioned that if staff are on the facility's premises, they are required to follow the facility's protocol which included hand hygiene after removing their mask. Surveyor interviewed MD2 via phone call on 09/21/20 at 2:28 PM. MD2 confirmed that he used the same face shield and N95 respirator	F 880		

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F 880	Continued From page 13 mask in the COVID-19 resident care unit and did not remove them upon exiting the unit because "no one told me that the process was changed." He further said that after he had received education from the facility in the evening of 09/09/20, he now discards all his personal protective equipment (PPE) after use and does hand hygiene afterwards. On 09/16/20 reviewed the PPE + Transmission-based Precautions in-service log and it showed LPN2 attended the PPE in-service on 03/08/20. On 09/16/20 reviewed the facility's policy titled "Clinical Services Policy and Guidelines for Implementation. Infection Prevention and Control Program (IPCP)" revised on 03/2020, it revealed: "Standard Precautions #2. Staff will perform hand hygiene, even if gloves are used: d. After removing PPE." On 09/16/20 reviewed the CDC guidelines in the "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic" updated on July 15, 2020 it revealed: "Eye protection and respirators be removed after leaving the care area." "Hand hygiene after removing PPE is particularly important to remove any pathogens that might have been transferred to bare hands during the removal process." When the survey team questioned the facility's Administrator on 09/09/20 and 09/15/20 about the outbreak, he deferred their inquiries to the facility's clinical management.	F 880		

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