DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long Term Care Residents Protection

DHSS - DHCQ
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Harbor Healthcare & Rehab Ctr **DATE SURVEY COMPLETED: February 11, 2021**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced COVID-19 Focused Infection Control Survey and Complaint Survey was conducted by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection from February 4, 2021 through February 11, 2021. The facility was found to not be in compliance with 42 CFR §483.80 infection control regulations and has not implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other documentation as indicated. The facility census on the first day of the survey was one hundred twenty-three (123). The survey sample totaled nineteen (19) residents.		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** This requirement is not met as evidenced by:		

Provider's Signature [signature] Title NHA Date 3/9/21

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TITLE 16 Health and Safety **CHAPTER 11.** **Subchapter III.** **1133**	Cross Refer to the CMS 2567-L survey completed February 11, 2021: F657, and F880. **Regulatory Provisions Concerning Public Health** **Long-Term Care Facilities and Services.** **Abuse, Neglect, Mistreatment, or Financial Exploitation of Residents or Patients.** **Contents of reports.** **The reports required under this subchapter shall contain all of the following information:** **(1) The name and sex of the patient or resident.** **(2) The name and address of the facility in which the patient or resident resides.** **(3) The age of the patient or resident, if known.** **(4) The name and address of the reporter and where the reporter can be contacted.** **(5) Any information relative to the nature and extent of the abuse, mistreatment, financial exploitation, or neglect and, if known to the reporter, any information relative to prior abuse, mistreatment, financial exploitation, or neglect of such patient or resident.** **(6) The circumstances under which the reporter became aware of the abuse, mistreatment, financial exploitation, or neglect.** **(7) What action, if any, was taken to treat or otherwise assist the patient or resident.** **(8) Any other information which the reporter believes to be relevant in establishing the cause of such abuse, mistreatment, financial exploitation, or neglect.**	1. Abuse report for E2 was amended during the 5 day Follow-up report. 2. All residents with an allegation of abuse have the potential to be affected. 3. The RCA was that staff was not aware of all 8 components of required for reporting alleged Abuse, Neglect, Mistreatment, or Financial exploitation of Residents or Patients. Regional VP of Operations educated administrative staff on correct procedure. 4. NHA/designee will audit 100% of Abuse Allegation initial reports made to the State Agency to assure required content is included for one month. The results will be reported in Monthly QA and will continue until 100% compliance is achieved for 3 months.	3/16/21

Provider's Signature [signature] Title NHA Date 3/9/21

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TITLE 16 Health and Safety			
3201	**Delaware Administrative Code**		
9.8			
9.8.1	**Skilled and Intermediate Care Facilities**		
9.8.1.1	**Reportable Incidents are as follows:** **Abuse as defined in 16 Delaware Code, §1131.** **Physical abuse with injury if resident to resident and physical abuse with or without injury if staff to resident or any other person to resident.** This requirement is not met as evidenced by: Based on record review and interview, it was determined that for one (R2) out of four residents sampled for abuse the facility failed to report the required content about the incident to the State Agency. 2/2/2021 7:13 PM – During review of a facility incident reported to the State Agency for an alleged physical abuse that R2's family reported, E2 (DON) reported that an "investigation is pending." The incident report lacked relevant information about the abuse. 2/5/2021 4:01 PM – An email communication with E2 (DON) confirmed that the facility did not report the required information on the incident, and she updated the incident report to the State Agency. 2/11/2021 5:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E4 (AIT) and E5 (Regional VP) during the exit teleconference.		
6.9.2			
6.9.2.4.2			

