STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155249	A. BUILDING 00 B. WING	08/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATEAU REHABILITATION AND HEALTHCARE CENTER	6006 BRANDY CHASE COVE FORT WAYNE, IN 46815

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F 0000 Bldg. 00	This visit was for a COVID-19 Focused Infection Control Survey. This visit resulted in Immediate Jeopardy. Survey dates: August 11, 12, & 13, 2021 Facility number: 000153 Provider number: 155249 AIM number: 100266910 Census Bed Type: SNF/NF: 88 Total: 88 Census Payor Type: Medicare: 8 Medicaid: 73 Other: 7 Total: 88 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review was completed on August 19, 2021.	F 0000		
F 0880 SS=J Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §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			

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

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	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. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin			

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	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. Based on observation, interview, and record review, the facility failed to follow CDC (Center for Disease Control) guidance during a pandemic and implement an infection control program to properly prevent/contain COVID-19. The facility failed to cohort and establish a red zone for COVID-19 positive residents, failed to cohort 4 COVID-19 positive residents (Resident B, Resident D, Resident F and Resident H) separately from 4 residents not testing positive (Resident C, Resident E, Resident G, and Resident J), and failed to implement PPE (Personal Protective Equipment) doffing and cleaning prior to exiting a room in TBP (Transmission Based Precautions) (CNA 1), to prevent the spread of COVID-19 in 2 of 2 wings (B-wing and C-wing) which included 4 of 6 halls (B-wing Hall #2, B-wing Hall #3, C-Wing Hall	F 0880	**F880 J Infection Prevention and Control** Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth, or the facts alleged, or the conclusion set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required by the provisions of the health and safety code section 1280 and 42CFR 483. This plan of correction constitutes the facility's written credible allegation of compliance. **1.What corrective actions will be accomplished for those**	08/13/2021

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	#1 and C-wing Hall #3). This deficiency affected 16 of 88 residents. (Resident B, Resident C, Resident D, Resident, E, Resident F, Resident G, Resident H, Resident J, Resident K, Resident L, Resident M, Resident N, Resident O, Resident P, and Resident Q) The immediate jeopardy began on 8-4-21 when Resident B tested positive for COVID-19 on 8-4-21. Resident C remained in the same room, despite testing negative on 8-4-21. Resident C continued to remain in the same room and subsequently tested positive for COVID-19 on 8-11-21. The Regional Director of Operations, the Director of Clinical Services, the Chief Operating Officer (COO), and the ADON (Assistant Director of Nursing) were notified of the immediate jeopardy on 8-11-21 at 4:28 p.m. The immediate jeopardy was removed, and the deficient practice corrected on 8-13-21 at 12:45 p.m. Findings include: 1. During an initial observation of the facility on 8-11-21 at 11:30 a.m., the following was observed: In B-wing, Hall #2, rooms 117, 118, 120, 124, 126 and 128 had TBP and donning/doffing instructions posted on the doors with PPE containers located outside the rooms. In B-wing, Hall #3, room 134 had TBP and donning/doffing instructions posted on the door with a PPE container located outside the room. In C-wing, Hall #1, rooms 203 and 206 had TBP and donning/doffing instructions posted on the doors with PPE containers located outside the rooms.		**residents found to have been affected by the deficient practice:** Facility residents identified with positive rapid testing had a PCR completed and were moved to the designated red zone. Appropriate singe was placed to indicate red, yellow, and green zones. Dedicated staff were assigned to the red zone. Facility staff, vaccinated and unvaccinated, were tested immediately and restricted from working at the facility pending the results of testing. Physician/family/responsible parties were notified regarding covid status. Orders received were noted. Reporting completed per requirements. Residents identified to be positive were assessed and documentation is present in clinical record. Ongoing monitoring of facility residents at least two times daily for signs and symptoms of covid. **2.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:** Residents who present with signs or symptoms of COVID-19, are tested immediately with rapid testing; PCR is collected immediately, and resident is placed on transmission-based precautions (TBP) in accordance with CDC guidelines at which time	

