STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		COMPLETED		
		155790	B. WING		08/12/2021		
			CTDEE	CADDRESS SITE OF SORE	l		
NAME OF P	ROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE			
5515.65		4.DE 051,TED	14751 CAREY ROAD				
BRIDGE\	WATER HEALTHC	ARE CENTER	CARM	IEL, IN 46033			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
F 0000							
Bldg. 00							
	This visit was for a	COVID-19 Focused Infection	F 0000	Preparation or execution of the	is		
	Control Survey.			plan of correction does not			
				constitute admission or agree	ment		
	Survey dates: Augu	ıst 12, 2021.		of provider of the truth of the fa	acts		
				alleged or conclusions set fort			
	Facility number: 01			the Statement of Deficiencies.			
	Provider number: 1	55790		The Plan of Correction is			
	AIM number: 2010	023760		prepared and executed solely			
				because it is required by the			
	Census Bed Type:			position of Federal and State			
	SNF/NF: 82			Law. The Plan of Correction i	s		
	Total: 82			submitted in order to respond			
				the allegation of noncompliand	l l		
	Census Payor Type	e:		cited during a Focused Infection	on		
	Medicare: 12			Control Survey on 8/12/2021.			
	Medicaid: 52			Please accept this plan of			
	Other: 18			correction as the provider's			
	Total: 82			credible allegation of compliar	nce.		
	These deficiencies	reflect State Findings cited in		The provider respectfully requ	ests		
	accordance with 41	_		a desk review with paper			
				compliance to be considered i	n l		
	Ouality review con	npleted on August 19, 2021.		establishing that the provider i			
				substantial compliance.			
				i i			
F 0880	483.80(a)(1)(2)(4)	)(e)(f)					
SS=E	Infection Preventi	on & Control					
Bldg. 00	§483.80 Infection	Control					
	The facility must e	establish and maintain an					
	infection prevention	on and control program					
designed to provide a safe, sanitary and comfortable environment and to help prevent		de a safe, sanitary and					
	•	and transmission of					
	communicable dis	seases and infections.					
	§483.80(a) Infecti	ion prevention and control					
	program.						
			1		ĺ		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

FORM CMS-2567(02-99) Previous Versions Obsolete

TITLE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155790		(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	TE SURVEY PLETED 2/2021			
	F PROVIDER OR SUPPLIED		STREET ADDRESS, CITY, STATE, ZIP CODE 14751 CAREY ROAD CARMEL, IN 46033					
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPP DEFICIENCY)	LD BE	(X5) COMPLETION DATE		
	prevention and co	establish an infection ontrol program (IPCP) that n minimum, the following						
	identifying, report controlling infection diseases for all revisitors, and other services under a based upon the factonducted accord following accepte  §483.80(a)(2) Writing and procedures for include, but are noted infections before the persons in the factor (ii) When and to wood communicable distributions to be of infections; (iv) When and how for a resident; incommunication (A) The type and depending upon the least restrictive under the circums (v) The circumstata facility must prohice communicable distributions and the communication distributions to be communications are sident; incommunications (v) The circumstata facility must prohice communicable distributions and other the distributions (vi) The circumstata facility must prohice communicable distributions (vi) The circumstata facility must prohice (vii) The circumstata facility must prohice (viii) The viii (viii) The viii (viiii) The viii (viiii) The viii (viiiii) The viii (viiiiiii) The viii (viiiiiiiiiiiiiiiiiiiiiiiiiiiiiii	rveillance designed to communicable diseases or they can spread to other cility; whom possible incidents of sease or infections should transmission-based followed to prevent spread visolation should be used luding but not limited to: duration of the isolation, he infectious agent or d, and that the isolation should be the possible for the resident stances. Incest under which the bit employees with a sease or infected skin						
PREFIX	REGULATORY OF  The facility must of prevention and comust include, at a elements:  §483.80(a)(1) A sidentifying, report controlling infection diseases for all revisitors, and other services under a based upon the faconducted accord following accepte:  §483.80(a)(2) Writing and procedures for include, but are not (i) A system of suidentify possible of infections before a persons in the faconducted infections before a persons in the faconducted infections; (iii) When and to we communicable distributions to be of infections; (iv) When and how for a resident; incompanism involved (B) A requirement the least restrictive under the circums (v) The circumstant facility must prohice communicable distributions and distributions are sidentifications.	establish an infection ontrol program (IPCP) that a minimum, the following system for preventing, ing, investigating, and ons and communicable esidents, staff, volunteers, individuals providing contractual arrangement acility assessment ling to §483.70(e) and donational standards; atten standards, policies, or the program, which must oot limited to: reveillance designed to communicable diseases or they can spread to other cility; whom possible incidents of sease or infections should transmission-based followed to prevent spread we isolation should be used luding but not limited to: duration of the isolation, the infectious agent or d, and at that the isolation should be the possible for the resident estances. Incest under which the bit employees with a	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPR	LD BE	COMP		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

