STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061901	A. BUILDING: _____ B. WING _____	04/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANDOVER SUBACUTE AND REHAB II	99 MULFORD ROAD ANDOVER, NJ 07821

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S 000	Initial Comments Survey Date 04/17/20 Census 419 Sample 25 The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. On 04/18/2020, in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations, a Directed Plan of Correction (DPOC) was issued. The DPOC included a curtailment of admissions and the hiring of a consultant Registered Nurse for the Director of Nursing position; a consultant Administrator; and a consultant Infection Control Preventionist.	S 000		
S1340	8:39-19.4(a)(1-6) Mandatory Infection Control and Sanitation (a) The facility shall develop, implement, comply with, and review, at least annually, written policies and procedures regarding infection prevention and control which are consistent with the most up-to-date Centers for Disease Control and Prevention publications, incorporated herein by reference, including, but not limited to, the following: 1. Guidelines for Handwashing and Hospital Environmental Control;	S1340		5/18/20

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

Electronically Signed | 05/18/20

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S1340	Continued From page 1 2. Guidelines for Isolation Precautions in Hospitals; 3. Prevention and Control of Tuberculosis in Facilities Providing Long-term Care to the Elderly; 4. Prevention of Nosocomial Pneumonia; 5. Prevention of Catheter Associated Urinary Tract Infections; and 6. Prevention of Intravascular Infections. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure: 1.) appropriate transmission-based precautions were ordered and implemented (immediate isolation from asymptomatic roommates) for suspected COVID-19 residents (R1, R2, R3, R13 and R14); 2.) a system of surveillance to prevent the spread of infection (screening, tracking, monitoring and/or reporting of fever and other signs/symptoms of COVID-19) for six residents (R1, R2 ,R3, R8, R12, R16); 3) staff properly used personal protective equipment (PPE) when caring for COVID-19 positive or COVID-19 suspected residents; 4.) staff were properly trained to use the infrared forehead thermometer on staff, visitors and residents; and 5.) implementation of hand washing practices; and 6.) posting of contact/droplet precaution signage throughout the facility, in accordance with CDC (Centers for Disease Control and Prevention) guidelines to reduce the spread of infections and prevent	S1340	S 1340 Element One – Corrective Actions 1. Transmission Based Precautions R13 and R14 were immediately separated and properly cohorted based on assessment of symptoms and test results which were documented in the medical record. Staff were re-educated about the facility cohort protocol on April 20. Residents 1, 2, and 3 were separated and properly cohorted based on assessment of symptoms and test results which were documented in the medical record. Staff were re-educated about the facility cohort protocol April 20. On April 17, 2020, the Director of Nursing obtained the number of residents asymptomatic or negative for COVID-19 as well as the number of residents	

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S1340	Continued From page 2 cross-contamination during the COVID-19 pandemic. The deficient practice was evidenced by the following: 1.) On 04/17/20 at 9:25 AM, an observation of the [redacted] floor) room assignments for room [redacted] revealed that R13 (awaiting COVID-19 test results since the resident was symptomatic) was placed in the same room with R14, who was not suspected of having COVID-19. Interview with E14 on 04/17/20 at 9:30 AM, revealed confirmation that R13 did show symptom which included fever of 100, and this was reason for resident being tested for COVID-19. When asked about R14's status. E14 did reveal that R14 did not have any symptoms of COVID-19 and was not suspected of having COVID-19. She explained that they did not move R13 because they are waiting for the COVID-19 test result to come back. A review of the medical record for R13 revealed the resident was admitted on [redacted] with a diagnosis of [redacted]. A review of the medical record for R14 revealed the resident was admitted on [redacted] with a diagnosis of [redacted]. Review of "[redacted]" (a lab report) dated 04/17/20 revealed that R13 was "POSITIVE" for SARS CoV-2 (Coronavirus).	S1340	symptomatic or under observation for COVID-19 on each wing on each floor. Based on the above information, 27 out of 30 room changes were done on April 17, 2019 to cohort residents who are asymptomatic and/or negative for COVID-19 from those residents who were symptomatic or under observation for COVID-19 to prevent the continued spread of COVID-19 in the facility. The last 3 room changes were completed on April 18, 2020. Residents with change in status were moved and cohorted accordingly on April 17, 2020. Residents who are negative or asymptomatic that begin to show symptoms of COVID-19, were moved to a unit for symptomatic residents and placed under observation. Room changes continued post April 18, 2020 as residents continued to be cohorted following the Infectious Disease and DON consultant's direction. To better utilize space units were consolidated and Residents and staff were cohorted according to the cohort protocol to prevent the transmission of the virus. Name plates by the door to the resident rooms were updated to reflect the room changes. Hand sanitizer was located at the entrance and the exit doors of the COVID unit as well as other locations in the facility to promote proper hand hygiene in addition to hand washing. Staff were re-educated	

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S1340	Continued From page 3 During an observation on the [redacted] Unit on 4/16/20 at approximately 2:45 PM, it was revealed a sign outside of room for R2 and R3, which indicated there was a COVID-19 positive resident in the room. During an interview with E8 on 04/16/20 at approximately 2:50 PM, when asked if there was a COVID-19 positive person in room with the COVID-19 signage in [redacted] unit, E8 stated that R1 had been moved to the COVID-19 isolation wing on South 2. E8 then took down the sign. On 04/16/2020 at approximately 2:55 PM, the HR (human resource) director also confirmed R1 was moved to [redacted] unit on 04/13/2020. Per record review, R1 was noted to have a high temperature on 04/08/20. R1 was seen by her provider and an order for "Swab COVID-19-PUI" was written on 04/08/20 at 9:30 AM. Per nursing progress note on 04/10/20 at 12:25 PM, the COVID-19 swab was obtained. The results for the test came back positive on 04/13/20. R1 was admitted to the facility on [redacted] with a past medical history that included [redacted] Per the IDT Progress Notes review, R1 was noted to have a high temperature (T) on 04/08/20. R1 was seen by her provider that same day and an order for "Swab COVID-19-PUI" was written at 9:30 AM. Per nursing progress note on 04/10/20 at 12:25 PM, the COVID-19 swab was obtained. The results for the test came back positive on 04/13/20. R1 was transferred to [redacted], the designated COVID-19 isolation unit, that same day. R2 was admitted to the facility on [redacted] with a past medical history that included [redacted]. On 04/06/20, R2 was moved to the	S1340	about proper handwashing and use of hand sanitizer to prevent the spread of infection. 2. System of Surveillance Resident1 was re-assessed on April 18, 2020 and monitored for symptoms of COVID-19 with findings documented in the medical record and on the revised COVID-19 Symptom Assessment form. Staff were re-educated about the facility assessment and monitoring protocol for COVID-19. Resident2 was re-assessed on April 18, 2020 and monitored for symptoms of COVID19 with findings documented in the medical record and on the revised COVID-19 Symptom Assessment form. Staff were re-educated about the facility assessment and monitoring protocol for COVID-19. S 1340 Element One – Corrective Actions Resident3 was re-assessed on April 18, 2020 and monitored for symptoms of COVID-19 with findings documented in the medical record and on the revised COVID-19 Symptom Assessment form. Staff were re-educated about the facility assessment and monitoring protocol for COVID-19. Resident16 expired. Staff that provided care to Resident 16 were counseled and re-educated about the facility assessment and monitoring protocol for COVID-19 that included proper documentation of	

