Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007116	A. BUILDING: ______ B. WING ______	09/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INTEGRITY HC OF SMITHTON	107 SOUTH LINCOLN SMITHTON, IL 62285

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S 000	Initial Comments Licensure Violations A COVID-19 Focused Infection Control Survey was conducted by Illinois Department of Public Health on September 29, 2020. Complaint #2047325/IL126841	S 000		
S9999	Final Observations Licensure Violations 300.610a) 300.696a)b) 300.1020a)b) 300.1210b) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.696 Infection Control a) Policies and procedures for investigating,	S9999		

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

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controlling, and preventing infections in the facility shall be established and followed. The policies and procedures shall be consistent with and include the requirements of the Control of Communicable Diseases Code (77 Ill. Adm. Code 690) and Control of Sexually Transmissible Diseases Code (77 Ill. Adm. Code 693). Activities shall be monitored to ensure that these policies and procedures are followed.

b) A group, i.e., an infection control committee, quality assurance committee, or other facility entity, shall periodically review the results of investigations and activities to control infections.

Section 300.1020 Communicable Disease Policies

a) The facility shall comply with the Control of Communicable Diseases Code (77 Ill. Adm. Code 690).

b) A resident who is suspected of or diagnosed as having any communicable, contagious or infectious disease, as defined in the Control of Communicable Diseases Code, shall be placed in isolation, if required, in accordance with the Control of Communicable Diseases Code.

Section 300.1210 General Requirements for Nursing and Personal Care

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b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These Regulations were not met as evidenced by:

Based on observation, interview and record review the Facility failed to develop and implement infection control procedures to prevent the spread of COVID-19 infection by: failing to implement transmission based precaution and cohort residents to prevent the spread of infection; using required personal protective equipment (PPE) when caring for COVID-19 positive residents; encouraging residents to wear masks and socially distance; and utilize procedures for effective waste disposal. This has the potential to affect all 50 residents living in the facility.

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Findings include:

1.The facility's COVID-19 Test Tracking Line List documents the facility's first COVID-19 positive case was R17 on 8/10/2020. No further cases were documented again until 9/4/2020. The COVID-19 test result date of 9/4/2020 documents, 17 residents (R1, R3, R4, R7, R18, R20, R25, R26, R35, R42, R45, R46, R47, R49, R51, R53 and R54) were positive. According to the line list 6 residents (R3, R18, R20, R25, R26 and R42) who tested positive for COVID-19 were residing in rooms with 6 residents (R12, R10, R8, R21, R24 and R27) who tested negative. The COVID-19 test result date of 9/9/2020 (five days later) documents R8, R10, R24, and R27 tested positive for COVID-19. R21 tested COVID-19 on 9/12/20. R12 tested positive on 9/14/20. After multiple request to the facility, no documentation has been provided indicating that the positive residents were moved to COVID-19 unit to be isolated. There was no documentation that the negative residents who were exposed to the positive residents were placed on transmission-based precautions.

There was no documentation of the residents that tested negative on 9/4/2020 being separated from the positive roommates. The Line List also documents the facility had 41 cases of COVID-19 positive cases for R3, R4, R5, R6, R7, R8, R10, R12, R14, R17, R20, R23, R24, R25, R26, R27, R32, R33, R34, R35, R36, R37, R38, R39, R40, R41, R42, R43, R44, R45, R46, R47, R48, R49, R50, R51, R52, R53, R54, R55 and R56 starting on 9/4/2020 to present.

2. The Residents Census and Conditions of Residents form, CMS 672, provided by the facility

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on 9/16/2020 documents the facility has 50 residents living in the facility.

Upon entering the facility on 9/16/2020 at 7:03 AM, V3, Licensed Practical Nurse (LPN) stated that all the residents who had tested positive for COVID-19 were on the 300 Hall.

3.R3's Physician Order Sheet (POS) for September 2020, document a diagnosis of Diabetes, Frontal-Temporal Dementia, and Hypertension.

R3's Lab Results dated 9/4/2020 document R3 was positive for COVID-19 on 9/4/2020.

R3's Progress Notes dated 9/5/2020 at 11:08 AM documented R3 tested positive for COVID-19. The Line Outbreak Log documents R3 and R12 shared a room together on the 100 Hall unit at that time.