Provider's Signature ____________ Title NHA Date 3/9/21

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	Specific Requirements for Tuberculosis **Any person having a positive skin test, but a negative X-ray shall receive an annual evaluation for signs and symptoms of active TB if they cannot provide documentation of completion of treatment for LTBI (latent TB infection).** This requirement is not met as evidenced by: Based on record review it was determined that for one (E11) out of six staff members sampled for Pre-employment tuberculosis (TB) testing, the facility failed to follow the State tuberculosis testing requirements. 10/26/2021 – E11 (Activities) was hired. 10/30/2021 – E11 documented on the TB Screening form, "yes" to the question: "Have you ever had a reaction to the TB skin test?" In addition, if the answer was yes it was required to please explain why you checked "yes", but no explanation was documented. 2/11/2021 5:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E4 (AIT) and E5 (Regional VP) during the exit teleconference. 2/12/2021 10:23 AM – An email communication from E1 (NHA) stated, "Will send you the information for (E11) when we receive it." 2/15/2021 2:26 PM – An email communication from E1 (NHA) stated that E11 had a positive TB test in 2010 and had a negative chest x-ray on 10/17/2018. The facility failed to provide evidence of follow-up on E11's (Activities) positive TB result when hired on 10/26/2021. The facility failed to obtain additional information until requested by the Surveyor on 2/11/2021.	1. E11 provided documentation of negative chest x-ray. 2. All staff with positive skin test history have the potential to be impacted by failure to follow Pre-employment State TB testing requirements. 3. The RCA was that the Staff Developer was not aware of all Pre-employment State TB testing requirements. Staff Developer has been properly educated. 4. HR/designee will audit 100% of New Employees' Pre-employment TB Testing for 1 month. The results will be reported in Monthly QA and will continue until 100% compliance is achieved for 3 months.	3/16/21

Provider's Signature [signature] Title NHA Date 3/9/21

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Provider's Signature Sue Sheridan Title NHA Date 3/9/21

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	085034	A. BUILDING ______ B. WING ______	02/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR HEALTHCARE & REHAB CTR	**301 OCEAN VIEW BLVD LEWES, DE 19958**

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F 000	INITIAL COMMENTS	F 000		

An unannounced COVID-19 Focused Infection Control Survey and Complaint Survey was conducted by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection from February 4, 2021 through through February 11, 2021. The facility was found to not be in compliance with 42 CFR §483.80 infection control regulations and has not implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other documentation as indicated. The facility census on the first day of the survey was one hundred twenty-three (123). The survey sample totaled nineteen (19) residents.

Abbreviations and Definitions used in this report are as follows:

ADON- Assistant Director of Nursing;
AIT - Administrator in Training;
CNA - Certified Nurse's Aide;
DON - Director of Nursing;
LPN - Licensed Practical Nurse;
MD - Medical Doctor;
NHA - Nursing Home Administrator;
NP - Nurse Practitioner;
OT - Occupational Therapist;
RN - Registered Nurse;
SSA - Social Services Assistant;
SW - Social Worker;
UM (Unit Manager) - manager of a nursing unit;
VP - Regional Vice President;

ADL (Activities of daily living) - tasks needed for

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 03/05/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 daily living, e.g. dressing, hygiene, eating, toileting, bathing; BIMS (Brief Interview for Mental Status) - test to measure thinking ability with score ranges from 00 to 15: 13-15 - cognitively intact. 08-12 - moderately impaired. 00-07 - severe impairment; Cognitively intact - able to make appropriate decisions; CDC - Centers for Disease Control and Prevention; CMS - Centers for Medicare & Medicaid Services; COVID-19/Coronavirus -a respiratory illness that can be spread person to person; Dementia - a brain disorder with memory loss, poor judgement, personality changes and disorientation; Doff - remove PPE; Don - put on PPE; HCP - Health Care Personnel; i.e. - that is; Interdisciplinary Team (IDT) - a coordinated group of staff from several different fields who work together towards a common goal or project; MDS (Minimum Data Set) - an assessment tool used for residents in nursing homes; PPE - Personal protective equipment is protective clothing, or other garments designed to protect the wearer's body from infection; SARS-Cov-2 - Coronavirus.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of	F 657		3/16/21

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F 657	Continued From page 2 the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R1) out of four residents sampled for care plans, the facility failed to ensure that all required members of the Interdisciplinary Team (IDT) participated in, or provided input, to the formation of R1's care plans. Findings include: 1/13/2018 (last revised) -The facility policy entitled Comprehensive Care Plan included that "The comprehensive care plan must be prepared with input from the IDT (includes but not limited to): - attending physician;	F 657	1. Care plan ad hoc meeting for R1 was held providing evidence of participation and input provided by specifically named IDT members to include C.N.A. and Physician/NP/Psychologist. 2. All residents have the potential to be affected by the failure to include input and participation in the care plan process by required IDT members. 3. The RCA was that the IDT consists of new employees who were not familiar with the facility's process for documenting care plan participation/input by specific members. The Staff Educator will train	

