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	274086	A. BUILDING _____ B. WING _____	02/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTANA STATE HOSPITAL	**100 GARNET WAY WARM SPRINGS, MT 59756**

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A 000	INITIAL COMMENTS An Unannounced Federal Complaint Survey (# MT00051249, MT000253, MT000254, MT00051273, and MT00057253) was conducted by Centers for Medicare and Medicaid Services Dallas from 02/8/2022 through 02/10/2022 to determine compliance with 42 CFR 482 Conditions of Participation (CoP) for Hospitals. An entrance conference was held on the morning of 02/08/2022. The purpose, scope, and process of the complaint survey was explained and an opportunity for questions and discussion was provided. An exit conference was held 02/10/2022 with key administrative personnel. Preliminary findings of the survey were discussed, next steps in the survey process were explained, and again, an opportunity for questions and discussion was provided. The facility census at entrance was 107. Deficient practices in the following Conditions of Participation were determined to pose an Immediate Jeopardy (IJ) to patient health and safety and placed all patients in the facility at risk for likelihood of harm, serious injury and possibly death. On 02/09/2022 at 4:00 P.M. the facility COO was informed of the findings of the Immediate Jeopardy and no plan of removal was received by exit on 2/10/2022: The following Condition of Participation were found to be out of compliance: 42 CFR 482.13 Patient Rights 42 CFR 482.42 Infection Control Abbreviations Utilized: ADON Assistant Director of Nursing	A 000		

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

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A 000	Continued From page 1 APRN Advanced Practitioner Registered Nurse CNA Certified Nursing Aide COO Chief Operations Officer DON Director of Nurses ICP Infection Control Preventionist NM Nurse Manager PT Psychiatric Technician QAPI Quality Assurance Performance Improvement RT Recreational Therapist MAR Medication Administration Record QD Everyday Mg Milligram SQ Subcutaneous Mcg Micrograms ADL Activities of Daily Living TAR Treatment Administration Record OOB Out of Bed BHCP Behavioral Healthcare Planner Pt Patient W/C Wheelchair VS Vital Signs Q Every	A 000		
A 115	PATIENT RIGHTS CFR(s): 482.13 A hospital must protect and promote each patient's rights. This CONDITION is not met as evidenced by: Based on interviews and record review, the facility failed to prevent falls with serious injury, for two (Ps 3 and 8 of five patients reviewed for falls. P8 had thirteen falls from 12/02/2021 to 01/27/2022. On 01/27/2022. P8 had a fall that resulted in hospitalization and diagnosis of subdural and other hematomas with mid-line shift in brain herniation. P8 expired 01/30/2022. P3	A 115		

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A 115	Continued From page 2 had an undated no time progress note that reflected a fall on or around 02/06/2022 that resulted in a laceration to head and Emergency Room visit. No incident report for post fall was completed, inaccurate assessments (Neuros) completed and no Physician Orders for c-collar, transfer to hospital paperwork and no report to ER staff. The hospital staff failed to: 1. Implement safety measures to prevent the patient for sustaining frequent falls. 2. Failed to ensure Post Fall Assessments were completed when the patient had falls. 3. Failed to ensure the nurse assigned staff to 1:1 supervision as indicated on the treatment plan.. The cumulative effects of these deficient practices placed patients at risk of serious illness and/or death. These findings resulted in an Immediate Jeopardy (IJ) situation that was called on 02/09/22 at 4:00 PM and presented to the Chief Operating Officer (COO), related to 42 CFR 482.13, requirement for the condition of participation of Patient Rights. The IJ was still in place at the time of exit on 02/10/22 at 2:00 PM	A 115		
A 142	PATIENT RIGHTS: PRIVACY AND SAFETY CFR(s): 482.13(c) Patient Rights: Privacy and Safety This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to prevent falls with serious injury, for two (Ps 3 and 8 of five patients reviewed for falls.	A 142		

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A. P8 had thirteen falls from 12/02/2021 to 01/27/2022. On 01/27/2022. P8 had a fall that resulted in hospitalization and diagnosis of subdural and other hematomas with mid-line shift in brain herniation. P8 expired 01/30/2022.

B. P3 had a fall that caused a visible head injury with bleeding. P3 had two lacerations to the head and was transferred to a local hospital for treatment. She returned to the facility that same date.

From 01/01/2022- 02/09/2022 there were a total of 41 falls on four of four units.

Findings included:

A:
P8 was a 73-year-old female admitted to the hospital on 08/06/21 per the current face sheet in the clinical record.

Review of a Montana State Hospital Discharge Summary date 02/09/2022 revealed diagnosis/medical history including: Major neurocognitive disorder- dementia with behavioral disturbances, Mixed Anxiety and Mood disorder, Falling-head injury acute on (sic) chronic, Diabetes, HTN (hypertension), prior history of stroke January 2021, RLS (Restless leg syndrome), COVID 19 01/2022, thyroidectomy, neurogenic bladder, constipation, COPD (chronic obstructive pulmonary disease), and cataracts.

Review of a current Medication Administration Record (MAR) dated 01/13/2022 through 02/09/2022 for P8, revealed she was on the

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following routine medications: Milk of Magnesia 30 ml QD (Everyday) (indication for use is relief of occasional constipation), Senakot 2 tabs at bedtime (indication for use is constipation), Aspirin 81 milligrams (mg) QD (indication for use fever reducer, mild pain reliever and/or prevention of stroke and heart attack), Requip 0.5 mg at bedtime (indication for use is restless leg syndrome), Lantus Insulin 45 units subcutaneous (SQ) every am (indication for use is to treat diabetes mellitus), Neurontin 400 mg three times a day (indication for use is to treat seizures and can be used for pain), Trazadone 50 mg before breakfast and at 2pm (indication for use is to treat depression), Zyprexa 2.5 mg at bedtime (indication for use is to treat mental disorders such as schizophrenia or bipolar disorder), Losartan-Cozaar 100 mg QD (indication for use is to treat high blood pressure), Norvasc 10 mg QD (indication for use is to treat high blood pressure), Detrol LA 4 mg QD (indication for use is to treat an overactive bladder or incontinence), Cymbalta 30 mg QD (indication for use is to treat depression), Synthroid 150 micrograms (mcg) QD (indication for use is to treat hypothyroidism), Inderal LA 20 mg twice a day (indication for use is to treat high blood pressure), Lamictal 75 mg QD (indication for use is to treat seizures and bipolar disorder), Humalog insulin sliding scale twice a day (indication for use is to treat diabetes mellitus).