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S1340	Continued From page 4 [redacted] unit. R3 was admitted to the facility on [redacted] with a past medical history that included [redacted]. R3 was R1's and R2's roommate before R1 was moved to [redacted] R2 and R3 roomed with R1 for 5 days from 04/08/20 to 04/13/20 when R1 was a person under investigation for COVID-19, until subsequently moved to the COVID-19 isolation wing. 2.) Record review during the 5 days R1 was suspected COVID-19 and cohorting with R2 and R3 revealed no indication of an assessment or additional monitoring for COVID-19 symptoms that include in part: cough, shortness of breath or difficulty breathing, and chills aside from temperature checks. Review of the facility documentation, "Temperature Check (Coronavirus monitoring)" logs for [redacted] unit from April 1, 2020 to April 16, 2020 revealed several monitoring sheets missing. Of the 16 days reviewed, there were 18 out of 48 shifts missing temperature logs. The dates were: 04/01, 04/02, 04/05 to 04/09, and 04/11 to 04/16. On the provided temperature check logs, there were also columns for "Other Symptoms" and "Comment." Review of the temperature logs on East 1 for R1, R2 and R3, did not reveal any documentation in those columns. Review of R1's Interdisciplinary Progress Notes also did not reveal any additional monitoring of signs and symptoms of COVID-19 while on [redacted] from 04/01/20 to 04/13/20.	S1340	assessment, notifying the physician timely with changes in resident condition and provision of CPR for residents designated as full code. Staff that provided care to Resident8 were re-educated about the facility assessment and monitoring protocol for COVID-19. The nurse was counseled and re-educated for failing to document assessment of Resident8 including the effect of medication provided to alleviate fever and timely notification of the physician. The fall experienced by Resident 12 was re-investigated, and the nursing staff were re-educated about the facility assessment and monitoring protocol for COVID19 and the assessment of a resident including neuro checks after an unwitnessed fall. Nursing staff that provided care to Resident 12 were counseled and re-educated regarding timely notification of the physician when changes in condition occur with resident and proper documentation of neuro checks following an unwitnessed fall. Presumptive (PUI) COVID-19 residents have their temperature checked every shift and are monitored daily for symptoms of COVID-19 including fever, dry cough, shortness of breath, tiredness, aches and pains, and nasal congestion. 3. Proper Use of PPE Staff were re-educated on proper donning and doffing of PPE and proper hand hygiene via instructional video from the	

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S1340	Continued From page 5 Review of R2's Interdisciplinary Progress Notes also did not reveal any additional monitoring of signs and symptoms of COVID-19 while on [redacted] from 04/06/20 to 04/16/20. Review of R3's Interdisciplinary Progress Notes did not reveal any additional monitoring of signs and symptoms of COVID-19 while on [redacted] from 04/01/20 to 04/16/20. A review of the medical record for R16's revealed the resident was admitted on [redacted] with a diagnosis of [redacted]. Record review of the Progress Notes dated 04/6/2020 at 7:00 PM revealed R16 had a high T of 104.9. The next T of 99.1 was documented at 11:22 PM on that same day. A physician order, dated 04/6/20, ordered COVID-19 test and labs to be drawn. Orders were carried out, and results were pending. Further review of the Medication Administration Record (MAR) for April 2020 revealed that there were no medications given/charted that addressed the high temperature of 104.9. Review of the Temperature log dated 04/7/2020 revealed that R16 temperature was not documented at all. This was the day after he had a temperature of 104.9. Review of the Progress Notes dated 04/8/2020 at 5:30 AM, stated resident was unresponsive and was pronounced dead at 6:09 AM. No documentation of coronavirus monitoring was found regarding the respiratory symptoms which included coughing or shortness of breath	S1340	CDC. The completion date for this training was April 21, 2020. Employee 1 and Employee 2 received immediate re-education and counseling regarding the proper use of PPE on April 18, 2020. Employees who are out sick or in quarantine are required to complete the PPE training before they return to work. Observations of employees donning, and doffing PPE is completed during supervisor rounds with staff on the spot re-education as needed. 4. Proper Use of Thermometers Thermometers in use at the reception desk were checked for type and model to determine the manufacturer's recommendations for proper usage to effectively take body temperature. Signs showing correct usage of thermometers was posted to remind staff to calibrate thermometers before use. All employees or essential personnel or allowed visitors are screened before entry onto the resident units, including monitoring of the temperature. Thermometers used at the reception area are calibrated to ensure accuracy following the manufacturer directions. S 1340 Element One – Corrective Actions 5.Handwashing Staff providing resident care on the isolation unit, South 2, were re-educated	

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S1340	Continued From page 6 assessment of R16 from 04/6/2020 to 04/8/2020. In an interview with the Administrative Assistant (AA) on 04/17/2020 at 6:00 PM, she was asked about the lack of documentation regarding assessment notes and medications or nursing interventions given for the fever. The AA attempted to find documentation, but no further documentation could be provided. Review of "[redacted]" (a lab report) dated 04/15/2020 revealed that R16's SARS CoV-2 (Coronavirus) was "Detected". On 04/16/20 at 2:53 PM, the surveyor observed R8 lying supine on a stretcher in the hallway on the [redacted]-floor unit. The surveyor observed R8 wearing an [redacted] and heard R8 making a vibrating noise during breathing. During that observation, R8 was being wheeled to the elevator by emergency personnel in PPE that included face masks, gowns and gloves. During an interview with the surveyor on [redacted] at that time, E3 at the [redacted]-floor nurse's station stated R8 was being taken to the emergency room for [redacted] and stated she did not know how long R8 had been like that. During an interview with the surveyor on 04/16/20 at 2:58 PM, E4, stated R8 started with [redacted] that morning and "spiked" a temperature in the afternoon. During an interview with the surveyor on 04/17/20 at 2:32 PM, E4 stated the staff does not always call the physician when a resident had a temperature and that the PRN [redacted] would be tried first and if that didn't work, the staff should call the physician. E4 stated that she would have	S1340	starting on April 17, 2020 and completed on April 21, 2020 to wash their hands for 20 seconds covering all surfaces, before leaving the resident rooms on [redacted]2 and/or to sanitize their hands before leaving [redacted] Hand sanitizer units were placed by the entrance and exit doors to the unit. Employees 11, 12, 13, 1, 5, 16, and 6 were counseled and re-educated regarding proper handwashing and sanitizing to prevent the spread of infection. Competency evaluations were completed that required a return demonstration. Nursing staff on [redacted] and [redacted] were re-educated on April 18, 2020 regarding the proper storage of linens to prevent contamination. The hallway floor on the COVID 19 unit was immediately swept and mopped clean on April 17, 2020. The Housekeeping District Manager conducted training and retraining of all Porters and Managers on proper floor care. The National Guard deployed to the facility on May 8, 2020 and is assisting housekeeping staff with cleaning and disinfecting floors and rooms. 6. Posting Contact/Droplet Signage Signs reminding staff to “Please SANITIZE your HANDS before leaving the unit” were immediately posted on April 18, 2020 by the exit door of [redacted]	