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	In C-wing, Hall #3, rooms 230, 234, and 235 had TBP and donning/doffing instructions posted on the doors with PPE containers located outside the rooms. On 8-11-2021 at 1:30 p.m., the Director of Clinical Services provided a resident room list and identified the residents who were positive for COVID-19 and the date the residents tested positive. This list included residents not testing positive for COVID-19, but on TBP due to being recently admitted to the facility. The following rooms were identified with COVID-19 positive residents: Room 117 - 2 residents Room 118 - 1 resident positive and 1 newly admitted resident with a negative COVID-19 test on 8-11-2021. Room 120 - 2 residents Room 124 - 1 resident Room 128 - 2 residents Room 134 - 2 residents Room 203 - 1 resident Room 230 - 1 resident Room 234 - 1 resident Room 235 - 1 resident The following rooms were identified as yellow rooms with newly admitted residents in TBP: Room 118 - 1 resident Room 126 - 1 resident Room 206 - 1 resident 2. Resident B tested positive for COVID-19 via a rapid test on 8-4-21. Resident C remained in the same room, despite testing negative on 8-4, 8-5, and 8-9-21. He subsequently tested positive for COVID-19 on 8-11-21.		the facility takes appropriate actions based upon the results. All staff and residents are tested, regardless of vaccination status and staff and residents that tested negative are re-tested every 3-7 days until testing identifies no new cases of COVID-19 infection among staff or residents for a period of at least 14 days since the most recent positive result. When two residents share the same room, and one is identified to test positive, and the other resident tests negative the resident that tested positive will be moved to the appropriate section in the facility (red zone). Education with re-demonstration was provided on donning and doffing of Personal Protective Equipment and cleaning, which includes mask, gloves, gown, and eye protection. **3.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Staff members received Directed In-servicing education per Director of Nursing/Infection Preventionist/Chief Operation Officer and the Director of Clinical Services on requirements of establishing a Red Zone. Testing logs and outbreak logs will be kept current per the Director of	

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	(Documentation was lacking in Resident C's record to indicate the resident was asked by facility staff about moving out of the room.) Resident D tested positive for COVID-19 via a rapid test on 8-9-21. Resident E remained in the same room, despite testing negative on 8-9-21. He subsequently tested positive for COVID-19 on 8-11-21. Resident F tested positive for COVID-19 via a rapid test on 8-9-21. Resident G was admitted to the facility on 8-9-21 at 10:00 a.m., from home, was unvaccinated, and her COVID-19 status was unknown. Resident G was placed in TBP in the same room as Resident F and continued to remain in the same room. Resident H tested positive for COVID-19 via a rapid test on 8-9-21. Resident J remained in the same room, despite testing negative on 8-9-21. He subsequently tested positive for COVID-19 on 8-11-21. 3. During an observation on 8-11-21 at 12:12 p.m., CNA 1 (Certified Nurse Aide) donned a gown, performed hand hygiene, then donned gloves and entered room 235. The room had TBP signage on the door. At 12:16 p.m., CNA 1 was observed to exit room 235. She had doffed her gown and gloves in the room but maintained wearing the same mask and goggles she wore into the room. The CNA then went and entered Room 227 without changing her mask or changing/disinfecting her goggles. Room 227 was identified as a room not needing TBP. During an observation on 8-11-21 at 12:10 p.m., Nurse 2 was observed to don a gown and gloves. She had a N95 mask and goggles already donned.		Nursing/ Executive Director and reviewed daily during regularly scheduled departmental meetings. Infection Control Facility Assessment was completed. (ICAR) as well as Root Cause Analysis. Administrative staff were educated on ensuring residents are appropriately placed in respective zones based off CDC guidelines. Staff educated on infection control practices, with a focus on out-break testing requirements and county positivity testing. Daily review of covid testing, surveillance will continue for 3 months (to include all shifts) and or until compliance has been maintained at 100% consecutively. Identified issues will be corrected immediately upon identification with 1-1 education. **4.How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The responsible party for this plan of correction will be the Executive Director/Director of Nursing/Infection Preventionist. Visual daily audits/rounds throughout facility to ensure infection control practices are appropriate and compliance is maintained for 3 months. Daily review of Covid testing results, and appropriate placement has	