Review of a Treatment Plan dated 11/02/2021 for P8 revealed, "Nursing staff to meet with [P8] daily on the unit and assess her for ADL [Activities of Daily Living] needs and provide assistance as needed. Nursing to assign 1: 1 staff supervision. Nursing to monitor for unsafe behavior. Nursing

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to provide [P8] with simple instructions and allow her adequate time to process on transfers from her bed and wheelchair to encourage an increase in safe behavior and awareness. Nursing to offer reassurance to [Patient #8} and attempt to engage her in the completion of her ADLs ...." The treatment plan did not include interventions to prevent falls.

Review of a Treatment Administration Record (TAR) dated 12/16/2021 through 01/12/2022, for P8 revealed the orders including: 1) Hi/low bed at low position, 2) PT to wear padded cap when OOB (out of bed) and 3) Place bed alarm on bed continuous place bed alarm on bed for high fall risk with recent fall on 12/20/21 HIGH FALL RISK." There were boxes on the form, indicating the current day of the month. All of the boxes for the timeframe were blank for the Hi/low bed and the Padded cap when OOB. For the Bed alarm, there were initials in the boxes on 01/10/2022 and 01/11/2022.

Review of a Monthly Physician's Progress Note dated 01/13/2022 for P8 revealed, " ...Patient experienced multiple falls beginning in early January 2022, however investigations found that medical causes such as limited vision and previously unidentified cardiac abnormality are contributing ...."

Review of a Medical Consult dated 01/13/2022, for P8 revealed, " ... repeat EKG ventricular rate 60 appears to be a sinus arrhythmia and not supra ventricular bigeminy ...."

Review of a Monthly Summary dated 01/18/2022 for P8 completed by the Behavioral Health Care

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Planner (BHCP) revealed, " ...Pt expressed interest in a nursing facility ...BHCP agreed that once pt was no longer receiving 1 to 1 supervision that referrals could go out. Discussed goal for December would be to off 1 to 1 staffing and maintain her safety ...Discussed pt has had recent falls but it was determined that medical issues were likely cause. Pt has some cardiac related and vision issues ...."

Review of a Physician' Order Sheet for P8 dated 01/21/2022 at 1900 revealed, "Place pt in camera room due to numerous, unwitnessed falls.

Review of a Post Fall Assessment Form for P8, dated 12/02/21 at 12:40 PM, revealed, "Pt [patient] was ambulating [with] 1:1 staff, gait belt, walker in room and when attempting to sit in the w/c [wheelchair] pt lost balance [and] fell forward to the right onto floor." The form indicated there was no injury and that the patient was 'slightly hypertensive' with a blood pressure of 166/89. The Fall Risk assessment update indicated a score of 8, indicating patient was a 'low risk' for falls. Immediate Changes were noted as, "Pt and staff educated on transfer [and] ambulation safety.' The form reflected to complete VS (vital signs) q (every) 8 hrs. (hours) x (times) 48 hrs. VS were completed at 12:40PM on 12/02/2021, then on 12/03/2021 at 9:00 PM, 12/04/2021 am and pm, 12/05/2021 am and pm. There were missing VS on 12/02/2021 and 12/03/2021.

Review of a Post Fall Assessment Form for P8, dated 12/20/2021 at 9:00 PM, revealed, "Pt went to bathroom and states she stood too far forward [at] toilet and fell on buttocks missing toilet seat. Pt denies injury. No injury noted." The form

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indicated there was no injury. The Fall Risk assessment update indicated a score of 10, indicating patient was a 'low risk' for falls. Immediate changes were noted as, "recommend pt to use call light.' The form reflected to "Perform neuro assessment initially, then every 30 minutes x 2 hours, then hourly x 4 hours, then every shift for a total of 72 hours from the time of fall." VS and assessment was blank for 12/20/2021 at 11:30 PM, and 12/21/2021 at 12:30 AM and 1:30 AM. There was a note on the form, "Pt recommended to use call light. Remains 1:1 while awake and q15min while in bed. *NOC nurse missed neuros during 2330-0130-notified RN Management."

Review of a Post Fall Assessment Form for P8, dated 12/22/2021 at 11:00 AM, revealed, "Staff assisting pt to bathroom, pt leaned too far forward and slid off of the toilet. No noted injuries. Denies pain. Did not hit head." The form indicated there was no injury. The Fall Risk assessment update indicated a score of 11, indicating patient was a 'high risk' for falls. Immediate changes were noted as, "Pt remined [sic] to use call light when needing assistance. Staff at pts side when she slid off of the toilet. No injuries noted." The form reflected to "complete VS (vital signs) q (every) 8 hrs. (hours) x (times) 48 hrs."

Review of a Post Fall Assessment Form for P8, dated 01/08/2022 at 10:18 AM revealed, "Per video review-pt walking to her room [with] walker incorrectly [and] uneven-fell to left side/tripped to [left] side. No injury." The form indicated there was no injury. The Fall Risk assessment update indicated a score of 11, indicating patient was a

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A 142	Continued From page 8 'high risk' for falls. The form reflected to "complete VS (vital signs) q (every) 8 hrs. (hours) x (times) 48 hrs." (Note, the patient fell again one hour later, assessments continued with that fall). Review of a Post Fall Assessment Form for P8, dated 01/08/2022 at 1118, revealed, "Pt was using N [north] end bathroom and was found on floor [with] pants down. Pt states she fell off the toilet. Denies pain, was using walker for ambulation. Pt found lying on [right] side [with] head against the wall.' The form indicated there was no injury. The Fall Risk assessment update indicated a score of 12, indicating patient was a 'high risk' for falls. There were no immediate changes noted. The form reflected to "Perform neuro assessment initially, then every 30 minutes x 2 hours, then hourly x 4 hours, then every shift for a total of 72 hours from the time of fall." Review of a Post Fall Assessment Form for P8, dated 01/12/2022 at 11:15 AM revealed, "Patient was observed ambulating in the hallway while using her walker. She suddenly veered to the left and lost her balance, falling into the wall and promptly sliding down to the floor." The form indicated there was no injury. The Fall Risk assessment update indicated a score of 6, indicating patient was a 'low risk' for falls. Immediate changes indicated, "15 min [minute] checks, padded pants." The form reflected to "complete VS (vital signs) q (every) 8 hrs. (hours) x (times) 48 hrs." (Note, the patient fell again less than one hour later, assessments continued with that fall). Review of a Post Fall Assessment Form for P8, dated0 1/12/2022 at 11:50 AM revealed, "Pt was	A 142		

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going too fast [and] lost balance forward. Didn't hit head." Under Detailed Description of injuries was, "None noted. HR [heartrate] very low 33 [with] bigeminy type regularity. Stat EKG done." The Fall Risk assessment update indicated a score of 13, indicating patient was a 'high risk' for falls. The form reflected to "complete VS (vital signs) q (every) 8 hrs. (hours) x (times) 48 hrs."