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S1340	Continued From page 7 to monitor the symptoms and that any changes should be documented in the notes. E4 stated they would not ask for a COVID-19 test right away and confirmed no test was ordered for R8. E4 stated the staff would communicate symptoms and the temperatures would be on the temperature logs for the staff to monitor but that she was unaware of anything until yesterday when R8 just wasn't themselves. E4 also stated that as of today, R8 had to be [redacted] Review of the Admission Record revealed R8 was admitted to the facility on [redacted] with diagnoses that included but were not limited to: [redacted]. Review of the Annual Minimum Data Set (MDS - an assessment tool), dated [redacted], revealed R8 had a Brief Interview for Mental Status (BIMS) score of [redacted] Review of the Quarterly MDS, dated [redacted], revealed R8 had a BIMS of [redacted] Review of R8's Physician's Order Form, dated 03/2020, revealed an order dated 03/14/18 for [redacted] administer 2 tablets [redacted] every 6 hours as needed (PRN) for a temperature above 101 Fahrenheit (F).	S1340	[redacted] Signs reminding staff to “Please SANITIZE your HANDS before leaving the building” were immediately posted on the table (with a hand sanitizer on top) located at the [redacted] Floor Center Core and by the glass doors leading to the Front Lobby on April 18, 2020. Signs reminding staff to Please SANITIZE your HANDS before entering the building” were immediately posted on April 18, 2020 by the hand sanitizer stand by the table where staff fill out the screening questionnaire as well as by the glass door leading towards the [redacted] Floor Center Core. Element Two - Identification of Residents at Risk All residents have the potential to be affected by these infection control practices. All COVID-19 residents could be affected by these infection control practices. All presumptive (PUI) COVID-19 residents could be affected by these practices. All other residents positive for or presumed to have COVID-19 could be affected by these practices. Element Three – Systemic Change The facility retained the consulting services of a Clinical Nurse Practitioner, a DON consultant, an Infectious Disease consultant, and an Administrator	

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S1340	Continued From page 8 Review of the Medication Administration Record for PRN medications, dated 04/2020, revealed the physician's order for [redacted] but no documentation that the medication had been administered to R8. Review of R8's Interdisciplinary Progress Notes, completed by nursing revealed: 04/14/20 at 2:35 PM, a temperature (T) of 100.7 F, pulse (P) 95, blood pressure (BP) 139/75, oxygen level (SPO2) of 98% on room air (RA), R8 was alert and two [redacted] were administered as needed (PRN). There was no documentation that a follow up temperature was obtained to determine the effectiveness of the [redacted] . There was no other documented clinical assessment or follow-up documentation. 04/15/20 at 2:15 AM, T 102 F, BP 130/80, pulse (P) 60 beats per minute (bpm), respirations (R) 22 and SPO2 98 % RA. [redacted] was administered. The T was rechecked at 3 AM and noted to be 99 F. There was no other documented clinical assessment or follow-up documentation. 04/15/20 at 8:00 AM, "slept fairly the whole night." There was no other documented clinical assessment or follow-up documentation. 04/15/20 at 3:00 PM, the latest T was 99 F "post [redacted] " that was administered for a T of 100.6 during the shift. There was no other documented clinical assessment or follow-up documentation. 04/15/20 at 6:00 PM, T of 100.6 F, [redacted] administered and "will monitor." There was no other documented clinical assessment or follow-up documentation.	S1340	consultant to assist the facility with corrective actions and systemic changes. Education is provided daily to re-enforce best practices outbreak to contain to contain and mitigate the COVID outbreak in the facility. S 1340 Element Three – Systemic Change Further cohorting of Residents was completed and the designated COVID positive unit was restructured to include a clean room for donning and a soiled room for doffing PPE with staff re-educated about the use of these areas to contain the virus. Staff on all shifts were retrained from April 18 – April 20, 2020 regarding the correct donning of masks and doffing of gowns and hand hygiene via instructional video from the CDC. A subcommittee of the Quality Assurance Compliance Committee ("Compliance Committee") organized the video training, obtaining signatures of staff in attendance, and maintaining on file these attendance sheets. Direct handwashing observations with return demonstrations and completion of competencies were completed for staff in addition to the video training – completion May 15, 2020. Direct observation of staff donning, and doffing PPE was completed during on unit rounds and staff provided with immediate re-education as appropriate. New thermometers were ordered, and	

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S1340	Continued From page 9 04/15/20 at 9:45 PM, T 99 F, BP 136/84, P 92, R 20 and SPO2 94% on RA. [redacted] at 2:30 PM, "Resident noted to be in [redacted], O2 Sat (arrow down symbol) 60's..." call to physician to send to hospital emergency room for evaluation and treatment. There were no previous documented calls to the physician regarding R8's temperature readings, vital signs, or changes in condition over the two days from 04/14/20 to 04/16/20. 04/16/20 (no time written), SPO2 of 70% on RA, T 102.9 F, change in status, increased and labored breathing "use of accessory muscles" (utilized by people with respiratory distress to help the flow of air in and out of the lungs). [redacted] at 7:00 PM, report from hospital emergency room that Resident #8 was admitted with [redacted] Review of the facility provided, "Temperature Check (Coronavirus monitoring)" logs for the [redacted]-floor units revealed the following: On 04/14/20: 7 AM-3 PM shift: T 99.9, blank "other symptoms," blank "comments," and signed "checked by wing-nurse signature." On 04/15/20: 11 PM-7 AM shift: T 98.6, blank "other symptoms," blank "comments," and signed "checked by wing-nurse signature." 3 PM-11 PM shift: T 100.3, blank"other symptoms," blank "comments," and signed "checked by wing-nurse signature."	S1340	manufacturer's recommendations were ascertained, and staff educated re use of the new thermometer. Staff were educated on proper usage of the thermometer to take the body temperature effectively and correctly. Laundry staff folding clean linen now place the clean linen in clear plastic bags to be handed for distribution. Housekeeping Assistant Manager supervises and checks that clean linens are delivered and stored in a hygienic manner. Staff on [redacted] unit were reeducated on April 18, - April 20, 2020 to wash all surfaces of their hands for 20 seconds after handling dirty linen. COVID-19 protocols were reviewed and revised as needed by the DON consultant and Clinical Nurse consultant to ensure compliance with CDC COVID-19 guidance. Changes were reviewed with staff at clinical and management meetings held by the consultant Administrator. A CPR protocol for use during COVID-19 was developed and staff educated about the procedures to use when administering CPR to a resident with COVID-19. The protocol includes identification of code status to assure proper procedures are followed. This protocol is included with the COVID-19 Outbreak plan. The code status of each resident was reviewed by the unit manager and properly noted for easy access by staff in case of an emergency.	