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	She was observed then to enter room 203 for Resident N (a room identified with contact and droplet precaution signs) to administer medication. A few minutes later, the Nurse 2 came out of the room without the gown and gloves. The nurse indicated she disposed of the gown and gloves in the resident's room and washed her hands. Nurse 2 was asked about her N95 mask and goggles, and she indicated she wore the same mask/goggles throughout her shift. Room 203 was in C-wing Hall #1 and there were 2 residents without TBP in this hall and 2 residents with their rooms in the yellow zone with TBP for COVID-19. An updated state line listing was provided by the Director of Clinical Services on 8-13-2021 at 11:46 a.m. and indicated from 8-4-2021 through 8-11-2021, there were 14 residents and 9 staff who tested positive for COVID-19. (This was the 3rd state line listing provided by the Director of Clinical Services. The first was on 8-11-2021 at 3:37 p.m. and the second was provided on 8-13-2021 at 11:24 a.m.) Conflicting COVID-19 positive date information on the state line list versus the initial resident by room list provided on 8-11-2021 at 1:30 p.m., indicated Resident B's positive date was 8-5-21 instead of 8-4-21, Resident K's positive date was 8-4-21 instead of 8-9-21, Resident N's positive date was 8-4-21 instead of 8-9-21, and Resident P's positive date was 8-5-21 instead of 8-4-21. The following positive 9 staff and 14 residents information was taken from the state line list provided by the Director of Clinical Services on 8-13-21 at 11:46 a.m. On 8-4-21, the DON (Director of Nursing) had signs and symptoms of a headache and tested		occurred based off results. Documentation will be kept current and reflective on online listing reports and reviewed weekly per Director of Clinical Services. Identified areas will be addressed immediately. The results of audits will be reviewed in Quality Assurance Meeting for 6 months or until 100% compliance has been maintained for 3 consecutive months. The facility through the QAPI program, will review, update, and make changes as needed for sustaining substantial compliance for no less than 6 months. **5.DOC** 8-13-2021	

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	positive for COVID-19 with a rapid test. The facility then tested the residents and staff for COVID-19 with a rapid test. On 8-4-21, Resident N had no signs and symptoms, tested positive for COVID-19, and was quarantined in room 203 in C-wing Hall #1 without a roommate. On 8-4-21, Resident K had no signs and symptoms, tested positive for COVID-19, and was quarantined in room 124 in B-wing Hall #2 without a roommate. On 8-5-21, Resident P tested positive for COVID-19 and was quarantined in room 234 in C-wing Hall #3, without a roommate. Mucinex 600 mg (milligrams) 2x a day for 30 days was ordered on 8-5-21 for congestion for Resident P. An interview with Nurse 3 on 8-12-21 at 9:58 a.m., indicated Resident P had body aches and chest congestion when he tested positive on 8-5-21. On 8-5-21, Resident B had no signs and symptoms, tested positive for COVID-19, and was quarantined in room 120 in B-wing Hall #2 with Resident C, who tested negative for COVID-19 on 8-9-21. Resident C remained in room 120. On 8-9-21, CNA 5 had signs and symptoms of fatigue and tested positive for COVID-19. On 8-9-21, Staff 6 had signs and symptoms of fatigue and tested positive for COVID-19. On 8-9-21, Resident H had no signs and symptoms, tested positive for COVID-19, and was quarantined in room 117 in B-wing Hall #2			

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	with Resident J, who tested negative for COVID-19 on 8-9-21. On 8-9-21, Resident F had no signs and symptoms, tested positive for COVID-19, and was quarantined in room 118 in B-wing Hall #2 with Resident G, who tested negative for COVID-19 on 8-9-21. Resident G remained in room 118. On 8-9-21, Resident Q had no signs and symptoms, tested positive for COVID-19, and was quarantined in room 235 in C-wing Hall #3, without a roommate. On 8-9-21, Resident D had no signs and symptoms, tested positive for COVID-19, and was quarantined in room 128 in B-wing Hall #2 with Resident E, who tested negative for COVID-19 on 8-9-21. Resident E remained in room 128. On 8-10-21, Nurse 7 had no signs and symptoms and tested positive for COVID-19. On 8-10-21, CNA 8 had no signs and symptoms and tested positive for COVID-19. On 8-10-21, the Administrator had no signs and symptoms and tested positive for COVID-19. On 8-10-21, Resident O had signs and symptoms of a headache, fever and a cough and tested positive for COVID-19. Resident O was quarantined in room 230 in C-wing Hall #3 On 8-10-21, Staff 9 had no signs and symptoms and tested positive for COVID-19. On 8-11-21, Resident L had signs and symptoms			

