STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315346	A. BUILDING _____ B. WING _____	04/22/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
N J VETERANS MEM HOME PARAMUS	1 VETERANS DRIVE PARAMUS, NJ 07652

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0550 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, review of the facility's documents, and review of the facility's policy, it was determined the facility failed to ensure resident's right to a dignified existence was promoted and enhanced for two of two sampled residents (Resident (R) 8 and R7). On [DATE], facility nursing staff incorrectly identified, pronounced deceased , and notified R8's family that he had expired; however, the resident who had expired was R7 and his family was not notified until five hours later. This failure placed all residents at risk for not having their rights honored. On [DATE] at 6:15 PM the Administrator, the Clinical Assistant Administrator, and the Non-Clinical Assistant Administrator were notified of the immediate jeopardy under the area of Resident Rights for a failure to correctly identify and make family notifications after a resident expired. The facility presented an acceptable plan for removal of the immediate jeopardy on [DATE] at 4:30 PM. The removal plan included all residents' ID bands, room name plates, medical records, and unit rosters were all checked and verified for accuracy. The facility started educating all nursing staff. To ensure all staff were educated, nursing staff could not begin their shift prior to receiving the education related to properly identifying residents. The removal plan was validated through observation, interviews and record review. Observations revealed all doors on the units were clearly identified with a D or a W to indicate if the resident was in the bed by the door or window. Observations also revealed all resident who were wore their ID bands on their person. Interviews were completed with staff related to identifying residents, specifically how they were instructed to identify residents who they were not familiar with their names. Record review revealed that staff had received inservice training regarding how to identify residents and the use of the ID bands on all residents in the facility. The facility was notified the facility that the immediate jeopardy was removed on [DATE] at 5:10 PM. Findings include: Review of the facility's undated form titled, Resident Rights, revealed, .each resident of the New Jersey Veterans Memorial Home (VMH) should be entitled to the following rights which included the right to a dignified existence . Review of the facility's policy titled, Death of a Veterans Home Resident, revised 2018, revealed, .the Division of Veterans Healthcare Services (DVHS) required that each of the New Jersey Veterans Memorial Homes (VMH) would establish a protocol assuring that the responsibility for the pronouncement of death was discharged in accordance with County or State Regulations, and in a [MEDICATION NAME], dignified , and expeditious manner. Continued review of the policy revealed when a VMH resident expired, the County Medical Examiner would be notified of the resident's death and would be provided with contact information for the resident's next of kin. The policy also revealed the VMH would promptly notify the Power of Attorney, guardian, or other designated person about a resident's death and the notification should be made at the time of the pronouncement of the resident's death, and the time between the pronouncement of the resident's death and the notification should not exceed one hour, unless the family member, guardian, or other designated person to be contacted provided other instruction as to when the required notification was to occur . Review of the facility's form titled, Final Investigation, dated [DATE] revealed for the section Fact Summary it was documented, Residents (R8 and R7's initials) were both residents from other units who were transferred to Valor Unit on [DATE]; and were cohorted in the same room for their Covid (sic)19 positive diagnosis. On [DATE] at approximately 10 AM (sic) while the wing nurse was passing meds (medications) in room V8, she administered (R8's initials) his medication, and then recalled that the night shift nurse had stated in the change of shift report that (R8's initials) had expired. The nurse immediately contacted the Supervisor and the DON (Director of Nursing). Upon investigation, it was noted that the night nurse and the night supervisor mistakenly contacted (R8's initials) family, documented in the wrong chart and also placed the wrong ID (identification) band on (R7's initials) when in fact it was (R7's initials) that had expired and not (R8's initials). Continued review of the Final Investigation revealed for the section Conclusions/recommendations, indicated, both residents' families were immediately contacted and notified of the error, both the night shift nurse and the supervisor were immediately contacted