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S1340	Continued From page 10 7 AM-3 PM shift: T 101.7, blank "other symptoms," blank "comments," and signed "checked by wing-nurse signature." On 04/16/20: 7 AM-3 PM shift: T 102.9, blank "other symptoms," blank "comments," blank CNA signature and signed "checked by wing-nurse signature." On 04/17/20 at 4:08 PM, the surveyor requested the missing "Temperature Check (Coronavirus monitoring)" logs [redacted]-floor unit from 04/14/20 the 11 PM - 7 AM and 3 PM - 11 PM shifts and 04/16/20 11 PM - 7 AM shift from the DON. The surveyor also requested any policies or procedures on the Temperature Check Coronavirus monitoring logs, Monitoring Residents for COVID-19 or related topics. The facility was given opportunity and could not provide additional policies/procedure, information or documentation regarding any of the above. The Centers for Disease Control and Prevention (CDC), "The COVID-19 Long-Term Care Facility Guidance," dated 04/02/20, revealed the symptoms of Coronavirus in older adults and people who have severe underlying medical conditions, including but not limited to, [redacted] seem to be at higher risk for developing more serious complications from COVID-19 illness. Symptoms reported may range from mild to severe illness. These symptoms may appear 2-14 days after exposure to the virus and may include, but are not limited to: fever, cough, shortness of breath or difficulty breathing, chills and repeated shaking with chills. R12 was admitted to the facility on [redacted] with	S1340	Element Four - Quality Assurance Daily observations of the use of PPE and proper handwashing are completed by Unit Managers and the nursing management team to assure staff properly don and doff PPE. The Quality Assurance Compliance Committee will meet weekly for sixty (60) days and monitor staff proficiency and observance of these infection preventive measures and re-evaluate to determine whether there is a need to continue with the PPE and handwashing education. S 1340 Element Four - Quality Assurance The Quality Assurance Compliance Committee (“Compliance Committee”) will meet weekly for sixty (60) days (or until the outbreak is resolved if longer) to monitor proper cohorting of Residents and Staff in the building as a means of mitigating spread of COVID-19. Findings will be discussed and serve as the basis for additional staff education as required. Daily the Quality Assurance Certified Nursing Assistant (QA-CNA) or designee will monitor light-duty CNA and nurses assigned to take temperatures to check whether temperature-taking is being done correctly. Findings of these audits will serve as the basis for additional education as needed. The QA-CNA or designee will check the thermometers daily to ensure that the thermometers as well as the batteries are working properly and will replace the thermometers and/or batteries when needed.	

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S1340	Continued From page 11 diagnoses of [redacted] Review of the facility's New Jersey Universal Transfer Form revealed on [redacted] R12 was transferred to the hospital emergency room (ER) for a T of 104.2 degrees Fahrenheit (F) and being very weak. The ER After Visit Summary, dated [redacted], revealed discharge instructions for [redacted]. These included: call 911 for a seizure, if resident cannot be woken, chest pain or trouble breathing, stiff neck, bad headache, sensitivity to light, feeling weak, dizzy, or confused, stop urinating or urinate is less than normal, coughing up of blood or thick, yellow or green mucus, severe abdominal pain or abdomen is larger than usual. R12's " End of Visit Vitals" were blood pressure (BP) -131/93, T- 99.3 F, pulse (P)-101, respirations (R)-26 and oxygen saturation (SaO2) 95 percent (%). The discharge instructions also included to follow-up with the attending physician in three days (04/08/20) and to call the physician for a T of 100.4 F or higher. Review of the IDT on 04/05/20 at 7:30 AM, documented R12 had returned to the facility with a discharge diagnoses of "[redacted]" and COVID-19 screening completed. At 8:00 AM the nursing note documented the following vitals: BP-130/70, 97.8 (T) P-76 and SaO2-82 %, "Continue to monitor." The next documented IDT nursing note was on 04/09/20 at 9:00 PM. It revealed "Resident in bed fighting the disease, no fever or pain noted on this shift. Resident cooperates well regarding care..." On 04/10/20 at 6:40 PM, a late entry nursing note revealed on 04/06/20 R12 was found on the floor by [redacted] bed, had fell on the wet floor and obtained a [redacted] on the [redacted]. The	S1340	An audit of the code status of residents was completed and resident wishes properly noted for easy access in case of an emergency. The ADON/designee will include review of code status during completion of monthly chart audits. Results will be reported to the Quality Assurance Compliance Committee (“Compliance Committee”) monthly for action as appropriate. In addition, QA-CNA or designee will check the screening questionnaire filled out by staff to see that the temperatures have been recorded. The Quality Assurance Compliance Committee (“Compliance Committee”) will meet weekly for sixty (60) days to monitor that body temperatures are indeed correctly taken and recorded, and that the thermometers and batteries are always functioning properly. Daily the Unit Manager/designee will review the Resident unit-based temperature and assessment log tool required during the COVID19 outbreak to ensure compliance with the procedure for completion. The Unit Manager will discuss findings at daily clinical meetings for action as appropriate. The DON/designee will conduct 20 chart audits of residents noted with changes in condition on the 24 hour report and/or discussed at morning meeting monthly for three months and then quarterly on an ongoing basis to ensure compliance with assessment and documentation of vital signs including temperatures and	

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S1340	Continued From page 12 resident's vitals were taken, range of motion assessed and pupils (eyes) were found to be equal, round and reactive to light and accommodation (PERRLA). The next IDT note was on [redacted] at 7:15 AM. It read "Entered room, Resident (with symbol) eyes open, ashen, no verbal response, no painful response, no respiration, no pulse." R12's physician and registered nurse pronounced the resident deceased at 7:35 AM. Review of the facility's Internal Medicine Monthly Visit/Acute visit/Readmission form dated [redacted], revealed the following hand written notes from R12's physician: "Found dead this am, Rigor Mortis present, CPR (Cardiopulmonary Resuscitation) not performed Physical-COVID-19 test was done?... High fever for the last few days-that was not brought to my attention. Flu like illness, likely COVID-19." On 04/16/20 at 3:15 PM, the COVID-19 surveillance monitoring and tracking was discussed with the DON. The DON stated all working staff temperatures were checked at the beginning of each shift upon entering the facility. If any staff person's temperature was equal or greater than 100.0, they are sent home. In regard to the residents' temperatures, the DON stated they were checked by the CNA's at the beginning of each shift every eight (8) hours. The CNA's recorded the temperatures on a Temperature List form. This form could be found at the Nurses' Station on each floor. If there were other COVID-19 symptoms such as shortness of breath, coughing, weakness, etc. this information would be documented by the nurse and found in the progress (IDT) notes. On 4/17/20 at 7:30 PM, the DON was asked for the facility's practice on assessment and	S1340	oxygenation levels and notification of POA and physicians with changes in condition in compliance with facility procedures and standards of practice. Findings will be acted upon immediately and will be reported in aggregate to the QAPI committee and Administrator at quarterly meetings. The DON/designee will complete chart audits of residents' code status monthly for three months and then quarterly on an ongoing basis to ensure code status is current and reflects the resident end-of-life wishes. Findings will be acted upon immediately and will be reported in aggregate to the QAPI committee and Administrator at quarterly meetings. A double-check system will be strictly enforced, with Housekeeping District Manager reviewing the QCI sheets completed by Assistant Managers and verifying that clean linens and other clean laundry are kept clean and unexposed. The Quality Assurance Compliance Committee ("Compliance Committee") will meet weekly for sixty (60) days to monitor the proper storage of clean linen and handling of dirty linen. Housekeeping Assistant Manager will conduct quality care inspection ("QCI"), document on QCI sheets for Floor Technicians, and re-educate if necessary. The Quality Assurance Compliance Committee ("Compliance Committee") will meet weekly for sixty (60) days to monitor the proper cleaning of floors. Completion Date – May 18, 2020	

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monitoring after an unwitnessed fall. The DON stated the nurses perform Neuro (neurological) checks every four (4) hours for 72 hours. It was also stated the neuro checks should have been performed after R12's fall. This surveyor was unable to locate the Neuro checks or the resident's Advanced Directive/ MOLST (Provider Orders for Life Sustaining Treatment) information on the clinical chart. Later the DON confirmed R 12 was a full code, the Advanced Directive/ MOLST information were never provided.