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F 657	Continued From page 3 - a registered nurse with the responsibility for the patient, - a nurse aide with responsibility for the patient, - a member of food and nutrition services staff... - other appropriate staff or professionals in disciplines as determined by the residents...". Undated - The facility document entitled Care Plan Work Flow from Admission to Discharge included that throughout the stay the "care plan is updated with changes in resident condition and goals." Care Conferences are held quarterly, "with significant change or as needed, with resident and resident representatives and documented in the Care Conference notes." Review of R1's clinical record revealed: 6/19/2018 - R1 was admitted to the facility. 10/21/2020 - A quarterly MDS assessment revealed that R1's BIMS was 13 (cognitively intact). 10/29/2020 - A Care Conference Report by E7 (SSA) documented the attendees were only E7 and E10 (Medicaid Case Manager) and that "Care Conference scheduled for 10/29/2020. Resident and his daughter were invited to attend but neither participated. Care plan reviewed and input provided by clinical team, including physician, nursing, and CNA, as well as Dietician, Activity staff. 1/14/2021 - A Care Conference Report by E4 (AIT) documented the only attendee was E4 and that "Care Conference held on 1/14/2021. Resident and his daughter were invited to the care conference but neither participated. Care	F 657	the IDT on the correct procedure. 4. The RNAC/designee will audit 100% of care conferences held for one month to monitor the participation/input from the IDT Team. The results of these audits will be reported in Monthly QA ad will continue until 100% compliance is achieved for 3 months.	

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F 657	Continued From page 4 plan reviewed and input provided by interdisciplinary team, including physician, nursing, CNA, Dietician, and Activity staff." 1/15/2021 5:03 PM - A Social Service Progress Review note by E4 (AIT) documented in the section any changes in cognition, communication, mood, behavior, psychosocial, physical function, and family status "There are no changes at this time." 1/15/2021 - A quarterly MDS assessment revealed R1's BIMS was 11 (moderately impaired). 2/9/2021 at 4:30 PM - A phone interview with E6 (LPN, UM) revealed that prior to care plan meetings the social worker asks her for input from the nurses and the CNAs, but because of care needs on the unit neither she nor the CNAs have been able to attend the meetings. 2/9/2021 5:05 PM - An email communication from E1 (NHA) revealed that the facility does not have a sign in sheet for attendees at Care Conferences. E1 attached the EMR (electronic medical record) print out of R1's Care Conference Report notes with a handwritten list of "IDT names." For the 10/29/2020 Care Conference, the list contained E7 (SW), E12 (Dietician), E13 (Activities) and E6 (LPN, UM). For the 1/14/2021 Care Conference, the list contained E4 (AIT, SW), E12, E11 (Activities) and E6. 2/10/2021 4:36 PM - When asked the names of the CNA and physician who provided input and what input was provided for R1's Care Conferences, an email communication from E1	F 657		

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F 657	Continued From page 5 (NHA) stated, "The Unit Manager is the one who pulls together the input from the clinical team, i.e. aides, other nurses and physician." The facility was unable to provide evidence that R1's CNA, physician or Psychologist/NP responsible for R1 participated in or provided input to the care plan for the 10/29/2020 and 1/15/2021 Care Conference meetings. 2/11/2021 5:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E4 (AIT) and E5 (Regional VP) during the exit teleconference.	F 657		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		3/16/21

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F 880	Continued From page 6 §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 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.	F 880		