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	of a cough and shortness of breath, tested positive for COVID-19 and was quarantined in room 134 in B-wing Hall #3 with Resident M. On 8-11-21, Resident M had no signs and symptoms and tested positive for COVID-19. Resident M was quarantined in room 134 in B-wing Hall #3 with Resident L. On 8-11-21, Resident E had no signs and symptoms and tested positive for COVID-19. Resident E was quarantined in room 128 in B-Wing Hall #2 with Resident D who had tested positive on 8-9-21. On 8-11-21, Resident J had no signs and symptoms and tested positive for COVID-19. Resident J was quarantined in room 117 in B-wing Hall #2 with Resident H, who tested positive for COVID-19 on 8-9-21. On 8-11-21, Resident C had no signs and symptoms and tested positive for COVID-19. Resident C was quarantined in room 120 with Resident B who tested positive for COVID-19 on 8-5-2021. On 8-11-21, Staff 10 had no signs and symptoms and tested positive for COVID-19. On 8-11-21, Staff 11 had signs and symptoms of congestion and tested positive for COVID-19. On 8-12-21, another resident with signs and symptoms of a cough tested positive for COVID-19 and was quarantined in room 233 in C-wing hall #3. Room 233 was next to room 234 and across from room 230, which had positive COVID-19 residents. The rest of the 9 residents in this hall were not in TBP. The state			

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	line list indicated no signs and symptoms for this resident when reported. During the entrance conference with the Regional Director of Operations, Chief Operating Officer, the Director of Clinical Services and the ADON on 8-11-21 at 11:32 a.m., it was explained when the new "Named" company began at the beginning of August, the new electronic system was not completely in place as the resident information from the previous electronic system did not transfer. The group indicated the residents' records were currently being transferred to the new electronic system and staff had been documenting resident information on paper forms until the transition and training was complete. The ADON (Assistant Director of Nursing) indicated since the change in ownership, they were unable to access the reporting systems for COVID-19 positive residents and staff as their email had changed. An interview with the Regional Director of Operations on 8-11-21 at 2:50 p.m., indicated the "Named" company assumed ownership of the facility on 8-1-21 and he returned today to assist after the Administrator tested positive for COVID-19 on 8-10-21. He indicated Resident F, who had been vaccinated, and had lacked signs or symptoms of COVID-19, was tested on 8-9-21 with a rapid test and was positive. He indicated the facility had just conducted PCR tests for the variant on 8-11-21 for Resident F and were waiting for the results. Resident F's roommate, Resident G was admitted to the facility on 8-9-21 at 10:00 a.m. Resident G was not vaccinated, had no signs or symptoms of COVID-19, and was placed in quarantine with Resident F. Resident G had a negative rapid test			

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	for COVID-19 done on 8-9-21. The Regional Director of Operations indicated Resident G was tested again on 8-11-21 and was negative. Resident G was moved out of the room she shared with Resident F on 8-11-21 in the afternoon. The Regional Director of Operations indicated he did not want to move residents because the move would be detrimental to the residents' psychosocial state and could spread the virus to the whole house. He indicated moving the residents around would encounter bigger problems. During the Immediate Jeopardy notification with the Regional Director of Operations, the Director of Clinical Services, the Chief Operating Officer and the ADON on 8-11-21 at 4:48 p.m., the ADON indicated the facility was bed locked and did not have the ability to move the COVID-19 positive residents to one area. The Regional Director of Operations indicated the most recent guidance from the State indicated they were not to move a resident without signs and symptoms and who tested positive for COVID-19 with the rapid test, until a PCR test was completed to confirm the positive status. He indicated there were no residents who had any signs and symptoms of COVID-19 when they tested positive with the rapid test. The Chief Operating Officer indicated the most recent guidance from the State indicated the facility did not have to create a COVID-19 unit. On 8-12-21 at 9:18 a.m., the Regional Director of Operations indicated he had the most recent COVID-19 LTC (Long Term Care) facility infection control guidance SOP (Standard Operating Procedure) updated by the state on 7-23-21. He indicated the facility was following the guidance on page 6, if an asymptomatic			