The facility's Temperature Check (Coronavirus monitoring) form was composed of eight columns, titled, Resident Name, Rm No. (room number), Date, Time, Temp.(temperature), Other Symptoms, Comment and CNA (Certified Nursing Assistant) Signature.

On 04/18/20 at approximately 10:40 AM, the Temperature Check form was reviewed with the DO . A request for temperature checks and COVID-19 monitoring was requested for R12.

The facility presented the [redacted] List for Temperature Check, dated April 10, 2020, 11-7 (11:00 PM- 7:00 AM) Shift. R12 'S name was on the list in room 2131 with a Temp reading of 99.1. All other columns were blank. The facility was unable to provide the requested temperature checks for five (5) days in April (4/5, 4/6, 4/7, 4/8, 4/9 and 4/10/20 [7-3 and 3-11 shift]).

On 04/20/20 the facility emailed R12's Neurological Flow Sheet, which revealed neurological assessments were only assessed for 56 hours, with the last documented time of 3:15 PM on 04/08/20.

3.) On the [redacted] (non COVID-19) unit, an

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observation with the HR Director on 4/16/20 at approximately 3:30 PM, E7 was seen not wearing a gown upon entering resident room [redacted]. E7 was then observed walking out of resident room [redacted] and exited the unit through the closed double doors. On 04/16/20 at 5:51 PM in an interview with the DON, when asked what personal protective equipment (PPE) staff were currently required to wear on non COVID-19 units, the DON stated they were to wear a face mask (currently N95) and a gown.

On 04/16/20 at 2:56 PM, the surveyor observed the [redacted]-floor unit nurse's station. The surveyor observed a staff member standing on the outside perimeter of the round, nurse's desk with their face mask positioned below their nose. The staff member was talking to and in close proximity to five other staff members behind and around the nurse's station. The staff member was identified as E1. The surveyor observed one of the other staff members had been within arm's length from E1.

On 04/16/20 at approximately 3:00 PM, E1 stated she had lowered her face mask because it was "change of shift." E1 stated she had no excuse for the improper use of the face mask and that she had been in-serviced the beginning of March 2020 on the proper use of PPE. E1 stated she should have positioned the face mask "the right way" over her nose "to protect everyone."

On 4/16/20 at 3:24 PM, the surveyor observed, on the main floor between the nurse's station and the [redacted] hall, a staff member with her face mask positioned below both her nose and mouth, down below her chin. The staff member was in close proximity to eight other staff members and was loudly projecting her voice and was calling out

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assignments and instructions. The staff member was identified as E2. The surveyor observed three other staff members had been within arm's length from E2.

On 04/16/20 at approximately 3:30 PM, E2 stated her mask was positioned below her nose and mouth because sometimes it was hard to breathe with the mask fully on the face. E2 stated she knew that was not the correct way to don the face mask and that the purpose of the face mask was important to prevent the spread of the virus.

During an interview with the surveyor on 04/16/20 at 2:58 PM, E4 stated the staff had been in-serviced on the use of PPE by the facility educator who was now out sick. E4 stated it was everyone's responsibility to check that their own PPE and "each other's" PPE was on correctly.

During an interview with the surveyor on 04/16/20 at 3:50 PM, the DON stated that all staff had been trained on how to use and wear their PPE. The DON stated face masks should always be worn correctly and cover the nose and mouth. The DON identified E2 as a staff member who worked in the Quality Assurance position at the facility.

During an interview with the surveyor on 04/17/20 at 2:40 PM, the DON stated there was no record of an in-service regarding PPE for E2. The DON stated E2 "never showed up for it (the in-service)" because E2 mostly worked the 3 PM - 11 PM shift. The DON acknowledged that all staff should have been in-serviced.

Review of E1's, "Personal Protective Equipment (PPE) Competency Validation, dated 03/26/20, revealed a competent, "Return verbal

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demonstration" to prevent cross contamination between staff. The PPE Competency Validation also revealed, 4. Don Mask/Respirator - secure ties/elastic bands at middle of head and neck; 5. fit flexible band to nose bridge and 6. fit snug to face and below chin. The competency also included to correctly identify the appropriate PPE to be worn based on anticipated level of exposure.

Review of the facility handout addressed to the employees, dated 04/8/20, revealed that with the COVID-19 outbreak in the facility, staff may have been exposed. Staff may continue to work provided the included but not limited to 1. Healthcare Personnel (HCP) should report temperature and absence of symptoms each day prior to starting work for the 14-day period after their exposure and 2. HCP wears a facemask while at work for the same 14-day period.

Review of the facility, "PPE Strategies for LTCFs during Cluster of COVID-19 Infections:", not dated, revealed when there are cases in the facility universal masking of HCP while in the facility.

The CDC recommendation from https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html.
"...In addition to the actions described above, these are things facilities should do when there are COVID-19 cases in their facility or sustained transmission in the community

Healthcare Personnel Monitoring and Restrictions:

Because of the higher risk of unrecognized infection among residents, universal use of all

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S1340	Continued From page 17 recommended PPE for the care of all residents on the affected unit (or facility-wide depending on the situation) is recommended when even a single case among residents or HCP is identified in the facility; this should also be considered when there is sustained transmission in the community. The health department can assist with decisions about testing of asymptomatic residents." 4.) On 04/17/20 at 8:50 AM entered the front door of the facility into the reception area. Upon observation, surveyor's temperatures were checked on the neck, and not the appropriate area of the forehead. One reading obtained on a surveyor read "94.7 Fahrenheit (F)." On 04/16/20 at 2:30 PM, the surveyor entered the front door into the reception area of the facility. There were three staff members observed at the screening table. One of the staff was identified as a Certified Nursing Assistant and requested to take the surveyors temperature. The CNA pointed the infrared digital thermometer at the center of the surveyor's forehead and received a temperature of 91 degrees Fahrenheit (F). The surveyor requested a confirmation of the temperature. The CNA pointed the infrared digital thermometer above the surveyor's right ear, the temporal area, and received a temperature of 91 degrees F. Review of the Medical Infrared forehead thermometer manufacturer's information provided by the facility, revealed an illustration that indicated the area to obtain the temperature was in the middle of the forehead. The instructions also revealed after entering the room from a low or high temperature outside, to wait for 20 minutes until the temperature of the "subject" is	S1340		

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adjusted to the temperature environment; before measurement, please be sure there is no hair, sweat, makeup or hair covering and that the ambient (relating to the immediate surroundings) temperature should be stable and not tested in places with large airflows.

During an interview with the surveyors on 04/16/20 at 4:10 PM, the Central Supply staff member stated he handled the ordering of the digital thermometers and that they "were starting to break down." The Central Supply staff member also stated that the facility had three digital thermometers on order. He also stated, "I don't know how or if the thermometers are calibrated because we never had to do that before." Upon request, the facility was unable to provide information regarding the calibration requirements for the thermometers being used during the survey.

During an interview with the surveyors on 04/16/20 at 4:12 PM, the Medical Director stated the CNAs were taking the screening temperatures and were trained just as part of their CNA training and not specifically in-serviced by the facility.