4.R12's Physician Order Sheet (POS) dated 9/2020 documents a diagnosis of COVID-19 on 9/14/2020, Chronic Pulmonary Disease, Emphysema, Schizophrenia and psychosis.

On 9/16/2020 at 7:10 AM, R12 resided on the 100-hallway in a room with R13. R12 was formerly roommates with R3 who was moved to the COVID-19 unit.

The Facility's undated Line List for COVID-19 Outbreaks in Long Term Care Facilities, documents R12 tested positive for COVID-19 on 9/14/2020.

R12's Lab results dated 9/16/2020 document R12 was positive for COVID-19 on 9/14/2020.

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On 9/16/2020 at 7:08 AM, R12's door was opened to the 100 hallway and there was a sign on the door documenting, "Special Droplet/Contact Precautions." Outside of R12's room door there was a dresser with Personal Protective Equipment (PPE) inside of it. R12 was not in her room. R13 was in this room lying on her bed and was not wearing a mask. There was no hand sanitizer available for use on the dresser with the PPE.

On 9/16/2020 from 7:12 AM to 8:40 AM, R12 was walking from the nurse's station to the dining room. R12 was not wearing a mask. R9 was sitting at the dining room table when R12 walked past R9 did not maintain social distancing of 6 feet away. R9 was wearing the mask around her neck. R12 was pacing back and forth with her walker in the dining room, sat down in the dining room chair and then got back up and started roaming the halls (100 and 200). No staff was redirecting R12 or encouraging her to don a mask. R12 was not maintaining social distancing of 6 feet away from staff and or any resident who would come by.

On 9/16/2020 at 7:28 AM, V3, Licensed Practical Nurse (LPN) stated, "(R12) likes to roam the halls. We can't keep a mask on her. I am not sure if she tested positive for COVID-19. (V3) instructed (R12) to put a mask on her face; however, R12 ignored her and kept pacing the hallways. V3 stated, they are unable to keep her from wandering the halls and they have a hard time getting her to wear a mask.

On 9/16/2020 at 7:51 AM, V4, Certified Nursing Assistant (CNA) stated, "I do not know why (R12) is on contact isolation. I am the only CNA on these 2 halls (100/200 Halls) today. (R12) likes to

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roam the halls and we have a terrible time getting her to keep her mask on when she leaves the room and to stay six feet away from everyone. Yes, she is always roaming the halls here without her mask."

On 9/16/2020 at 8:51 AM, R12 was not wearing a mask when she entered her room and sat down on her bed. R13 was in the room at that time. Neither R12 nor R13 were wearing a mask.

On 9/17/2020 at 7:25 AM, V1, Administrator stated, "Yes, (R12) tested positive for COVID-19. (R12) was tested on 9/11/2020 but we did not get the results back until 9/14/2020 and she was positive for COVID-19."

5.R13's POS dated September 2020 document a diagnosis of Dementia, Hypertension, and Heart Disease.

On 9/16/20, R13 was seen sharing a room on the 100-hall with R12 who has tested positive for COVID-19.

R13's Lab results dated 9/14/2020 document R13 was negative for COVID-19 on 9/14/2020.

On 9/18/2020 at 8:06 AM, R13 was propelling herself in her wheelchair down the hall. R13 had a mask with her but was not wearing the mask. R13 entered the telephone room. R13 was coughing slightly. The staff did not encourage R13 to perform hand hygiene. R13 did not cover her mouth when coughing.

On 9/18/2020 at 8:08 AM, R13 was eating breakfast in the dining room assisted by V15, CNA. R13 and V15 were not six feet apart from each other. R13 was coughing slightly. V15 did

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not perform hand hygiene.

On 9/18/2020 at 9:17 AM, V14, Business Office Manager was standing in the dining room and was only wearing a surgical mask. R13 was at the nurse's station and wheeled by V14 and they greeted each other. R13 was not wearing a mask. V14 did not encourage R13 to don a mask and V14 was less than 3 feet away from R13.

On 9/18/2020 at 9:24 AM, R13 was in the hallway and was not wearing a mask.

On 9/18/2020 at 9:30 AM, V15 came and got R13 and began to give her a shower. R13 was not wearing a mask and R13 was coughing off and on while waiting in the hallway and inside the shower room.

6. R16's POS dated September 2020 documents a diagnosis of Hypertension, Diverticulosis Emphysema, Disorder of the Arteries, and Peripheral Vascular Disease.