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	resident tested positive on an antigen (rapid) test, they were to be placed in TBP and not moved to a COVID-19 unit unless they had a confirmatory positive on a PCR test. He indicated the facility tested all the COVID-19 positive residents with a PCR test and they were not going to move the residents until the results of the PCR tests were back. The Regional Director of Operations was asked about the length of time the facility waited to do the PCR testing, as the first resident tested positive on 8-4-21, and he indicated they wanted to get the PCR tests which would test for the variant. He indicated he didn't know how long it would take the state to come to the facility with the PCR test which would test for the variant, so he opted to get an independent company to come and perform the PCR tests. He indicated the independent company did the PCR testing with the variant yesterday (8-11-21) and they were waiting on results. He indicated if the residents' results were positive, then the facility would implement their emergency plan and create a COVID-19 unit. An observation on C-wing Hall #3 on 8-12-21 at 9:58 a.m., indicated an additional room had TBP signage on the door, room 233. This room was next to Room 234 and across the hall from room 230. Each of those 3 rooms had a resident positive for COVID-19. An interview with Nurse 3 at this time, indicated the resident in room 230 tested positive this morning and had signs of a cough without a fever. The nurse indicated this resident spent a lot of time with Resident N, who tested positive for COVID-19 on 8-4-21. Nurse 3 indicated the resident in room 233 was tested frequently and was negative until this morning. The nurse indicated Resident Q in room 235 tested positive for COVID-19 on 8-9-21 and had no symptoms until 8-11-2021. Resident Q's			

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	symptoms were congestion and a cough. The nurse indicated Resident P in room 234 had body aches and chest congestion when he first tested positive for COVID-19 on 8-5-21. Nurse 3 indicated Resident O in room 230 had a fever and pneumonia when she tested positive on 8-10-21. An interview with CNA 4 on 8-12-21 at 10:08 a.m., indicated in C-wing Hall #1, Resident L was moved from B-wing to room 201 yesterday, 8-11-21, as she was positive for COVID-19. CNA 4 indicated Resident G was moved from B-wing to a C-wing Hall #1 room 208 on 8-11-21 due to being exposed to the COVID-19 virus from her roommate. On 8-12-2021 at 12:53 p.m., the Regional Director of Operations and the ADON indicated Resident L had signs and symptoms of shortness of breath and a cough when she tested positive on 8-11-21. (The state line list provided by the Director of Clinical Services on 8-13-2021 at 11:46 a.m., indicated for Resident O, Resident P, and Resident L, signs and symptoms, "N" for no was entered, when all three residents had signs and symptoms when they tested positive for COVID-19.) A review of Resident O's nurse's notes on 8-12-21 at 3:00 p.m., indicated on 8-9-21 at 5:00 p.m., the resident complained of a headache and not feeling well. The notes indicated the resident did not have a fever and denied any shortness of breath or difficulty breathing. Tylenol 500 mg (milligrams) 2 tabs were administered with good effect. On 8-10-21 at 3:00 a.m., the resident complained of a severe headache, difficulty breathing and shortness of breath. Resident O's temperature was 99.5 degrees Fahrenheit and oxygen saturations were			

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	83%. The NP (Nurse Practitioner) was notified and orders were received to administer Duoneb (an inhaler) every 6 hours prn (as needed), oxygen at 2 LPM (liters per minute) via N/C (nasal cannula) for oxygen saturations < 90. The nurse administered another COVID-19 test related to symptoms and was positive. On 8-10-2021 at 2:30 p.m., a chest X-ray was ordered and stat CMP and CBC (blood tests). Orders for Mucinex 600 mg by mouth 2 times a day x 14 days, Robitussin 15 milliliters every 8 hours for 3 days, then every 8 hours as needed x 14 days, oxygen as needed to titrate to keep oxygen saturations >92% were received. On 8-10-21 at 11:05 p.m., orders for Azithromycin (an antibiotic) 250 mg, administer 2 tabs tonight, then 1 tab daily for 4 days and for Rocephin (antibiotic) 1 gram IM (intramuscular) daily x 3 days with first dose tonight were received. On 8-12-21 at 4:00 p.m., no additional COVID-19 positive residents had been moved and the facility had not provided any information regarding a removal plan. The current community transmission rate during the survey time period was listed as "high" from the CDC COVID-19 Data Tracker at https://covid.cdc.gov/covid-data-tracker/#county-view and the positivity rate for the county was 18.12% through 8-12-21. Upon arrival to the facility on 8-13-2021 at 9:00 a.m., the National Guard was present (2 members) and indicated they had brought COVID-19 tests to the facility and would be testing today. An interview with the Director of Clinical Services indicated she had not checked to see if the results of the COVID-19 PCR tests from 8-11-2021 had been posted from the			