Review of a Post Fall Assessment Form for P8, dated 01/14/2022 at 0800, revealed, "Pt found lying on her [left] side of the toilet room. She slipped off [after] voiding attempting to get off. Denies loss of [surveyor not able to read]. Did strike [left] side head again. A [alert] [and] o [oriented] x 3. ' The Fall Risk assessment update indicated a score of 12, indicating patient was a 'high risk' for falls. Immediate changes were noted as "wheel chair." The form reflected to "Perform neuro assessment initially, then every 30 minutes x 2 hours, then hourly x 4 hours, then every shift for a total of 72 hours from the time of fall." Assessments were blank on0 1/14/2022 at 1:30 PM and 01/16/2022 in the am. The note on the form indicated, "Small lac [laceration] to [left] elbow treated."

Review of a Post Fall Assessment Form for P8, dated 01/21/2022 at 5:00 PM, revealed, "Pt was found sitting on the floor reporting that she had fallen ...No evidence of head or limb injury was found." The Fall Risk assessment update indicated a score of 7, indicating patient was a 'low risk' for falls. The form reflected to "Perform neuro assessment initially, then every 30 minutes x 2 hours, then hourly x 4 hours, then every shift for a total of 72 hours from the time of fall."

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Review of a Post Fall Assessment Form for Patient #8, dated 01/22/2022 at 12:15 PM revealed, "Patient threw herself onto pad next to her bed. CNA [certified nurse assistant] responded and helped pt. into bed. Incident fully visible by camera." Under Detailed Description of injuries was, "No injuries found." The Fall Risk assessment update indicated a score of 8, indicating patient was a 'low risk' for falls. The form reflected to "complete VS (vital signs) q (every) 8 hrs. (hours) x (times) 48 hrs."

Review of a Post Fall Assessment Form for P8, dated 01/24/2022 at 12:30 PM, revealed, "Patient crawled onto her bed and slipped of the mattress between the wall and her bed." The Fall Risk assessment update indicated a score of 11, indicating patient was a 'high risk' for falls. The form reflected to "Perform neuro assessment initially, then every 30 minutes x 2 hours, then hourly x 4 hours, then every shift for a total of 72 hours from the time of fall."

Review of a Post Fall Assessment Form for P8, dated 01/27/2022 at 3:20 PM, revealed, "Patient was wheeling self from her room to the hall and staff heard her fall. Pt stated she slipped on a blanket and staff report pt had a bed sheet wrapped around wc wheel." Under description of injuries was, "Bloody nose." The Fall Risk assessment update indicated a score of 13, indicating patient was a 'high risk' for falls. The form reflected to "Perform neuro assessment initially, then every 30 minutes x 2 hours, then hourly x 4 hours, then every shift for a total of 72 hours from the time of fall." On 01/27/2022 at 3:20 PM, P8's BP (blood pressure) was documented at 216/79. Under physician notified,

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a name was handwritten in but was crossed out, and 'via report' was checked. At 3:50 PM, P8's blood pressure was documented as 142/76, 4:20 PM 132/81, 4:50 PM 132/77 and 5:20 PM 141/82.

Review of a Progress Note for P8 dated 01/27/2022 3:40 PM, completed by a physician revealed, "Fall observed camera ...Does have area on head/face of [surveyor unable to read] emerging swelling."

Review of a Post Fall Assessment Form for P8, dated 01/27/2022 at 5:30 PM, revealed, "Called to room. Tech sitting with patient. Patient stated head hurt, wanting to go back to bed. Placed pillow. Patient then fell asleep snoring. Unable to arouse (B/P 210/90, P-20). She was snoring, pupils fixed @ 4. Notified other staff. Called MD [and] supervisor. Patient sent out via EMS)." Under physician notified, a name was handwritten in indicating the MD was notified on 01/27/2022 at 6:15 PM (45 minutes after the nurse was called to the room and the BP was 210/90). The form reflected to "Perform neuro assessment initially, then every 30 minutes x 2 hours, then hourly x 4 hours, then every shift for a total of 72 hours from the time of fall."

Review of a Progress Note for P8 dated 01/28/2022 Late entry for 01/27/2022 completed by RN1 Revealed, "After fall when pt was unable to arouse spoke with staff attempted to call front to get ahold of house supervisor [and] MD. Attempted to call on call MD @ approx. (approximately) 1750 unable to reach. Unable to leave msg (message). Attempted to call [DR2], unable to reach. LPN called [Dr3] on speaker

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phone, unable to reach. 1st attempt @5:59p, called again just after 1800-wanted her to be evaluated, he called hospital. EMS called @ 1839 patient left facility."

Review of a Progress Note for P8 dated 12/21/2022 10:28 AM revealed, "Patient had a fall last night due to impaired mobility and misjudging distance to toilet. Continues to benefit from 1:2 observation while awake and 15-minute checks while in bed."

Review of a Progress Note for P8 dated 12/22/2021 11:15 AM revealed, "Staff assisting pt to the bathroom. Pt leaned too far forward and slid off of the toilet."

Review of a Progress Note for P8 dated 12/29/2021 4:05 PM revealed, "Removed 1:1 observation @9:30 this morning."

Review of a Progress Note for P8 dated 01/06/2022 1:00 PM revealed, " Psychology-She wasn't feeling well and was dizzy. This morning she also left group after just a couple of minutes because she was dizzy."

Review of a Progress Note for P8 dated 01/08/2022 12:45 PM revealed, "Pt had 2 falls today 1 hour apart."

Review of a Progress Note for P8 dated 01/12/2022 11:35 AM revealed, "Psychology-Pt visual acuity screened but visual issues interfered. With +1.75 readers pts acuity appeared to be 20/50 OU. Pt indicated that she used glasses and her husband has them. It may be worthwhile to obtain pts glasses ...."