The Facility's undated Line List for COVID-19 Outbreaks in Long Term Care Facilities documents R16 resided on the 300 COVID-Unit on 9/12/2020. The Line list documented R16 tested negative for COVID-19; however, R16 was residing on the unit with all residents who tested positive for COVID-19.

On 9/17/2020 at 9:21 AM, V3, LPN, stated, "(R16) was housed on the 300 hall COVID-19 unit but was just recently moved to the 200 Hall. (R16) was tested multiple times and was negative so we moved him to the 200- hall. (R16) is still on droplet precautions. I think he was moved yesterday (9/16/20) that is why his chart was on the 300 unit."

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S9999	Continued From page 8 On 9/18/2020 at 7:58 AM, R16's room was located on the 200-hall. R16's room door was open, there was sign on the door documenting, "Special Droplet/Contact Precautions" and PPE was outside of the door. R16 was not inside his room. There was no hand sanitizer available for use. On 9/18/2020 at 8:30 AM, there were 2 sets of doors closed. Upon entering the first closed door there was a hallway followed by the common area with a television. This common area led to the 300-hall where the designated COVID-19 Unit was in place. R16 was in this area and was not wearing a mask as he wandered the hallways, confused, holding up his pants. No staff was nearby to assist R16. R16 was not sure if he should enter the 300 unit or go back through the double doors and was pacing back and forth. On 9/18/2020 at 8:50 AM V7, Regional Clinical Nurse, Infection Control Specialist stated, "No, (R16) should not be there (near the 300 hall)" and encouraged R16 to go back with her to his room. V7 stated "(R16) is on 'droplet precautions because he was on the COVID-19 Unit. He just moved to the 200 Hall yesterday I believe." On 9/17/2020 at 7:21 AM, V7 stated "If a resident test positive for COVID-19, I would expect the resident to be moved to the special COVID-19 Unit." V7 stated the facility was not housing any positive or negative residents together. V7 stated "No, I did not realize (R12) was positive for COVID-19 and her roommate (R13) was negative. I don't know residents and/or room numbers. No, they should not be housed together. If a resident cannot stay in their room, I would expect the resident to be on the COVID-19	S9999		

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unit. I would not expect a COVID-19 positive resident to be roaming the building on the non COVID-19 hall or sharing a room with a resident who is negative for COVID-19."

On 9/22/2020 at 10:03 AM, V27, Local Health Department, Director of Infection Disease stated, "The facility has been sporadic in sending us their numbers. The person in charge seems confused and is always telling us they will get back to us, they are still working on it. I finally set up a call with the State Infection Control Specialist, because their numbers are increasing. We talked about cohorting residents, infection control measures, screening staff. Initially, the facility had 3 confirmed COVID-19 cases on 9/2/2020. Then on 9/10/2020 they reported 22 new cases. On 9/13/2020 they had 2 more new cases and 1 more new case on 9/15/2020 and then 9/16/2020 15 more cases. On 9/21/2020 1 more case. As far as COVID-19 deaths, (R53) expired from COVID-19 death on 9/2/2020. (R49) expired from COVID-19 related death on 9/3/2020, (R49) was also on hospice but it was COVID-19 related. (R54) expired on 9/18/2020. We got a report yesterday that another COVID-19 related death occurred yesterday but at this point we do not have a name yet for the resident. No, I would not expect a resident who is positive or on the positive unit to be cohorting with a negative resident. We went over this with the facility and they told me they were not doing cohorting with anyone."

On 9/22/2020 at 10:30 AM, V28, State Infection Control Specialist stated, "We had a meeting with the facility on 9/18/2020. I asked them if they had enough supplies, hand sanitizer and they assured me there was plenty. (V1) did not seem to grasp everything that they needed to know and seemed

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overwhelmed. We talked about ideas for staffing and they told me they were housing 100 percent of residents only on the COVID-19 unit. No, I was not aware that there were residents on contact/droplet precautions on the 100/200 halls. That is not what they told me they were doing. We talked about the dangers of cohorting and quickly it can spread which it is spreading right now. With the incubation period of 2-14 days this can affect the whole building and with their population and vulnerability of the elderly this can be a major problem. As of Friday, 9/18/2020 the facility has a total of 42 COVID-19 positive residents, 21 staff members and 3 deaths."