The CDC interim guidance included, "Preparing for COVID-19: Long-term Care Facilities, Nursing Homes" which indicated that "given the high risk of spread once COVID-19 enters a nursing home, facilities must take immediate action to protect residents, families, and healthcare personnel (HCP) from severe infections, hospitalizations, and death. Visitors and HCP continue to be sources of introduction of COVID-19 into nursing homes. To protect the vulnerable nursing home population, aggressive efforts toward visitor restrictions and implementing sick leave policies

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S1340	Continued From page 19 for ill HCP, and actively checking every person entering a facility for fever and symptoms of illness continue to be recommended." https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhealthcare-facilities%2Fprevent-spread-in-long-term-care-facilities.html#interim-guidance The CDC interim guidance included, "Key Strategies to Prepare for COVID-19 in Long-term Care Facilities (LTCFs)" which indicated to "Keep COVID-19 from entering your facility: ... Actively screen anyone entering the building (HCP, ancillary staff, vendors, consultants) for fever and symptoms of COVID-19 before starting each shift... ." https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care-strategies.html On the [redacted] (non COVID-19) unit, an observation with the HR Director on 4/16/20 at approximately 3:30 PM, E7 was seen not wearing a gown upon entering resident room [redacted]. E7 was then observed walking out of resident room [redacted] and exited the unit through the closed double doors. On 04/16/20 at 2:56 PM, the surveyor observed the [redacted]-floor unit nurses' station. The surveyor observed a staff member standing on the outside perimeter of the round, nurses' desk with her face mask positioned below her nose. The staff member was talking to and in close proximity to five other staff members behind and around the nurses' station. The staff member was identified as a E1. The surveyor observed one of the other staff members had been within arm's length from E1.	S1340		

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S1340	Continued From page 20 At that time, the surveyor interviewed E1 who stated she had lowered her face mask because it was "change of shift." E1 stated she had no excuse for the improper use of the face mask and that she had been in-serviced the beginning of March 2020 on the proper use of PPE. E1 stated she should have positioned the face mask "the right way" over her nose "to protect everyone." On 04/16/20 at 3:24 PM, the surveyor observed, on the main floor between the nurses' station and the [redacted] hall, a staff member with her face mask positioned below both her nose and mouth, down below her chin. The staff member was in close proximity to eight other staff members and was loudly projecting her voice and was calling out assignments and instructions. The staff member was identified as a E2. The surveyor observed three other staff members had been within arm's length from E2. At that time, the surveyor interviewed E2 who stated her mask was positioned below her nose and mouth because sometimes it was hard to breathe with the mask fully on her face. E2 stated she knew that was not the correct way to wear the face mask and that the purpose of the face mask was important to prevent the spread of the virus. During an interview with the surveyor on 04/16/20 at 2:58 PM, the [redacted] floor E4 Unit Supervisor stated the staff had been in-serviced on the use of PPE by the facility educator who was now out sick. The E4 stated it was everyone's responsibility to check that their own PPE and "each other's" PPE was on correctly. During an interview with the surveyor on 04/16/20 at 3:50 PM, the Director of Nursing (DON) stated	S1340		

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that all staff had been trained on how to use and wear their PPE. The DON stated face masks should always be worn correctly and cover the nose and mouth. The DON identified E2 as a staff member who worked in the Quality Assurance position at the facility.

During an interview with a surveyor on 04/16/20 at 5:51 PM, when asked what personal protective equipment (PPE) staff were currently required to wear on non COVID-19 units, the DON stated they were to wear a face mask (currently N95) and a gown.

Review of E1's, "Personal Protective Equipment (PPE) Competency Validation, dated 03/26/20, revealed a competent, "Return verbal demonstration" to prevent cross contamination between staff. The PPE Competency Validation also revealed, 4. Don Mask/Respirator - secure ties/elastic bands at middle of head and neck; 5. fit flexible band to nose bridge and 6. fit snug to face and below chin. The competency also included to correctly identify the appropriate PPE to be worn based on anticipated level of exposure.

During an interview with the surveyor on 04/17/20 at 2:40 PM, the DON stated there was no record of an in-service regarding PPE for E2. The DON stated E2 "never showed up for it (the in-service)" because E2 mostly worked the 3 PM-11 PM shift. The DON acknowledged that all staff should have been in-serviced.

Review of the facility educational document to the employees, dated 04/08/20, revealed that with the COVID-19 outbreak in the facility, staff may have been exposed. Staff may continue to work provided the included but not limited to 1.

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S1340	Continued From page 22 Healthcare Personnel (HCP) should report temperature and absence of symptoms each day prior to starting work for the 14-day period after their exposure and 2. HCP wears a facemask while at work for the same 14-day period. Review of the facility, "PPE Strategies for LTCFs during Cluster of COVID-19 Infections," not dated, revealed when there are cases in the facility: "universal masking of HCP while in the facility." The CDC's, "Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings," updated 04/13/19, included, "Minimize Chance for Exposures...Universal Source Control: As part of source control efforts, HCP should wear a facemask at all times while they are in the healthcare facility...HCP should have received job-specific training on PPE and demonstrated competency with selection and proper use (e.g., putting on and removing without self-contamination). https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html#minimize 5.) An observation on the [redacted] unit at 2:50 PM on 04/16/20, E11 was observed handling soiled linen at the doorway in room [redacted]. She discarded it in the soiled linen cart and did not change her gloves. She then went to another room without performing any hand hygiene. At 3:05 PM, E11 was observed at the doorway of the COVID-19 unit removing and discarding her gloves first. She then removed her contaminated PPE gown with ungloved hands and discarded the gown. She did not perform hand hygiene	S1340		

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S1340	Continued From page 23 before leaving the unit. At 3:10 PM, E12, was observed removing her soiled PPE at the doorway of the COVID-19 unit. She did not perform hand hygiene before leaving the unit. There was only one large trash bin at the main entrance of the unit. A used PPE gown was not thrown in the proper receptacle but instead was thrown into a smaller size trash bin which was overflowing. It was noted that the door could only be opened with a turn handle knob. There was no place designated at the entry in which staff could perform hand hygiene measures. Upon opening the door, there was a hallway with still no place to perform hand hygiene. The hand sanitizer was not close by, and it was found on top of the nursing medication cart two rooms away. It was not easily accessible to the staff who needed to perform hand hygiene. At 3:15 PM, E13 was observed at the doorway of the COVID-19 unit, wiping her face shield with ungloved hands. She was using the Sani wipes to clean and disinfect the face shield. After cleaning, she did not perform hand hygiene. An interview with E10 on 04/16/20 at 3:15 PM revealed E11 and E12 should have performed hand hygiene before leaving the unit. On 04/17/20 at 9:55 AM, two physical therapy staff members (E15 and E16) were observed walking in the hallway. They were still wearing gloves as they opened the door to exit the [redacted] unit [redacted] floor). They removed their gloves after exiting and did not perform hand hygiene afterwards. An interview with E15 04/17/20 at 10:00 AM, revealed that he was not aware he should wash	S1340		

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his hands before leaving the closed unit. He stated he will wash his hands downstairs in the therapy room. Both staff members stated that they will wash their hands downstairs in the therapy room.

In an observation on 04/17/20 at approximately 9:30 AM, E6 was observed on [redacted] unit, entering and exiting rooms [redacted] and [redacted]. E6 failed to sanitize hands before donning new gloves and entering in room [redacted]. Finally, E6 failed to perform hand hygiene after exiting room [redacted] after removal of gloves.