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	independent lab. An interview with the DON on 8-13-2021 at 9:01 a.m., indicated the COVID-19 positive residents had been moved to a COVID unit. An observation of B-wing Hall #2 with the DON on 8-13-2021 at 9:05 a.m., indicated from room 116 to the end of the hall, was a dedicated COVID-19 unit. There was a zippered wall and a PPE container outside the zippered wall. The DON indicated there were 15 residents in the unit and the COVID-19 unit had dedicated staff. An interview with the Director of Clinical Services on 8-13-2021 at 12:44 p.m., indicated the test results were beginning to come for the 8-11-21 PCR tests and most were positive. A "Clinical Questions about COVID-19: Questions and Answers" updated March 4, 2021 was obtained at the following web address, https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html and indicated "...If a nursing home is concerned about a false-positive antigen test result, what confirmatory test should be performed...In most instances, CDC guidance currently recommends performing confirmatory testing when asymptomatic individuals are antigen positive...Use nucleic acid amplification tests (NAAT), such as reverse-transcriptase polymerase chain reaction (RT-PCR), as the confirmatory test...Optimize sensitivity of the confirmatory test by collecting a high-quality specimen...Perform the confirmatory test within 2 days of the initial test...." A current facility policy, COVID-19 LTC Infection Control Standard Operating Procedures dated 7-1-21, was provided by the COO on			

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	8-11-21 at 1:30 p.m. The policy indicated "...Identify dedicated employees to care for COVID-19 resident and provide infection control training...Cohort confirmed or presumed COVID-19 positive residents...Cohort, if possible, direct care providers caring for confirmed or presumed COVID-19 residents into one area of the building. Staff should be dedicated for the COVID unit...All LTC facilities, should have a plan to rapidly implement, or implement now, how they will cohort confirmed or presumed COVID-19 residents in their facilities. This can be by wing, floor, or if available, by building. This should be done with expediency. Residents should be cohorted depending on COVID-19 status. Colors can be used on facility maps to help visualize results to facilitate moving of residents...COVID-19 positive (red)- These are residents who are confirmed COVID-19 positive and who, based on CDC criteria, still warrant transmission-based precautions (TBP). Health care providers (HCP) will wear single gown with each resident, gloves, N95 mask and eye protection. These residents should be placed in TBP (droplet and contact) and cohort into a COVID-19 wing, floor, or building...For any resident who tests negative for COVID-19, but has had a roommate who is positive, it is not recommended to place them with another roommate until 14 days after their exposure, assuming they have not developed symptoms or had a positive test. They should be placed in TBP contact droplet and the positive resident moved to the COVID unit...Infection control steps when health care worker or resident test positive for COVID-19-facilities should follow the CDC guidelines for health care workers and personnel protective equipment. Cohort staff and equipment for COVID-19 residents to minimize			

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	transmission in the building...." A current facility policy, Long-term Care Facilities Guidelines in Response to COVID-19 vaccination, dated 8-11-21, was provided by the COO on 8-11-21 at 1:30 p.m. The policy indicated " ...New admissions or Readmissions: The CDC allows for options that may include placing the resident in a single-person room in general population area or in a separate observation area so the resident can be monitored for evidence of COVID-19 ...." The Immediate jeopardy that began on 8-4-21 was removed and the deficient practice corrected on 8-13-21 when the facility created the COVID-19 unit to cohort the COVID-19 positive residents, moved a resident who tested negative for COVID-19 to another private room as the roommate had tested positive for COVID-19, provided dedicated staff to care for the positive COVID-19 residents and educated staff on correct use of PPE. 3.1-18(a) 3.1-18(b)(1) 3.1-18(b)(2) 3.1-18(b)(4)			