On 9/23/2020 at 12:18 PM, V7 stated, "For residents who are exposed to positive residents once we have validation a resident is positive then we move the positive patient to a different area, either the 300 halls, or our sister facility. It's hard to explain how the room numbers are tracked. With so many positives coming in all at once, it is hard to keep the census up to date. We triage room moving by who is positive, look at who their roommates are, and decide where to move them as soon as we can. We do not have room moves documented on a log. Nursing staff are monitoring the residents respiratory, appetites, vitals, really anything that changes with their condition. Any question about their status we would keep them on isolation. The staff should wear Full PPE- Gown, faces shield or goggles, mask, gloves, and shoe covers. We did not have a step-down area while you all were here. COVID-19 positive residents get their vital signs every 4-hours, the CNAs take them and give them to the nurse to log. The nurses would put it on the log, I will be honest it is a struggle to get them on everyone every 4 hours. That is a big challenge. Sometimes stacks of vital signs

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papers are at the nurse's station and may not get entered. I have not talked with local health department."

On 9/22/2020 at 4:02 PM, V29, Medical Director stated, "No, I was not aware there were over 32 residents that were positive for COVID-19 in the facility. They have a designated unit for COVID positive residents now on the 300-hall. The positive residents should be on Contact/Droplet precautions on the designated unit for 14 days, then on step down another 14 days before cleared to move to a negative unit. The residents who are new admissions should be on contact/droplet precautions too because you don't know if they have COVID-19, even if they tested negative. The facility may also send positive residents to the (sister facility). I was not aware they had that many positives cases. There have been no COVID-19 related deaths that I am aware of, they will transfer residents to the hospital if they have any change in condition. I would expect them to call me if a resident has change of condition, or COVID-19 symptoms. If their pulse oximeter would persist below 90% with other symptoms they should call. I know there are staffing issues in all of the nursing homes, since the Pandemic it is even more of an issue. If they are not on an emergency staffing plan they should be. I am not sure who the Infection Control Preventionist is at the facility. You know it is hard to keep some of their population from wandering due to mental issues. You want to isolate positive residents on the designated unit. You should not have any negative tested residents sharing a room with any positive tested residents ...If the COVID unit is full then they need to open up another unit. No, negative residents should never share the same room with positive residents. They should not allow negative

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and positive residents to share a room. They would not do this. If a resident who is negative shares a room with a positive resident, they would likely be infected, this should never be done."

7. On 9/18/2020 at 8:15 AM, while working on the 100-200 halls, V15, Certified Nursing Assistant/CNA, was not wearing her mask correctly and the elastic bands were both around her neck and the mask was not fitting around her mouth and nose. V15 stated "Today is my first day. No, I have not been trained on PPE, what to wear, or how to take on and off. No, I am not sure what anyone is on contact isolation for on this hall or why anyone is on contact isolation, I only just started. I started this morning at 7 AM. I am assisting residents, toileting, I assisted 2 residents this morning with eating. I think everyone with COVID-19 is on the 300- hall."

On 9/18/2020 at 9:35 AM, V16, Registered Nurse/RN stated, "I am only filling into today this is my first time here. I work at their sister facility. No one told me there were any positive or potential positive residents with COVID-19 on these halls. I thought they would all be on the COVID unit or I would have been wearing the N95 mask now. If they would have informed me that there were residents being housed on these halls for potential COVID-19 I would have had the right mask (N95) on because I don't want to get it or take it home. I did not know it was on this side of the hall."

On 9/18/2020 at 9:44 AM, V13, Registered Nurse (RN)/Administrator at Sister Facility, was only wearing a surgical mask. V13 stated "I did not know they were housing any COVID-19 residents on this hall. All COVID-19 residents should be on the COVID-19 hall and no, staff are not wearing

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the correct mask (N95 mask) as I don't think they are even aware there are positive COVID-19 positive residents on this side of the building."

The following was observed on the COVID-19 positive unit on 9/16/2020 and 9/17/2020:

8. On 9/16/2020 at 9:06 AM, V18, LPN, stated there are about 33 residents who have tested positive for COVID-19 on the COVID-19 Unit (300-hall).

On 9/16/20 at 9:06 AM, V6 Activity Director, V17 Agency Registered Nurse and V18 LPN were working on COVID-19 positive unit (300-hall). V6, V17 and V18 were not wearing eye protection when entering residents' rooms on the COVID-19 unit. V17 was wearing a loose-fitting surgical mask, not a N95 mask, which dropped below her nose when she talked and was frequently touching and adjusting the mask with her hands.