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F 880	Continued From page 7 The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of facility policy and procedures, it was determined that for three (R5, R7 and R8) out of four residents sampled for non-emergent transportation review, the facility failed to ensure that COVID-19 symptom screening was conducted for transportation staff entering the building. A tour of the laundry facilities revealed that the facility failed to prevent contamination of clean laundry. Additionally, the facility failed to ensure that staff doffed PPE correctly in two (2) out of three (3) nursing units. Findings include: 3/2020 - The facility policy entitled COVID-19 Screening of Staff indicated that "to ensure that staff use the proper procedure per CDC/CMS recommendations to screen all staff and/or other appropriate individuals (staff, HCP, approved vendors, approved Compassionate Care Visitors or Representatives from State or Federal Agencies)...Take accurate temperature reading of all staff and/or appropriate individuals who enter the building. Direct employee to the list of critical questions to ensure compliance with regulations related to COVID-19...Identify when a staff member and/or appropriate individuals' temperature are abnormal (above 99.5)...Logs will be kept for every individual that enters the premises...". 2/10/2021 (last updated) - The CDC's Infection Control Guidance indicated to "Establish a process to ensure everyone (patients, healthcare personnel, and visitors) entering the facility is assessed for symptoms of COVID-19, or	F 880	1. Covid-19 Screening a. Once the facility was made aware the surveyor was not screened, appropriate screening did take place. The staff facility is now trained to screen all non-emergent transport staff. b. All residents have the potential to be affected by failure to conduct COVID-19 symptom screening. c. The RCA was the failure of staff to screen non-emergent personnel. Staff Educator will re-educate staff on the requirement to conduct COVID-19 symptom screening for non-emergent transportation crews to the facility. d. DON/designee will audit 100% of non-emergent scheduled transports for one month to assure COVID-19 symptom screening was conducted upon entrance to the building. The results of these audits will be reported in Monthly QA and will continue until 100% compliance is achieved for 3 months. 2. PPE Doffing a. Lewes and Henlopen Units were immediately addressed to place doffing stations in the appropriate locations so gowns were doffed prior to exiting the COVID-19 Unit. b. All residents have the potential to be affected by failure of staff to doff PPE correctly. c. The RCA for staff failure to correctly doff PPE was inattention to proper procedure. The Staff Educator will	

F 880

Continued From page 8

exposure to others with suspected or confirmed SARS-CoV-2 infection and that they are practicing source control." (https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html)

1. COVID-19 Screening:

a. 2/4/2021 1:50 PM - The Surveyor was not screened for COVID-19 when she entered the facility.

2/4/2021 4:20 PM - After E1 (NHA), E2 (DON) and E4 (AIT) were notified that this Surveyor was not screened for COVID-19 upon entering the facility, E4 confirmed this in the screening log and the Surveyor was then appropriately screened.

b. The following was reviewed in R5's clinical record:

1/18/2021 1:47 PM - A nursing progress note documented that R5 was "transported to (another LTC facility) via stretcher...".

2/9/2021 9:51 AM - An email communication from E1 (NHA) documented, when asked for evidence of COVID-19 screening of R5's transport crew, "I do not see that the ambulance crew was screened on that day."

c. The following was reviewed in R7's clinical record:

1/11/2021 10:17 PM - A nursing progress note documented that R7 was "Transferred via ambulance (by non-emergent transport staff) from (name of hospital)...".

F 880

re-educate staff on proper procedure to doff gowns and place in identified bins prior to exiting the COVID-19 Unit. For preservation of PPE during a shift, an employee may doff their gown and place the gown on a hanger with an identifier so they can recognize their gown, prior to exiting the COVID-19 Unit.

d. DON/designee will audit units every shift for correct doffing procedures and to check for the presence of identifiers on gown hangers on racks for one month to monitor that correct procedure is being followed. The results of these audits will be reported in Monthly QA and will continue until 100% of compliance is achieved for 3 months.

3. Contamination of clean Laundry

a. Laundry staff was educated immediately to have laundry room doors always closed.

b. All residents have the potential to be affected by failure to prevent contamination of clean laundry.

c. The RCA for the open laundry room door was new department employee was unaware of need to keep laundry doors always closed and therefore the door was open while he was inside working. This will be included in new hire orientation for laundry department staff to know that the laundry room doors must remain closed at all times. Staff Educator will re-educate all laundry department staff on Infection Prevention & Control processes.

d. AIT/designee will audit laundry room door 2 times daily for one month to assure it remains closed. The results of these audits will be reported in Monthly QA and