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A 142	Continued From page 13 Review of a Progress Note for P8 dated 01/21/2022 5:39 PM revealed, "Pt found sitting on floor complaining of falling while attempting to transfer from wheelchair to bed. No s/s of injury ...." Review of a Progress Note for P8 dated 01/23/2022 12:20 PM revealed, "Heard yelling found client in the BR by fish bowl nursing station sitting on her buttocks by the toilet ...no s/s injury ...." Review of a Progress Note for P8 dated 01/24/2022 3:00 AM revealed, "Monthly Summary- ...Patient has fallen multiple times in the last couple days. Patient has been placed in an observation room for closer monitoring ...." Review of a Progress Note for P8 dated 01/24/2022 1:15 PM revealed, "Patient was being assisted from her bathroom to bed [with] 1 staff. [Patient #8] crawled up onto her bed slipping between the head of her bed and the wall. [No] injury noted ...." Review of a Progress Note for P8 dated 01/27/2022 3:05 PM revealed, "Patient wheeling herself from her room to the hallway when staff heard her fall. Found lying on her left side with blood droplets on the floor. When rolled over it was noted that blood was coming from her [left] nostril." Review of a Progress Note for P8 dated 01/27/2022 3:40 PM revealed, "Fall observed camera ...Does have area on head/face of [surveyor unable to read] emerging swelling."	A 142		

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A 142	Continued From page 14 Review of a Progress Note for P8 dated 01/27/2022 5:20 PM revealed, "Overhead page noted requesting nurses to room #17. Upon getting to room, [Patient #8] was noted to laying on her [left] side on the floor next to her bed. Upon reviewing the camera, [Patient #8] wheeled herself into her room. She did not attempt to lock the brakes on her W/C. She attempted to stand x 1 and sat back down as her W/C slid slightly back. She then leaned forward and to the left pushing herself out of the w/c striking her head on the oxygen concentrator landing on the floor. [Patient #8] did not respond to staff when they attempted to speak with her. Hoyer lift used to get her from the floor into her w/c. 98, 62, 209/98, 87% then up to 96%, fixed pupils @4. No response noted to sternal rub. [DR3] notified." Review of a Progress Note for P8 dated 01/31/2022 10:52 AM revealed, "Voicemail from pt's son ...pt had passed away at [hospital] 1/30/22 ...." Review of a fall log revealed P8 had a fall without injury on 01/12/2022 at 11:15 AM. The log reflects "[P8] was ambulating with her Walker, veered to the left and lost her balance falling into the wall and slotting down to the floor." Review of a fall log revealed P8 had a fall without injury on 01/21/2022 at 5:00 PM. The log reflects,"[P8] was found on the floor in her room." Review of a fall log revealed P8 had a fall without injury on 01/23/2022 at 12:20 PM. The log reflects, "[P8] had an unobserved fall, she stated 'she[sic] fell while trying to get off the toilet'.	A 142		

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A 142	Continued From page 15 Review of a fall log revealed P8 had a fall without injury on 01/24/2022 at 12:30 PM. The log reflects, "[P8] was in her room returning from the bathroom when she crawled up into her bed falling from the head of her bed and wall per camera." Review of a Fall Risk Assessment Update, dated 01/25/2022 for P8 revealed patient scored a 13, indicating a "High Risk" for falls. The form reflected, "Implement fall prevention strategies. Notify LIP." Review of a fall log revealed P8 had a fall without injury on 01/27/2022 at 3:05 PM. The log reflects, "While Wheeling out of her room Patient #8 slipped on her blanket and fell to the floor she was found lying on her left side next to her WC [wheelchair]." Review of a fall log revealed P8 had a fall requiring medical intervention on 01/27/2022 at 5:20 PM. The log reflects, "There was an overhead page to have nurses respond to [Patient #8] room immediately. [P8] was laying on her left side on the floor. [P8] was unresponsive and would not respond to staff when spoken to. Sent to [hospital] P8 is still not responsive [sic]." Review of a Montana State Hospital Discharge Summary for P8, signed by P8s physician on 02/09/2022, revealed diagnosis included Major neurocognitive disorder, dementia with behavioral disturbances, Mixed anxiety and Mood disorder, and Falling, head injury acute on [sic] chronic. Under Course in the Hospital, it reflected, "On the afternoon she was believed to	A 142		

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have fallen by the nurse and was quickly checked at about 3:15 PM. This reported fall was not seen on camera. She was back in her wheelchair and returned to independent movement about unit. She was checked by Psychiatrist and observed to be wheeling down the hall, she was alert and awake, had minor abrasion as noted by nurse and did not want further intervention. She had verbal interaction. And appeared at baseline cognitive status. She was placed on Q4hr neurochecks. Later that afternoon she was observed on camera to return to her room about 5:30 PM, to rise from her wheelchair without setting the wheel break and fall, striking oxygen concentrator device and then to floor. Nurse responded immediately and she appeared to quickly have reduced alertness and responsiveness. The nurse called medical service and patient was taken to [local hospital]. Under Further Course, was, "Patient was admitted to hospital evening of one 2722 ...The imaging studies reported as subdural hematoma, with midline deviation and possible herniation. Family elected for only comfort measures .... Husband reported he was able to have a brief few words with her. The nurse reported she was able to have a few words with husband on Saturday, but she is reported expired on Sunday 1/30/2022."

Telephone interview on 02/09/2022 at 1:25 PM with RN1, revealed he/she was the nurse that assessed Patient #8 on 01/27/2022 after the fall. He/She stated the Spratt Unit was not his/her usual unit. RN1 stated he/she heard an overhead page to come to the room. When he/she arrived, P8 was alert, but quickly became unresponsive and began snoring. RN1 added that P8 had

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fallen earlier in the day, and had bruising to the face. RN1 stated he/she had issues contacting a physician, as one voice mailbox was full. He/She added once he/she was able to speak to a physician, he/she received an order to transfer the patient to a local hospital. When asked about specific times, RN1 was not able to recall as he/she was not in the facility and did not have access to the record.

Interview on 02/09/2022 with ADON, revealed she would locate the TARs for 01/13/2022 to present, and current physician orders for P8. This was not received by the time of end of day on 02/09/2022.

Interview on 02/10/2022 at 11:30 AM with the Director of Nurses (DON) revealed she had not been notified that P8 was transferred to a local hospital on 01/27/2022 due to she was not on call at that time. She stated the following morning, 01/28/2022, she was asked if she was aware P8 was transferred to the hospital and she stated she was not. The DON stated she referred the incident to the Compliance Specialist, onsite for review. When asked what they determined as a root cause of the incident on 01/27/2022, the DON stated the nurses were responsive and she had no concerns with patient care. The DON confirmed she did review the video of the second fall with the Compliance Specialist, but added the initial fall on that same day was not recorded, due to camera malfunction. The DON added they had recently discontinued the fall mat at the bedside as it was a hazard since P8 was ambulatory via a wheelchair. When asked about what she knew about P8's vision, the DON stated, "I don't know anything." When asked

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about what she knew about P8's dizziness documented on 01/06/2022, the DON stated, "I am not aware. When asked if she knew if anyone tried to obtain P8's glasses, as per the Progress Note dated 01/12/2022, the DON stated, "I don't know if they did." When asked if these types of issues noted in the Progress notes would be reviewed during an investigation of this nature, the DON stated she would have to discuss with the Compliance Specialist. The DON was asked to locate the items requested from the ADON on 02/09/2022, for P8.