KL4T11

Facility ID: 012548

If continuation sheet

Page 2 of 8

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION (X3)		(X3) DATE	3) DATE SURVEY	
AND PLAN OF CORRECTION ID		IDENTIFICATION NUMBER:	A. BU	A. BUILDING 00 COMP			ETED	
		155790	B. W	B. WING 08/12/20			/2021	
				STREET /	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIEF	₹		1	CAREY ROAD			
DDIDCE/	BRIDGEWATER HEALTHCARE CENTER				EL, IN 46033			
BRIDGEWATER HEALTHCARE CENTER			CARIVIE	EL, IN 46033				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	their food, if direct	contact will transmit the						
	disease; and							
	, ,	ene procedures to be						
		nvolved in direct resident						
	contact.							
	. , , , ,	ystem for recording						
		d under the facility's IPCP						
		actions taken by the						
	facility.							
	\$400.00/a) Linana							
	§483.80(e) Linens							
	Personnel must handle, store, process, and							
	of infection.	o as to prevent the spread						
	or intection.							
	§483.80(f) Annual	roviow						
	- , ,	nduct an annual review of						
		ate their program, as						
	necessary.	nte trien program, as						
	,	ons, interview, and record	F 0	880	F 880		09/08/2021	
		failed to properly prevent the	1 0	300			07/00/2021	
		are to COVID-19 by ensuring			Corrective actions			
		wore personal protective			accomplished for those			
		uring resident care and			residents found to be affecte	d		
		s in droplet/contact isolation			by the alleged deficient			
		sure used PPE was discarded			practice: The residents identi	fied		
	,	cans, and full trash bags and			are confidential related to			
	_	PPE in resident rooms were			complaint investigation.			
	not overflowing for	· 18 of 18 residents observed			Identification of other reside	nts		
	for infection control (Residents 41, 33, 50, 61,				having the potential to be			
	63, 66, 27, 28, 70, 1	1, 29, 65, 71, 11, 67, 75, 44,			affected by the same alleged			
	and 68).				deficient practice and			
					corrective actions taken: All			
	Findings include:				residents have the potential to			
					affected by this alleged deficie	nt		
	_	facility tour on 8/12/21 from			practice.			
		0 a.m., the following was						
	observed:				The DON or designee will			
					complete the following:			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

KL4T11

Facility ID: 012548

If continuation sheet Page 3 of 8

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>		COMPLETED		
		155790	B. W	NG	NG 08/12		2021
				STREET /	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹					
PDIDCE	MATED HEALTHO	ADE CENTED	14751 CAREY ROAD				
BRIDGEWATER HEALTHCARE CENTER			CARMEL, IN 46033				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI		TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	· · · · · · · · · · · · · · · · · · ·	ensed Practical Nurse (LPN)					
		Resident 41's room. A yellow			- Ensure staff involved are		
		the open door which indicated			educated or appropriate way t		
		"Droplet/Contact" isolation.			dispose of contaminated items		
	_	"Gowns: to be worn inside			with potentially infectious age		
		and changed between			Ensure the potentially infection	us	
		es: are to be used when			agents are transported in		
		at this time, LPN 8 was			biohazard containers and		
		blue isolation gown on, but it			disposed of according to polic	•	
		her neck, so that the gown			Follow CDC and facility policy		
	draped open in the front. LPN 8 leaned over						
	Resident 41 as she took the residents vital sings.				Policy: Criteria Covid		
	She did not have on gloves.				Tracking and Cohorting		
	_	e untied gown and discarded					
	-	can at the resident's door. She			- Ensure staff involved are		
		l used hand gel to sanitize her	educated on how and when to don		don		
		she indicated, there were 4			and doff PPE with return		
		idents on the 4000 hall, and		demonstration, including, but not		not	
		plet isolation as a COVID-19	limited to, mask, respirator				
	precaution.			devices, gloves, gown, and eye		e e	
	1 4 0 20 0	1.6. 13.6.1 4.1			protection. Follow CDC and		
		alified Medication Aid			facility policy.		
		l on Resident 33's door and			Doliny, Llos of DDE while in th		
		A yellow sign was posted on hindicated the resident was in			Policy: Use of PPE while in the		
	•		I		facility, General Hand Hygiene	<del>,</del>	
	_	solation. QMA 14 did not out on an isolation gown, or			CDC: PPE sequence Competency: AAPACN		
	_	_			Personal-Protective-Equipmen	at D	
	gloves before he en	nered the room.			PE-Donning-and-Doffing,	11-17	
	a On the 2000 Hall	at 0:42 a.m. Housekeener 7			AAPACN Hand Hygiene		
		l at 9:42 a.m., Housekeeper 7 sident 50 and 61's room. He			Competency		
	swept and mopped the floors. He was observed to have a blue isolation gown on, but it was not tied			Measures put in place a			
					systemic changes made to		
	behind his neck or behind his back, so the gown hung lose and away from his body and dangled at				ensure the alleged deficient		
	his wrists. He exited the room after he pulled off		practice does not recur:				
		rded it in a yellow trash can at			A Root Cause Analysis (RCA)		
	_	t sanitize his hands after he			was conducted with the Infect		
	left the room.				Preventionist (IP) and input from		
	ieit the foom.		1		I		