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	085034	A. BUILDING ______ B. WING ______	02/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR HEALTHCARE & REHAB CTR	**301 OCEAN VIEW BLVD LEWES, DE 19958**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 9 2/9/2021 9:51 AM - An email communication from E1 (NHA) documented, when asked for evidence of COVID-19 screening of R7's transport crew, "transported by (name of transport company) from (name of hospital) directly to Positive COVID Lewes wing via the outside door leading directly onto the unit. No additional screening done." d. The following was reviewed in R8's clinical record: 2/4/2021 9:56 PM - A nursing progress note documented that R8 "arrived at the facility from [hospital] via ambulance...". 2/9/2021 9:51 AM - An email communication from E1 (NHA) documented, when asked for evidence of COVID-19 screening of R8's transport crew, "transported by (name of transport company) from (name of hospital) directly to Positive COVID Lewes wing via the outside door leading directly onto the unit. No additional screening done." The facility lacked evidence that the Surveyor and non-emergent transportation staff received COVID-19 screening upon entry to the facility. 2. PPE Doffing: 8/19/2020 (updated) - The CDC's guidance Using Personal Protective Equipment (PPE) - How to Take Off (Doff) PPE Gear stated, "Remove gloves...Remove gown. Untie all ties (or unsnap all buttons). Some gown ties can be broken rather than untied. Do so in gentle manner, avoiding a forceful movement. Reach up to the shoulders and carefully pull gown down and away from the body. Rolling the gown down is an acceptable approach. Dispose in trash receptacle.*...HCP	F 880	will continue until 100% compliance is achieved for 3 months.	

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F 880	Continued From page 10 may now exit patient room. Perform hand hygiene...*Facilities implementing reuse or extended use of PPE will need to adjust their donning and doffing procedures to accommodate those practices...". (https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html) 2/4/2021 2:45 PM - 3:00 PM - During random observations on the Lewes Unit outside of the facility's COVID-19 Unit: 2/4/2021 2:45 PM - E15 (OT) was observed, after walking out of the COVID-19 Unit, removing her contaminated PPE gown, bunching it up then walking around the corner to the Dementia Unit (where there were only COVID-19 negative residents) to dispose of her gown in a red plastic container. There were residents sitting at tables near the red container in the Dementia Unit. 2/4/2021 2:50 PM - During an interview, E15 (OT) confirmed she was just in R11's room (COVID-19 positive resident). 2/4/2021 2:55 PM - E7 (SW) was observed, after walking out of the COVID-19 Unit, removing her contaminated PPE gown, bunching it up then walking around the corner to the Dementia Unit to dispose of her gown in a red plastic container. There were residents sitting at tables near the red container in the Dementia Unit. 2/4/2021 3:00 PM - During an interview, E7 (SW) confirmed she was just in R9 and R10's rooms (COVID-19 positive residents). 2/4/2021 3:15 PM - During an interview, E17 (Staff Educator) was notified of the above	F 880		

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

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F 880	Continued From page 11 observations and confirmed that the red plastic container on the Dementia Unit should not be there and that staff leaving the COVID-19 Unit should doff their contaminated PPE before leaving the COVID-19 Unit. E17 removed the red plastic container. 2/4/2021 5:15 PM - During an interview and observation in the Lewes Unit's COVID-19 Unit's don/doff room, E18 (LPN) confirmed there was a yellow gown hanging on a rack that was not labeled with a staff member's name. 2/4/2021 5:30 PM - 6:00 PM - During random observations on the Henlopen Unit in the Don/Doff area of their COVID-19 and Quarantine Unit revealed: - A sign posted stated, "Please take one gown per person to use for your shift." - On top of a white plastic isolation supply cart containing clean PPE, there was a white gown that appeared to have been worn by a staff member. - On a rack there were two yellow isolation gowns that were not labeled with a staff members names. 2/4/2021 6:00 PM - During an interview and observation with E6 (LPN, UM), E6 confirmed the above observations and explained that someone probably placed the contaminated gown on top of the clean PPE supply cart because there was no bag in the red container (to dispose of contaminated gowns). E6 added that the gowns hanging on the rack should be labeled with the staff members names (to reuse during their shift). 2/4/2021 6:15 PM - During a random observation in the hallway leading from the Henlopen Unit to	F 880		

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F 880	Continued From page 12 the courtyard, several dirty isolation gowns were hanging on a rolling rack. E4 (AIT) and E17 (Staff Educator) were present and confirmed that the gowns should not be in a non-COVID-19 Unit/area. E4 explained that the facility has a system to label isolation gowns when staff doff gowns to reuse when they leave the COVID-19 Unit and confirmed the gowns were not labeled. 2/11/2021 5:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E4 (AIT) and E5 (Regional VP) during the exit teleconference.	F 880		