Interview on 02/10/2022 at 1:30 PM with the DON revealed she was not able to locate the requested physician orders and treatment administration records for P8. She added they could be misfiled. These items had not been received at the time of end of day on 02/10/2022.

B:

Review of P3's physician "Admission History & Physical (H&P)" dated 01/21/22 at 3:15 PM, admitted to the facility Bravo Nursing Unit on 01/21/22 on an involuntary commitment for behavioral disturbances secondary to traumatic brain injury (TBI). P3 was noted to be alert and oriented to person, place, and time, disoriented to situation. P3 was noted to be sitting in a wheelchair at the time of the physician's H&P. P3 was transferred to the Spratt Nursing Unit on 02/01/22.

Review of P3's "Initial Nursing Assessment"

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dated 01/21/22 at 12:30 PM and signed at 3:38 PM failed to show the nurse's signature that completed the initial assessment. P3 was noted to have a fall risk score of 6 (low risk for fall). P3 was noted to have poor insight and judgement. Under the summary heading for safety and risk factors, the nurse noted, "patient currently uses a wheelchair." The only treatment team recommendation was assist as needed with activities of daily living [ADLs].

Review of P3's nurse "Progress Notes" no date, timed 6:30 PM, showed, "Pt. fell from her bed around 1300. Visible head injury with bleeding. Area cleansed - pt. had bump with (2) lacs [lacerations] approx.[approximately] 3 cm [centimeters] in length. Patient c/o [complaint of] only to head & [and] nose. Followed directions neuros initiated & WNL [within normal limits] ...v.o. [verbal order] to transfer to CHA [Community Hospital of Anaconda] ER [emergency room] admitting physician, place pt. [patient] in c-collar [cervical collar], call & transport by ambulance. Pt. left around 1515 (3:15 PM) & returned to unit at 1750 (5:50 PM).

Review of P3's Spratt Unit "Tier I Nursing Notes" showed:
02/05/22 at 6:22 AM - "Dramatic. Putting herself on the floor in the bathroom. Got up went to bed she is on vitals and neruos. Q shift [every shift] did not hit her head."
02/05/22 at 12:26 PM - "patient fell from bed during shift-reviewed on camera. She did not her head but did report right ankle pain."
02/06/22 at 4:25 PM - "approximately 1:00 PM patient had again fallen out of her bed this time

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A 142	Continued From page 20 with a visible head injury. Reviewed on the camera and patient appears to be turning over and rolled of the bed again landing face first. Areas cleansed thoroughly and has 2 lacerations approximately 3 cm but appear superficial [does not to need stitches or even steri strips]. Patient did not lose consciousness. Was at baseline during neuro assessments. Pt given as needed [PRN] Norco for pain. No reports of any further adverse effects from fall. The Medical Physician instructed this writer over the phone to 1) put patient in c-collar 2) write order for patient to be transferred to CHA with accepting physician ... .5) give report of ER RN. MD did not arrive on unit to assess patient before transfer to the hospital." 02/06/22 at 5:23 PM - "CHA reports that CT [computerized tomography] of patient's head and neck came back fine. C-collar removed; 2 cuts cleaned up and skin glue used and covered with band-aide." 02/06/22 at 6:02 PM - Back on the unit around 5:50 PM. Review of P3's "Physician's Order Sheet" dated 02/06/22 at 1:19 PM showed, "transfer CHA emergency room, accepted." During an interview on 02/10/22 at 11:05 PM, the Director of Nursing (DON) confirmed she was unable to tell who the RN was that performed the assessment for P3 since there was not a signature. The DON stated she would have to look at the staffing office signature book to see if she could determine who the nurse was the completed the initial fall assessment. The DON	A 142		

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confirmed P3's medical record failed to contain a completed Nursing Physical Health Assessment Form (Attachment A), which should be completed immediately upon reported or observed physical health complaint(s). The DON confirmed there was not an incident report filed as required by facility policy either.

During an interview on 02/10/22 at 11:05 AM, the DON confirmed the RN failed to write the order for P3 as instructed by the physician and should have included: 1) put patient in c-collar 2) get transfer paperwork ready 3) call an ambulance because they would need to use a back board. 4) give report of ER RN. The DON confirmed there was no nursing documentation that P3 was placed in a c-collar or that patient was transported to the hospital by ambulance with use of a backboard.

Review of the "Post Fall/Physical Assault Assessment Form" for P3 dated 02/06/22 at 1:00 PM, showed "Patient fell from bed and hit her head - camera review. Cleansed area to visualize injury. MD called and orders, c-collar, transferred to CHA hospital via ambulance. Neuros initiated per MS

Review of the facility's policy titled, "Nursing Physical Health and Neurological Assessment," effective August 16, 2019, showed, "Purpose: To assess a patient for actual or potential physical health problems, and abnormal neurological signs. Policy: Registered Nurses will perform a head to toe/focal assessment for patients reporting actual or potential physical health problems. The assessment information and ongoing assessment data will be documented on

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A 142	Continued From page 22 the Nursing Physical Health Assessment Form (Attachment A). A. Complete the Nursing Physical Health Assessment Form immediately upon reported or observed physical health complaint(s) (Attachment A)." Review of a Fall Risk Assessment, Fall Prevention Strategies and post Fall/Physical Assault assessment policy, dated 07/26/2019, provided by the DON as the current policy, revealed, 'All patients will be assessed for their risk of falls at the time of admission, when there is a significant change in status, following a fall and no less than annually. Strategies for fall prevention will be implemented and documented on the patients' Treatment Plan ...." Review of a Treatment Plan policy, dated 11/08/2021, provided as the current policy by the DON, revealed, "It is the policy of MSH (Montana State Hospital) to initiate, develop, implement and review treatment plans in accordance with state statutes ...E. The treatment plan is individualized to the needs of the patient ...I. The treatment plan reflects an active approach to identifying and treating the needs of the patient ...V. Procedures: ...B. Development of treatment plan ...6. The multidisciplinary treatment team will provide supplemental assessments of the patient and the results will be incorporated into the treatment plan ...."	A 142		
A 747	INFECTION PREVENTION CONTROL ABX STEWARDSHIP CFR(s): 482.42 The hospital must have active hospital-wide programs for the surveillance, prevention, and control of HAIs and other infectious diseases,	A 747		