On 9/16/20 at 9:52 AM, V19, CNA, entered the COVID-19 unit. V19 was taking vital signs of residents on the COVID-19 unit. V19 did not wear any eye protection when entering the residents' rooms. V19 would go into the resident's rooms with an overbed table, wrist blood pressure cuff, not touch forehead thermometer and finger pulse oximeter, and a logbook for documenting the resident's vital signs. As V19 entered and exited the rooms, there was no disinfectant on the table for cleaning and disinfecting the equipment after each resident's use. At 12:05 PM, V19 was taking residents vital signs on the COVID-19 unit. V19 did not wear gloves as she entered each residents room. V19 continued to take an overbed table into the room with equipment to take residents' vitals. She did not disinfect the

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equipment as she went from room to room and in between each resident's use.

On 9/16/20 at 10:35 AM, V11, Maintenance, entered the COVID-19 unit through a tarped entrance area and was only wearing a surgical mask, not an N95 mask. V11 was not wearing a gown, gloves or eye protection while on the COVID-19. V11 was retrieving an air mattress from a closet on the COVID-19 unit. V11 stated "I just came over her to get an air mattress for (R1's) bed because you all are here. Now I am embarrassed to say I forgot to put on the PPE. I should have on what you're wearing. V11 then exited back through he tarped off entrance area.

On 9/16/20, at 10:40 AM, V17, RN/Agency, pulled her surgical mask off her face exposing her nose and mouth while talking to V18 at the medication cart while on the COVID-19 positive unit.

On 9/16/20, from 9:07 AM until 11:30 AM, there was no trash can available near the designated COVID exit area for doffing PPE. There were multiple empty boxes stacked on the floor next to the door. At 2:45 PM, there was still no container to doff contaminated PPE prior to exiting the COVID-19 unit. There was no hand sanitizer available at the exit of the unit. The exit to the COVID-19 unit exits to the exterior of the facility.

On 9/16/20, at 11:34 AM, V6 was taking resident out to smoke through the COVID-19 designated exit door. V6 doffed her re-usable gown on top of a suitcase next to the door, which rests up against the hallway handrail. V6 assisted residents to step outside. V6 lit residents' cigarettes wearing gloves. V6 did not sanitize her hands between each resident while assisting with cigarettes. At 12:21 PM, V6 stated "I am really not

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sure what I can wear again or what I have to get new after taking residents out for smoke breaks. I have not been given any guidance to be honest. I am not sure." At 12:50 PM, V6 stated the suitcase sitting on the floor near the COVID-19 unit exit with the N95 mask and the reusable gown was hers. There was no trash or laundry barrel near the COVID-19 exit door to discard used PPE.

On 9/16/20 at 12:15 PM, V10 Housekeeping, entered the COVID-19 unit. V10 failed to don eye protection. At 12:20 PM, V10 stated when he is on the unit, he was supposed to wear masks, gown, gloves, and shoe covers.

On 9/16/2020 at 10:06 AM, V18, LPN stated, "I guess we are supposed to be wearing eye shields back here, but they give me a headache, so I don't wear them.

On 9/17/2020 at 9:10 AM, V25, who is this stated "I don't know what the procedures are for entering and exiting the COVID-19 units. I didn't get training about how to leave the unit. I mean, should I take all of this off and throw it away? I am not sure. I will need to go to lunch, and I guess we are supposed to leave through that door (pointing to the exit by 300 room) I am not sure if I re-use this stuff or not?"

On 9/23/2020 at 12:18 PM, V7, stated "there was supposed to be a trash can at the exit (on the COVID-19 unit) to throw away gloves and gowns. There was a small trash can set up there the last time I was in there."

9. On 9/16/20 from 8:50 AM through 12:15 PM, based on 15- minute or less observation intervals, there was no cleaning and disinfection of high

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touch surface areas on the entire COVID-19 unit. No housekeeper was present or working in the rooms on the COVID-19 unit.

On 9/16/20, at 12:20 PM, V10, Housekeeper, stated that he is to clean high touch surfaces every 2 hours using bleach. He noted he was last on the COVID-19 unit at 7:30 AM to disinfect high touch areas.