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
155790		155790	B. W	B. WING		08/12/2021	
				CTD FET A	ADDRESS CITY STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE		
					CAREY ROAD		
BRIDGEWATER HEALTHCARE CENTER				CARME	EL, IN 46033		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID BROWIDER'S DI AN OF CORRECTIO			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		<sub>TC</sub>	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)	' <sup>-</sup>	DATE
					the IDT and the facility Medica	ıl	
	At 9:44 a.m., House	ekeeper 7 partially donned			Director/IP/DON.		
		ation gown and entered					
		's room without sanitizing his			The root cause was identified		
		n gown was not fastened so it			resulting in the facility's failure		
		ddle of his chest and swished					
	_	t. He swept and mopped the			Solutions were developed and		
	•	exited the room after he			systemic changes were identif		
		and discarded it in a yellow			that need to be taken to addre		
	-	r. He did not sanitize his			the root cause.		
	hands after he left t						
					The Infection Preventionist and	d l	
	At 9:48 a.m., House	ekeeper 7 partially donned a			IDT reviewed the LTC infection		
		and entered Resident 27 and			control self-assessment and		
	_	not sanitize his hands. The			identified changes to make		
		not fastened so it hung lose			accurate		
		chest and swished open down					
		and mopped the resident's					
	_	e room after he pulled off the					
		l it in a yellow trash can at the			How the corrective measures	,	
		nitize his hands after he left			will be monitored to ensure t	he	
	the room.				alleged deficient practice do		
					not recur:		
	At 9:51 a.m., House	ekeeper 7 exited the 3000			After the IDT and Infection		
	Hall without sanitiz				Preventionist completed the R	CA	
					and LTC infection control		
	2. On 8/12/21 at 12	:29 p.m., Housekeeper 7 was			assessment, training identified	ı	
		nt 70's room. A yellow sign			above was implemented to fac		
		open door which indicated the			staff. The training will be	-	
	_	oplet/Contact" isolation.			conducted by the DON, IP or		
		not have on an isolation			Medical Director with		
	_	ned sweeping the resident's			documentation of completion.		
	-	exited the room and did not					
	sanitize his hands.				To ensure Infection Control		
					Practices are maintained, the		
	3. During a facility	tour on 8/12/21 from 1:40			following monitoring will be		
		., the following was observed:			implemented.		
	•	-					
	a. On the 3000 Hall	at 1:41 p.m., the yellow trash					
	cans for soiled PPE	inside Resident 1, 29 and			1. The IP nurse/DON/Designe	e	
		1					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>		00	COMPLETED	
		155790	B. WING			08/12/2021	
				OTTO FEET	ADDRESS OF A STATE OF SORE		
NAME OF P	ROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
					CAREY ROAD		
BRIDGEWATER HEALTHCARE CENTER			CARME	EL, IN 46033			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID D			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG CROSS-REFERENCED TO THE APPRODEFICIENCY)		IE	DATE
	65's rooms were ob	served to be overfilled.			will monitor each solution and		
		lled over the top of the lid and			systemic change identified in		
	touched the floors.	1			RCA and as noted above, daily	v or	
	to work and moore.				more often as necessary for 6		
	h At 1:42 nm Ho	usekeeper 7 partially donned			weeks and until compliance is		
		vn and entered Resident 29			maintained.		
	_	out sanitizing his hands. The			mamamod.		
		not fastened so it hung lose			ensure execute proper donning	a	
	-	chest and swished open down			and doffing of PPE, including		
		the room after he pulled off			but not limited to, mask, respir		
		rded it in a yellow trash can at			devices, gloves, gown, and ey		
		t sanitize his hands after he			protection		
	left the room.	t samuze ms nands after ne			Protection		
	ien me room.				ensure staff execute proper ha	and l	
	A+ 1.44 m m Hous	alraaman 7 mantially, dammad a			hygiene prior to donning and a		
	_	ekeeper 7 partially donned a				illei	
		and entered Resident 71's			doffing PPE		
		izing his hands. The isolation			anaura usad DDE is disparded	in	
	-	ned so it hung lose to the			ensure used PPE is discarded		
		and swished open down his			designated waste cans and ful	II	
		e room after he pulled off the			trash bags and cans used for soiled PPE in resident rooms a		
		l it in a yellow trash can at the				are	
		nitize his hands after he left			not overflowing		
	the room.						
	A+ 1.51 II	itality Aid Oyyoo ak1:			2 The ID pures/DON/Dasissi		
		itality Aid 9 was observed in			2. The IP nurse/DON/Design		
		. Her mask was observed			will complete daily visual round		
		ose, and the isolation gown			throughout the facility to ensur		
		neck so that it hung lose to the			staff are practicing appropriate		
	middle of her chest	•			Infection Control Practices and	ı	
		1 (. 1 14 11 1222			complying with the solutions		
		bag of trash, with soiled PPE			identified in B1 as above. This	5 WIII	
	, ,	oves, and isolation gowns) was			occur for 6 weeks and until		
		floor outside of Resident 67			compliance is maintained.		
	and 75's room.						
	4.0.0/10/01	46			Infection Control Practices	_	
		46 p.m., two nursing			ensure execute proper donning	-	
		ere observed at the 2000 Hall			and doffing of PPE, including		
		ich was located in the			but not limited to, mask, respir		
		ning area. Both medication			devices, gloves, gown, and ey	e	
	cart trash cans were	e observed full and overflowed			protection		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