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and for the optimization of antibiotic use through stewardship. The programs must demonstrate adherence to nationally recognized infection prevention and control guidelines, as well as to best practices for improving antibiotic use where applicable, and for reducing the development and transmission of HAIs and antibiotic resistant organisms. Infection prevention and control problems and antibiotic use issues identified in the programs must be addressed in collaboration with the hospital-wide quality assessment and performance improvement (QAPI) program.
This CONDITION is not met as evidenced by:
Based on record review, document review, observation, interview and review of Centers for Disease Control and Prevention (CDC) recommended infection prevention and control (IPC) practices when caring for a patient with suspected or confirmed SARS-CoV-2 infection, the facility failed to (1) develop and implement an annual risk assessment to assist with mitigation risks for infections, specifically COVID-19 (Coronavirus Disease 2019), (2) implement their Infection Control Prevention and Control Plan, (3) develop and implement a COVID-19 Pandemic Plan to prevent and/or decrease the risk of hospital acquired infections in patients and healthcare workers, (4) implement transmission based precautions to prevent transmission of COVID-19 infections to patients, (5) ensure staff wore recommended personal protective equipment (PPE)] to prevent transmission of COVID-19 staff infections in a healthcare setting.

The cumulative effects of these deficient practices placed patients at risk of serious illness and/or death. These findings resulted in an Immediate Jeopardy (IJ) situation that was called

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A 747	Continued From page 24 on 02/09/22 at 4:00 PM and presented to the Chief Operating Officer (COO), related to 42 CFR 482.42, requirement for the condition of participation of Infection Control. The IJ was still in place at the time of exit on 02/10/22 at 2:00 PM Findings include: 1. The facility failed to develop and implement an annual risk assessment specific to the facility to assist with mitigating risks for infections, specifically COVID-19, and formulation of surveillance priorities that are highest risk and require immediate attention. (Refer to A0749). 2. The facility failed to implement their Infection Prevention and Control Plan to ensure the facility had a functioning, coordinated process in place to minimize the risks of COVID-19 healthcare associated infections (HAIs) in patients and healthcare workers. (Refer to A0749). 3. The facility failed to develop and implement a COVID-19 Pandemic Plan to prevent and/or decrease the risk of hospital acquired COVID-19 infections in patients and healthcare workers. (Refer to A0749). 4. The facility failed to implement transmission-based precautions to prevent transmission of COVID-19 infections. The facility failed to cohort and separate patients with COVID-19 infections from patients not infected with COVID-19, resulting in 87 patients with hospital acquired COVID-19 infections and three COVID-19 patient infections (Patient (P) 5, P7, P10) that resulted in death. (Refer to A0749).	A 747		

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A 747	Continued From page 25 5. The facility failed to ensure staff wore recommended PPE to prevent transmission of COVID-19 infections in a healthcare setting. These failures resulted in 108 staff members acquiring COVID-19 infections. (Refer to A0749).	A 747		
A 749	INFECTION CONTROL PROGRAM CFR(s): 482.42(a)(2) The hospital infection prevention and control program, as documented in its policies and procedures, employs methods for preventing and controlling the transmission of infections within the hospital and between the hospital and other institutions and settings; This STANDARD is not met as evidenced by: Based on record review, document review, observation, interview and review of Centers for Disease Control and Prevention (CDC) recommended infection prevention and control (IPC) practice guidelines when caring for a patient with suspected or confirmed SARS-CoV-2 infection, the facility failed to: (1) Develop and implement an annual risk assessment to assist with mitigation risks for infections, specifically COVID-19 (Coronavirus Disease 2019); (2) Implement their Infection Control Prevention and Control Plan; (3) Develop and implement a COVID-19 Pandemic Plan to prevent and/or decrease the risk of hospital acquired infections in patients and healthcare workers; (4) implement transmission-based precautions to	A 749		

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A 749	Continued From page 26 prevent transmission of COVD-19 infections to patients; (5) ensure staff wore recommended personal protective equipment (PPE) to prevent transmission of COVD-19 staff infections in a healthcare setting. The cumulative effects of these deficient practices placed patients at risk of serious illness and/or death. These findings resulted in an Immediate Jeopardy (IJ) situation that was called on 02/09/2022 at 4:00 P.M. and presented to the Chief Operating Officer (COO), related to 42 CFR 482.42, requirement for the condition of participation of Infection Control. The IJ was still in place at the time of exit on 02/10/2022 at 2:00 P.M. Findings include: Review of P7's Face Sheet dated 10/19/2021 reflected a 75-year-old male admitted to the hospital on 10/19/2021. Review of P7's Covid-19 test results dated 01/14/2022 at 3:00 P.M. reflected indication for testing is exposure with Covid-19 test results Positive. Review of P7's Discharge Summary dated 02/03/2022 reflected date of separation as 1/26/22, expired from Sepsis, Covid-19 and cellulitis at 09:15 A.M. Review of P7's Certificate of Death dated 01/26/2022 reflected cause of death as Sepsis, Covid, and Cellulitis.	A 749		

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A 749	Continued From page 27 Review of P5's Initial Admission Nursing Assessment dated 06/08/2021 at 2:08 P.M. noted the patient was born on 01/18/1951 and was an Involuntary Commitment. The pertinent diagnoses listed were COPD (Chronic Obstructive Pulmonary Disease), Gastritis, Urinary incontinence, HTN (Hypertension), Back pain, Fracture OA (Osteoarthritis), Gouty Arthritis, Hypothyroid and Diabetes. A review of the Admission documents noted Patient was negative for COVID on admission. A review of the Provider Orders for Life Sustaining Treatment (POLST) noted the patient had a DNR (Do Not Resuscitate) noted on the record. A review P5's of the ABBOTT ID NOW COVID 19 TEST RESULTS dated 09/15/2021 showed positive results. A review of the Nurse Observations Flow sheet with the following categories; SOB, Cough, Temp > 99.9 and notify "MedClinic" if temperature is greater above 99.6 The form documented the following on 10/02/2021 and 10/03/2021 documented the Patient had shortness of breath and a temperature of 99.6 on 10/02/2021 and 102 on 10/03/2021. The Box for notification to the "MedClinic" was blank for notification the 102 temperature. The flow sheets did not include times both listed P.M on both dated the patient was symptomatic. A review of P5's form titled, "Neurologic Assessment Form" documented the patient vital signs on 10/03/2021 at 0800 A.M. the vital signs were temperature - 102, pulse - 112, respirations-28, Blood pressure 201/93, and Oxygen saturation level was and Oxygen saturation level	A 749		

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A 749	Continued From page 28	A 749		

was 93%. On 10/04/2021 the vital signs were; temperature - 100.3, pulse 124, respirations - 40, no Blood pressure was recorded, and oxygen saturation level was 85%.