Facility's policy entitled, "(Facility) COVID-19 Testing and Response Plan" effective 6/11/2020 documents, "It shall be the policy of the Facility to guard against the introduction and spread of SARS-CoV-2 within its community of residents and staff. The Facility uses available and current guidance from the Centers for Disease Control and Prevention (CDC), Center for Medicare and Medicaid Services (CMS), the Illinois Department of Public Health (IDPH), and Local Health Department (LHD) officials to instruct the development and implementation of policies and procedures that comprise its strategy to prevent, respond to, and mitigate the presence of SARS-CoV-2. This policy will provide the administrative framework for the development and implementation of specific subordinate policies, procedures, and protocols for the prevention, monitoring, testing, and responding to any incidence of SARS-CoV-2 within the Facility ...Infection Control Capacity: The Testing and Response Plan is part of the Facility's overarching Infection Control Policy ...Appropriate Personal Protective Equipment (PPE) is a critical component of the Facility's Infection Control Policy. PPE is necessary to both protect staff and reduce transmission within the Facility ..."

Facility Policy undated and entitled, "INTERIM GUIDANCE FOR COVID-19 Clinical

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S9999	Continued From page 17 Management Considerations (Facility) Long-Term Care Facility" documents, "If patients have been screened and their testing is NEGATIVE for COVID-19: a) Avoid placing with COVID-19 or symptomatic patients b) Consider discharge to home of post-acute/rehabilitation patients who can be home quarantined ...If patients have been screened and their testing is POSITIVE for COVID-19 OR if patients have signs/symptoms of a respiratory viral infection:. Full Vitals AND pulse oximetry every 4 hours (Q4hours) ...Private Room or Cohort with another symptomatic/positive patient ...Maintain standard, contact and droplet precautions (including eye protection) ...Consider that staff caring for positive or symptomatic patients do NOT care for negative or asymptomatic patients ...Positive or symptomatic patients should always be given a surgical mask and encouraged to wear. These patients should be wearing a surgical mask when close contact with others is anticipated." The Center for Disease Control (CDC) website page, "Responding to Coronavirus (COVID-19) in Nursing Homes, updated 4/30/2020, documented the facility should implement the following for residents who have tested positive for COVID-19: "Ensure the resident is isolated and cared for using all recommended COVID-19 PPE: Place the resident in a single room if possible pending results of SARS-CoV-2 testing; Cohorting residents on the same unit based on symptoms alone could result in inadvertent mixing of infected and non-infected residents (e.g., residents who have fever, for example, due to a non-COVID-19 illness could be put at risk if moved to a COVID-19 unit); if cohorting symptomatic resident, care should be taken to ensure infection prevention and control interventions are in place to decrease the risk of	S9999		

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cross-transmission; If the residents is confirmed to have COVID-19, regardless of symptoms, they should be transferred to the designated COVID-19 care units; Roommates of residents with COVID-19 should be considered exposed and potentially infected and, if at all possible, should not share rooms with other residents unless they remain asymptomatic and/or have tested negative for SARA-Co-V-2 14 days after their last exposure (e.g., date their roommate was moved to the COVID-19 care unit)." The webpage documents "Assign environmental services [EVS] staff to work only on the unit. If there are not a sufficient number of EVS staff to dedicate to this unit despite efforts to mitigate staffing shortages, restrict their access to the unit. Also, assign HCP (Health Care Personnel) dedicated to the COVID-19 care unit (e.g., NAs) to perform cleaning and disinfection of high-touch surfaces and shared equipment when in the room for resident care activities. HCP should bring an Environmental Protection Agency (EPA)-registered disinfectant (e.g., wipe) from List N into the room and wipe down high touch surfaces (e.g., light switch, doorknob, bedside table) before leaving the room."

The CDC website page, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic", updated on July 15, 2020, documents, "Source control refers to the use of cloth face covering or facemasks to cover a person's mouth and nose to prevent spread of respiratory secretions when they are talking, sneezing, or coughing. Because of the potential for asymptomatic and pre-symptomatic transmission, source control measures are recommended for everyone in a healthcare facility, even if they do not have

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S9999	Continued From page 19 symptoms of COVID-19." The website page documents "Patients and visitors should, ideally wear their own cloth face covering (if tolerated) upon arrival to and throughout their stay in the facility. If they do not have a face covering, they should be offered a facemask or cloth face covering as supplies allow. Patients may remove their cloth face covering when in their rooms but should put it back when around others (e.g. when visitors enter their room) or leaving their room." (A)	S9999		