KL4T11

Facility ID: 012548

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/15/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155790		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 08/12/2021	
	PROVIDER OR SUPPLIER		14751	ADDRESS, CITY, STATE, ZIP CODE CAREY ROAD EL, IN 46033	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	68 both sat in the co	on 8/12/21 at 2:30 p.m., with		ensure staff execute proper has hygiene prior to donning and a doffing PPE	
	Nursing (DON), the was in outbreak pre members who had r COVID-19. The DO Halls had been plac resident was in drop due to potential exp	ADM) and Director of ADM indicated the facility cautions due to three staff ecently tested positive for DN indicated, 2000 and 3000 ed on quarantine and every olet isolation as a precaution osure from one of the staff ested positive and had worked		ensure used PPE is discarded designated waste cans and fu trash bags and cans used for soiled PPE in resident rooms not overflowing	ıll
	on those units. Add admitted residents i because they were r vaccinated against t DON indicated resibeen placed in "yell should follow instrudonning (putting on PPE. The DON indibe tied both behind to completely cover	itionally, there were 4 newly in droplet precautions new admits and had not been the COVID-19 virus. The dents in droplet isolation had ow" rooms which meant, staff netions posted on the door for and doffing (taking off) feated, isolation gowns should the neck, and behind the waist the body, and staff should before and after leaving		Quality Assurance and Performance Improvement (QAPI): The facility through the QAPI program, will review, update a make changes to the DPOC a needed for sustaining substar compliance for no less than 6 months.	ntial
	copy of the yellow sign indicated, "G resident's room and	p.m., the DON provided a Droplet/Contact sign. The owns: to be worn inside of changed between s: are to be used when			
	8/12/21 at 9:00 a.m of current facility po "Infection Outbreak 4/22/21. The policy	ntrance conference on , the ADM provided a copy blicy. The policy was titled, Management Plan" dated, indicated, "Management Implementing droplet or			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

KL4T11

Facility ID: 012548

If continuation sheet

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/15/2021 FORM APPROVED OMB NO. 0938-0391

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155790	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY  COMPLETED  08/12/2021
	PROVIDER OR SUPPLIE		14751	ADDRESS, CITY, STATE, ZIP ( CAREY ROAD EL, IN 46033	CODE
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES  NCY MUST BE PRECEDED BY FULL  OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION
	implementation of reducing transmission implementation of reducing transmission implementation in the facility At for residents and seas directed by local authorities, and in the CDC [Centers second policy title Cohorting" dated Areas: full PPE is patient room which protection, gown, washed and or same	as where appropriate Timely of droplet precautions will aid in sion of respiratory plement the isolation protocol ctivate quarantine interventions staff with suspected exposure al and state public health keeping with guidance from for Disease Control]" A ad, "COVID Tracking and 7/8/21 indicated, "At risk required upon entry into a ach includes N95 mask, eye and gloves hands will be nitized prior to entering a ad upon exiting the room"			

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: KL4T11 Facility ID: 012548 If continuation sheet