Further observation of [redacted] unit at approximately 9:49 AM revealed E5 perform hand hygiene using a hand sanitizer but subsequently contaminated her left hand by touching the door handle when she exited the unit (double doors were closed). E5 failed sanitize hands again after contamination.

In an observation on 04/16/20 at approximately 3:55 PM while on [redacted] it was revealed that the linen cart at the end of the hallway was left uncovered. An 8 oz. used plastic water bottle was also observed to be on one of the shelves.

In an observation on 04/18/20 at approximately 9:35 AM while on [redacted] it was revealed that the linen cart at the end of the hallway was left uncovered.

On 04/16/20 an observation of the environment on the COVID-19 unit, revealed the floor was sticky and visibly soiled with stains on the unit hallway.

Per facility policy from Healthcare Services Group titled, "Infection Control Overview & Policy," last

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S1340	Continued From page 25 updated 03/24/20, read in part "Implement hand hygiene (hand washing) practices consistent with accepted standards of practice, to reduce the spread if infections ..." It also indicated, "hand hygiene should be performed ...after removing gloves." 6.) An observation of the [redacted] Unit on 04/16/20 at 3:15 PM was completed. The unit had one entry which was also the exit. There was one isolation sign at the point of entry. The sign did not specify the PPE to be worn for that unit. It was not clear what kind of PPE should be worn (such as gowns, gloves, goggles, N95 respirators, surgical masks). It also was not specified what type of transmission based precautions (TBP) should be implemented. For example contact, droplet, or airborne. At approximately 3:30 PM, revealed Rooms [redacted] to [redacted] did not display signage by the door designating what PPE needed to be worn and the type of transmission based precautions needed. Only rooms [redacted] to [redacted] had the COVID-19 signage present. When Nurse (E10) was questioned why only certain rooms had the signage, she could not indicate why. She admitted that the sign should be on all the rooms since it was the COVID-19 section. She explained that the census is 40, and all 40 residents are on isolation precautions for testing positive for COVID-19. She said they needed to wear PPE such as gowns, gloves, goggles and N95 respirators. The transmission-based precautions are contact and droplet. Review of the facility's policy "Guidelines on Isolation Rooms, last updated April 7, 2020, "revealed the following:	S1340		

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S1340	Continued From page 26 "Isolation Unit: [redacted] has been designated the wing for isolation for COVID -19 positive residents...2. A sign stating, "Residents SUSPECTED OF COVID-19 (PUI) (tested but results not yet available) in the room - observe DROPLET PRECAUTIONS" or "COVID-19 positive resident in the room - observe DROPLET PRECAUTIONS." will be posted on the door of the resident room. 10. All staff working on the isolation wing will use total personal protective equipment ("PPE") equipment, namely, disposable gown, gloves, eye protection, and mask. Signs will be posted on the isolation wing to remind staff of correct donning and doffing of PPE."	S1340		
S1720	8:39-27.1(a) Mandatory Quality of Care (a) The facility shall provide and ensure that each resident receives all care and services needed to enable the resident to attain and maintain the highest practicable level of physical (including pain management), emotional and social well-being, in accordance with individual assessments and care plans. This REQUIREMENT is not met as evidenced by:	S1720		5/18/20

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S1720	Continued From page 27 Based on observation, interview, and record review, it was determined that the facility failed to evaluate and document ongoing clinical assessments to identify and treat a change in condition, and notify the physician of any changes in condition. This deficient practice was identified for Residents #8 and #15, 2 of 25 residents reviewed for conditions related to COVID-19 in a facility experiencing a COVID-19 outbreak. The deficient practice was evidenced by the following: R15 was admitted to the facility on [redacted] with a past medical history that included [redacted]. Per copy of court documents found in R15's chart, R15's [redacted] was appointed their [redacted]. On 03/30/20, it was documented on the Interdisciplinary Progress Notes sheet, "MD was made aware that residents Roommate in hospital and tested positive for COVID." The progress note further mentioned to order for "COVID and move to [redacted]." R15 was swabbed for COVID-19 and moved to [redacted] that same day. Further review of R15's medical record revealed that the test results for COVID-19 came back positive on 04/04/20. Per nursing progress note on 04/04/20 at 11:00 AM, "Positive for COVID-19, NP ... made aware ..." On 04/10/20 at 09:40 AM, it was documented on the Interdisciplinary Progress Notes sheet, "Rc'd (received) telephone call from POA (power of attorney) ...updated on Residents DX (diagnosis) COVID-19. Resident is afebrile at this time no SOB (shortness of breath) noted MD verified/assessed on 04/09/20. POA wants to be	S1720	S 1720 Element One – Corrective Actions Nursing staff that delayed notifying the POA of Resident #15 of each change in condition were counseled and received re-education of the notification requirement to the POA whenever changes in condition occur. The requirement to promptly document these notifications in the resident medical record per standards of practice and regulations was also included in the re-education. Nursing staff that failed to accurately assess Resident #8 and notify the physician of changes in condition including temperature and oxygen saturation levels and then document changes in the medical record received counseling and re-education. Re-education included notification of the physician when a resident has a change in condition, proper assessment of changes, and required documentation of findings in the medical record per standards of practice and regulations. Nursing staff received re-education regarding timely completion of the COVID-19 outbreak temperature check logs as required. A copy of the required procedure was reviewed with nursing staff during the education program. Element Two – Identification of Residents at Risk All residents have the potential to be affected by these practices.	

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S1720	Continued From page 28 updated on [change] in health status. Requesting to speak with DON (director of nursing). DON notified." On 04/10/20 at 9:50 AM, it was documented on the Interdisciplinary Progress Notes sheet, "Spoke (POA) about (+) COVID- apologized for not informing (+) COVID ..." On 04/12/20 at 1:00 PM, it was documented on the Interdisciplinary Progress Notes sheet by nursing, "Resident has serious problems! Intake is just composed of fluids small quantity. Not able to eat or take medication. Continue to Monitor." There was no evidence found in the record that R15's POA was notified of this change in condition. On [redacted] at 4:00 AM, it was documented on the Interdisciplinary Progress Notes sheet, "Responded to nurse call on the floor ...no breathing, unresponsive to both verbal and tactile stimuli. Pupils fixed and dilated." R15 was pronounced dead at 5:00 AM per nurse's progress note. On 4/17/20 at 7:02 PM in an interview with the DON, she confirmed that the notification in change of condition was delayed regarding notifying the resident's POA of the positive COVID-19 results. She stated she spoke with the resident's POA and wrote the note on 04/10/20 at 9:50 AM. Review of facility policy titled, "Change of Condition," last revised 08/01/17, read in part "The Facility will promptly inform the resident, consult with the resident's Attending Physician, and notify the resident legal representative when	S1720	Element Three – Systemic Change A new COVID-19 vital sign and symptom assessment tool was developed by the DON consultant on May 5, 2020 to replace the temperature log and nursing staff were educated about the procedure for tool completion. On May 11, 2020 it was decided to modify the assessment tool and the procedure for completion with staff re-education and implementation of the revised assessment tool implemented effective May 12, 2020. A written procedure for completion of the COVID-19 Symptom Assessment Tool which include vital signs and symptoms to be used during the COVID-19 outbreak was implemented and nursing staff provided with re-education. A copy of the procedure was placed on each unit in the binder with the tool. Nursing staff receive education about documentation and notification of change in condition procedures on hire as part of the facility orientation program. Documentation education is also reviewed annually and as needed. Additional nursing education was provided to re-enforce resident assessment, notification of changes and documentation requirements per facility protocols and standards Element Four – Quality Assurance Daily the Unit Manager/designee will review the Resident unit-based temperature logs required during the COVID-19 outbreak to ensure compliance	