A review of P5's form entitled; "Resident Death Report" noted the patient 70-year-old was admitted on 06/08/2021 and expired on 10/04/2021 at 2100 hours (9 P.M.) The patient was assigned to the Spratt Unit (Geriatric Psyche). The causes of death were listed as; 1). Bilateral Pneumonia, 2). Severe Hypoxia, 3). Leukocytosis and S/P COVID Infection. There was no other COVID test in the record after the positive COVID test dated 09/15/2021 to verify the patient was no longer COVID positive.

A review P5's of the "Certificate of Death" dated 10/05/2021 listed the Cause of Death; 1. Bilateral Pneumonia three days duration, 2. Severe Hypoxia three days duration, 3. Leukocytosis three days duration, and 3. COVID Infection Recovery 14 days.

Review of P10's form titled; "Patient Information Face sheet" documented an admission date of 11/08/2021 and date of birth of 10/14/1941. A review of a form titled; "Treatment Cover Sheet" the Spratt Unit was listed as the assigned unit. The diagnoses listed were; Dementia, Benign Prostatic Hyperplasia with lower urinary tract symptoms, Hyperprolactinemia, Hyperkalemia, and VitA.M.in D deficiency.

Review of P10's "Abbott ID NOW COVID - 19 TEST RESULTS" dated 01/13/2022 documented a positive for COVID infection. A review of a form titled; "Resident Death Report" documented the

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A 749	Continued From page 29 patient's tine of death was 0902 A.M. and the location was the Spratt Unit. The cause of death was listed as COVID - 19, Sepsis, and Cellulitis. Review of P10's form titled; "Certificate of Death" dated 02/02/2022 listed the cause of death as; Cardiac Arrest, Sepsis, Cellulitis. The section labeled Part 2 listed COVID as a contributing factor to the cause of death. P10 expired on a non COVID unit on 02/04/2022 and was not on the designated COVID unit. Review of staff time cards reflected that on 02/04/2022 PT2 worked on Unit B (Designated Covid-19 Unit) from 6:42 P.M. through 11:00 P.M. and Unit E (Non-Covid-19 unit) 11:00 P.M. through 7:00 A.M. Review of the patient census dated 01/04/2022 through 02/08/2022 revealed 87 of 107 patients tested positive for Covid-19, and 95 staff campus wide tested positive for Covid-19 for the same time period. Review of The Covid-19 Data from 01/04/2022 through 02/08/2022 revealed the following: 1. The Bravo (B) Unit (designated Covid-19 unit) had a total of 6 patients; 2. The Spratt Unit had a total of 28 Covid-19 positive patients; 3. The Alpha (A) Unit had a total of 16 Covid-19 positive patients; 4. The Echo (E) Unit had a total of 6 Covid-19 positive patients. Review of staff time cards reflected that on 02/05/2022 PT2 worked on Unit A (Non-Covid-19 unit) from 7:01 P.M. through 11:00 P.M. and Unit	A 749		

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A 749	Continued From page 30 B (Designated Covid-19 Unit) 11:00 P.M. through 7:02 A.M. Review of staff time cards reflected that on 02/05/2022 PT3 worked on Unit B (Designated Covid-19 Unit) from 6:43 P.M. through 11:00 P.M. and Unit E (Non-Covid-19 unit) from 11:00 P.M. through 07:01 A.M. Review of staff time cards reflected that on 02/06/2022 PT4 worked on Unit B (Designated Covid-19 Unit) from 03:00 A.M. through 07:00 A.M. and Unit D (Non-Covid-19 unit) from 07:00 A.M. through 7:09 P.M. Review of staff time cards reflected that on 02/08/2022 PT5 worked on Unit B (Designated Covid-19 Unit) from 7:04 P.M. through 11:00 P.M. and on Unit S (Non-Covid-19 unit) from 11:00 P.M. through 07:02 A.M. During interview conducted on 02/09/2022 at 9:45 A.M., the facility Infection Preventionist ([IP)] stated, "prior to August the facility did not have an Infection Control [IC] plan, policies or a strong infection prevention and control program. Currently the facility does not have an Infection Control Plan, Risk Assessment or COVD-19 Pandemic Plan that has been approved or went through committee for approval, we only have rough drafts. The Joint Commission was contacted in June or July to perform a mock survey. They reviewed the IC program and made recommendations for us to develop an IC Risk Assessment and IC Plan. We do not have an active IC Plan or COVID-19 policies and procedures. We do have an IC Plan rough draft that was developed with the help of the Montana	A 749		

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Department of Public Health and Human Services to assist with COVID-19 issues. We do not have a policy or procedure related to CDC guidelines related to COVID-19. As of last Friday, we decided to move COVID-19 positive patients to the Bravo Nursing Unit. The Bravo Unit can handle up to 8 positive patients but was overrun with COVID-19 positive patients. We only place confirmed positives on the Bravo Unit. The patients being ruled out for COVID-19 infection are not moved off the units."

Observation on 02/08/2022 at 10:00 A.M. on Alpha Unit, reflected RT1 with a surgical mask on in residential common area with 3 patients and multiple staff present.

On 02/08/2022 at 10:15 a tour was conducted of the Spratt Unit, accompanied by the Senior Manager of Clinical Services. The Senior Manager of Clinical Services confirmed the Spratt Nursing Unit was primarily a neurocognitive unit for patients with dementia and Alzheimer's. The unit had a current census of 32 patients. The Senior Manager of Clinical Services stated the unit has had staffing shortages due to staff members out with COVID-19 infections.

Interview with NM1 on 02/08/2022 at 10:37 A.M. revealed that all staff in patient care areas should have goggles or face shield with N95 on at all times. NM1 stated that patients are to wear blue masks (surgical masks) if taken off the unit.

During an interview on 02/08/2022 at 10:45 A.M., the Spratt Unit Nurse Manager stated, "all but one patient over the last month has tested

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positive for COVID-19 infection. The facility IP tested nine more patients on the unit yesterday and results are pending. The Spratt Nursing Unit has had two patient deaths due to COVID-19 infection. Since the Spratt Nursing Unit is a cognitive unit, the patients could not be cohorted on the designated COVID-19-unit, Bravo." The Nurse Manager confirmed COVID-19 positive patients and COVID-19 negative patients were being treated on the Spratt Nursing Unit.