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S1720	Continued From page 29 the resident endures a significant change in their condition ..." On 04/16/20 at 2:53 PM, the surveyor observed R8 lying supine on a stretcher in the hallway on the [redacted]-floor unit. The surveyor observed R8 wearing an [redacted] and heard Resident #8 making a [redacted]. During that observation, Resident #8 was being wheeled to the elevator by emergency personnel in Personal Protective Equipment that included face masks, gowns and gloves.))))) On [redacted] at 2:56 PM, E3, standing at the [redacted]-floor nurse's station, stated Resident #8 was being taken to the emergency room for [redacted] and stated she did not know how long Resident #8 had been like that. During an interview with the surveyor on 04/16/20 at 2:58 PM, the [redacted]-floor Registered Nurse (RN) unit supervisor stated R8 started with shortness of breath that morning and "spiked" a temperature in the afternoon. Review of the Admission Record revealed R8 was admitted to the facility on [redacted] with diagnoses that included but were not limited to: [redacted]. Review of the Annual Minimum Data Set (MDS), an assessment tool, dated [redacted], revealed R8	S1720	with the procedure for completion. The Unit Manager will discuss findings at daily clinical meetings for action as appropriate. The DON/designee will conduct 20 chart audits of residents noted with changes in condition on the 24-hour report and/or discussed at morning meeting monthly for three months and then quarterly on an ongoing basis to ensure compliance with assessment and documentation of vital signs including temperatures and oxygenation levels and notification of POA and physicians in compliance with facility. S 1720 Element Four – Quality Assurance procedures and standards of practice. Findings will be acted upon immediately and will be reported in aggregate to the QAPI committee and Administrator at quarterly meetings. Completion Date – May 18, 2020	

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S1720	Continued From page 30 had a Brief Interview for Mental Status (BIMS) score of [redacted]. Review of the Quarterly MDS, dated [redacted], revealed R8 had a BIMS of [redacted]. Review of the Physician's Order Form, dated 03/2020, revealed a physician's order dated 03/14/18 for [redacted] administer 2 tablets [redacted] every 6 hours as needed (PRN) for a temperature above 101 Fahrenheit (F). Review of the Medication Administration Record for PRN medications, dated 4/2020, revealed the physician's order for [redacted] but no documentation that the medication had been administered to R8. Review of R8's Interdisciplinary Progress Notes (IDPN), completed by nursing revealed: On 04/14/20 at 2:35 PM, a temperature (T) of 100.7 F, pulse (P) 95, blood pressure (BP) 139/75, oxygen level (SPO2) of 98% on room air (RA), resident was alert and two [redacted] were administered as needed (PRN). There was no documentation that a follow up temperature was obtained to determine the effectiveness of the [redacted]. There was no other documented clinical assessment or follow-up documentation. On 04/15/20 at 2:15 AM, T 102 F, BP 130/80, P 60, respirations (R) 22 and SPO2 98 % on RA. [redacted] was administered. The temperature was rechecked at 3 AM and noted to be 99 degrees F. There was no other documented clinical assessment or follow-up documentation.	S1720		

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S1720	Continued From page 31 On 04/15/20 at 8:00 AM, "slept fairly the whole night." There was no other documented clinical assessment or follow-up documentation. On 04/15/20 at 3:00 PM, the latest T was 99 degrees F "post [redacted]" that was administered for a T of 100.6 during the shift. There was no other documented clinical assessment or follow-up documentation. On 04/15/20 at 6:00 PM, T of 100.6 F, [redacted] administered and "will monitor." There was no other documented clinical assessment or follow-up documentation. On 04/15/20 at 9:45 PM, T 99 F, BP 136/84, P 92, R 20 and SPO2 94% on RA. On [redacted] at 2:30 PM, "Resident noted to be resp (respiratory) distress, O2 Sat (arrow down symbol) 60's..." call to physician to send to hospital emergency room for evaluation and treatment. There were no previous documented calls to the physician regarding Resident #8's temperature readings, vital signs, or changes in condition over the two days from 04/14/20 to 04/16/20. On 04/16/20 (no time written), SPO2 of 70% on RA, T 102.9 F, change in status, increased and labored breathing "use of accessory muscles" (utilized by people with respiratory distress to help the flow of air in and out of the lungs). On [redacted] at 7:00 PM, report from hospital emergency room that R8 was admitted with [redacted]. Review of the facility provided, "Temperature	S1720		

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S1720	Continued From page 32 Check (Coronavirus monitoring)" logs for the [redacted]-floor units revealed the following: On 04/14/20: 7 AM-3 PM shift: T 99.9, blank "other symptoms," blank "comments," and signed "checked by wing-nurse signature." On 04/15/20: 11 PM-7 AM shift: T 98.6, blank "other symptoms," blank "comments," and signed "checked by wing-nurse signature." 3 PM-11 PM shift: T 100.3, blank"other symptoms," blank "comments," and signed "checked by wing-nurse signature." 7 AM-3 PM shift: T 101.7, blank "other symptoms," blank "comments," and signed "checked by wing-nurse signature." On 04/16/20: 7 AM-3 PM shift: T 102.9, blank "other symptoms," blank "comments," blank CNA signature and signed "checked by wing-nurse signature." During an interview with the surveyor on 04/17/20 at 2:32 PM, E4 stated the staff does not always call the physician when a resident had a temperature and that the PRN [redacted] would be tried first and if that didn't work, the staff should call the physician. E4 stated that she would have to monitor the symptoms and that any changes should be documented in the notes. E4 stated they would not ask for a COVID-19 test right away and confirmed no test was ordered for R8. E4 stated the staff would communicate symptoms and the temperatures would be on the temperature logs for the staff to monitor but that	S1720		

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S1720	Continued From page 33 she was unaware of anything until yesterday when R8 "just wasn't [redacted]." E4 also stated that as of today, R8 had to be [redacted] On 04/17/20 at 4:08 PM, the surveyor requested the missing "Temperature Check (Coronavirus monitoring)" logs [redacted]-floor unit from 04/14/20 the 11 PM-7 AM and 3 PM-11 PM shifts and 04/16/20 11 PM-7 AM shift from the DON. The surveyor also requested any policies or procedures on the Temperature Check Coronavirus monitoring logs, Monitoring Residents for COVID-19 or related topics. The facility was given opportunity and could not provide additional policies/procedure, information or documentation regarding any of the above. The Centers for Disease Control and Prevention (CDC), "The COVID-19 Long-Term Care Facility Guidance," dated 04/02/20, revealed the symptoms of Coronavirus in older adults and people who have severe underlying medical conditions, including but not limited to, heart or lung disease or diabetes seem to be at higher risk for developing more serious complications from COVID-19 illness. Symptoms reported may range from mild to severe illness. These symptoms may appear 2-14 days after exposure to the virus and may include, but are not limited to: fever, cough, shortness of breath or difficulty breathing, chills and repeated shaking with chills.	S1720		