During a phone interview on 02/08/2022 at 11:00 A.M., the facility IP confirmed the Spratt Nursing Unit has had 26 COVID-19 positive patient infections over the last three weeks and nine more patients had been tested yesterday, 02/07/2022, with results pending.

An interview on 02/08/2022 at 11:30 A.M. with the Chief Operating Officer (COO) revealed there were currently 11 positive COVID - 19 patients who were isolated on the Bravo Unit. The COO stated they had dedicated staff to work on the COVID designated Unit. The COO indicated the COVID infections started around December

During an observation on B Wing (designated COVID Unit) on 02/08/2022 at approximately 11:30 A.M., CNA 2 entered the B-Wing and stated to another staff member, "I was working on the Alpha Unit, then I was told to come to the B Wing, now I'm going back to Alpha Unit." CNA 2 removed her PPE and exited the unit. The census on B-Wing was 18.

Review of the B-Wing Dayshift schedule revealed Assignment #3 and listed the following assignment for PT# as follows;

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A 749	Continued From page 33 0700 1:1 #2 0800 Unit meal, get ice/Day Hall 0900 1:1 #1 1000 *Day Hall* 1100 Control Room 1130 Lunch (staff lunch confirmed with RN#) 1200 Census 15min checks day hall 1300 Day Hall Escort 1400 1:1 #2 ***MUST RESPOND TO CODES AND SHOWS*** CNA 2 did not return to the B wing as scheduled. In an interview with C.O.O. on 02/08/2022 at approximately 11:45 A.M. revealed that the Covid-19 infections started in late December. When questioned about dedicated staff for the designated Covid-19 Unit (Bravo) the C.O.O. indicated there were dedicated staff for the Covid-19 unit. Interview with CNA 1 on 02/09/2022 at 09:01 A.M. revealed staff had worked on Covid-19 positive unit (Bravo Wing) and then worked on other non-positive Covid-19 units the next day. Interview with PT1 on 02/09/2022 at 09:16 A.M. revealed that patients and staff are in unsafe situation and not able to meet the needs of the patient. Interview with CNA 2 on 2/9/22 at 09:43 A.M. revealed that staff work on other units and not just Covid-19 positive units. During an interview on 02/09/2022 at 9:45 A.M., the facility IP stated, "the Bravo Unit is the	A 749		

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designated COVID-19 unit and can handle up to eight patients. Due to the numerous COVID-19 positive patients throughout the facility, patients could no longer be moved to the Bravo Unit. Patients being ruled out for COVID-19 were not isolated or moved off the patient units they were located on and were kept with patients that did not have COVID-19 infections. The first staff COVID-19 infection occurred on 12/28/2021 and the first patient COVID-19 infection occurred on 01/04/22. As of today, there have been 108 staff members test positive for COVID-19 and 87 patients have tested positive since 01/04/2022. I think there have been two patients that have expired from COVID-19 infections. The isolation area on the Bravo unit is also the seclusion unit and when we tried to isolate the COVID-19 patients there, it resulted in outbreaks of violence and staff injury. There is an empty building that still needs construction and could possibly house the COVID-19 positive patients. The facility averages 5-8 admissions per day. The facility has been getting a lot of COVID-19 positives from the community and we have to take these patients because they have a court order. There is nowhere else to send these patients."

Interview with CNA 3 on 02/09/2022 at 09:50 revealed that staff circulate through the units, to include Bravo unit (Covid-19 positive unit).

Observation on 02/09/2022 at 10:01 A.M. reflected CNA 4 on Alpha Unit, throughout the unit with no goggles on.

Interview with CNA 5 on 02/09/2022 at 10:11 A.M. revealed that they rotated days and last week had worked Delta, Bravo, Delta. Stated

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A 749	Continued From page 35 staff would be scheduled for one unit but would be pulled to another unit. To include Bravo Unit (Covid-19 positive unit). In an interview with the C.O.O., DON, and ADON on 02/09/2022 at approximately 4:00 P.M. revealed the hospital did not have dedicated staff the designated Covid-19 unit (staff and patients were not confined to a designated Covid-19 unit. During an interview conducted on 02/10/2022 at 9:30 A.M., The Director of Nursing (DON) confirmed 26 patients on the Spratt Nursing Unit had a hospital acquired COVID-19 infection. The DON stated "we didn't have the capability to stop admissions and we had to continue to take COVID-19 positive patients. The Bravo Unit with 8 beds is the designated COVID-19, however we could not hold all of them on the Bravo Unit. We have not been able to keep dedicated staff on the nursing units where there are COVID-19 positive patients and staff are working on multiple units." Interview with COO on 02/10/2022 at 09:33 A.M. revealed that the expectation is that staff members do not work from positive unit to non-positive unit and that he would be disappointed to see that happened. After observation of staffing patterns, COO stated that he was not aware that had happened. Review of CDC COVD-19 guidelines showed, "recommended infection prevention and control IPC practices when caring for a patient with suspected or confirmed SARS-CoV-2 infection, even before results of diagnostic testing, including asymptomatic patients who have met	A 749		

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the criteria for empiric Transmission-Based Precautions, should be places in a single-person room. The door should be kept closed (if safe to do so). The patient should have a dedicated bathroom. However, these patients should NOT be cohorted with patients with confirmed SARS-CoV-2 infection unless they are confirmed to have SARS-CoV-2 infection through testing. Facilities could consider designating entire units within the facility, with dedicated healthcare personnel [HCP] to care for patients with SARS-CoV-2 infection. Dedicated means that HCP are assigned to care only for these patients during their shifts. Only patients with the same respiratory pathogen should be housed in the same room. HCP who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH-approved N95 or equivalent or higher-level respirator, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face)."

There was no rationale for why all units had Covid-19 positive patients when the Bravo (B) unit was the designated Covid-19 unit. There was no policy or procedures for new admissions and length of time or criteria for a transitional unit for patients to be monitored for Covid-19 and then transferred to the assigned unit.

Review of the list of staff who tested positive for Covid-19 revealed there were safety officers, direct care, business office, therapy, contract staff, dietary and administrative staff. Chief Executive Officer (CEO) was "out with Covid-19" when the RO team entered on 02/08/2022. The Quality Assurance staff who interacted with the

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A 749	Continued From page 37 survey team on entrance to the main building was absent on 02/09/2022 and subsequently tested positive for Covid-19 as verified by DON.	A 749		