and corrected the documentation in the appropriate charts, night nurse who was working on [DATE], when (R7's initials) expired at 5 AM (sic), grabbed the chart looking at the name outside the door and that is why the error occurred, and in order to prevent this event from occurring again in the future, the following precautionary measures were taken. a. On all units, resident's ID (identification) bands, room name plates, and unit rosters were all immediately checked and verified for accuracy. c. All resident room name plates had been amended to show D or W to clearly demonstrate the resident's location in each room. Review of R8's undated Face Sheet, located in the resident's hard copy closed medical record, revealed the resident was admitted to the facility on [DATE]. Continued review of the face sheet revealed the resident's unit/room was documented as TV (Valor Unit) V008W (room V008 window). Review of R'8s quarterly Minimum Data Set (MDS), assessment with an assessment reference date (ARD) of [DATE] revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of three out of 15, which indicated the resident was severely cognitively impaired. Review of R8's undated Funeral Plan, located in the resident's hard copy closed medical record revealed the resident's chosen funeral home was (name of funeral home.) Review of R8's Interdisciplinary Progress Notes, dated [DATE] at 1420 (2:20 PM) (notes have a line drew threw them with initials) revealed a nursing progress note that stated the resident was transferred from the RS (Serenity Unit) to room V8W due to COVID-19 positive test result. Continued review of the Interdisciplinary progress notes revealed on [DATE] at 0500 (5:00 AM) nursing documented, Resident in bed unresponsive, pale, pupils dilated .no pulse, no respirations, no B/P (blood pressure) .called MD (medical doctor) and notified regarding death and RN (Registered Nurse) arrival and pronounced, MPOA (medical power of attorney) notified. I (nurse) will call funeral home. Further review of the Interdisciplinary progress notes revealed on [DATE] at 0730 (7:30 AM) nursing documented Body picked up at this time by name of funeral home. Review of R7's undated Face Sheet, located in the resident's hard copy closed medical record, revealed the resident was admitted to the facility on [DATE]. Continued review of the face sheet revealed the resident's unit/room was documented as TV (Valor Unit) V008D (room V008 door). Review of R7's admission MDS, with an ARD of [DATE], revealed the facility assessed the resident as having a BIMS score of five out of 15, which indicated the resident was severely cognitively impaired. Review of R7's undated Funeral Plan, located in the resident's hard copy closed medical record revealed the resident's chosen funeral home was (name of a different funeral home.) Review of R7's Interdisciplinary Progress Notes, dated [DATE] at 1435 (2:35 PM) revealed a nursing progress note that indicated the resident was transferred from the RS (Serenity Unit) room R12D to room V8D due to COVID-19 positive test result. Continued review of the progress notes dated [DATE] at 0700 (7:00 AM) (line is drawn through documentation with initials) revealed the nurse documented, Tylenol given at 0630 am for increased temp of 99.8, fluids encouraged . no SOB (shortness of breath), HOB (head of bed) elevated . Further review of R7's progress notes dated [DATE] at 1505 (3:05 PM) nursing documented a late entry for [DATE] at 10:15 AM which revealed the nurse informed R8's POA (power of attorney) that his dad expired this morning (morning of [DATE]). The notification was

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

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 0550 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) made five hours after the resident had expired. Interview on [DATE] at 9:54 AM with Unit Clerk (UC) 38, who was assigned to the Valor Unit, revealed on [DATE] he received paperwork for R8 and R7 to come to the Valor Unit from the Serenity Unit. Continued interview with UC38 revealed per the paperwork, R8 was assigned to the Window side of room V8 and R7 was assigned to the door side of room V8. The UC stated he placed the resident's names outside the door of room V8 per the paperwork, updated the unit roster, and updated the residents' chart to show the same. The clerk also stated he did not know how R7 ended up in R8's bed by the window. The UC also stated he knew the residents were in the correct beds (R8 by window and R7 by the door) because the residents' social worker came to the room and checked on them both. Interview on [DATE] at 10:15 AM, Social Worker (SW) 34 stated that she was the social worker for both Serenity and Valor Units. SW34 stated that she was very familiar with R8 and R7. The SW stated that on [DATE] she became aware that both residents had been transferred from the Serenity unit to the Valor Unit, room V8. SW34 stated when she went into V8, R7 was in the bed by the door and R8 was in the bed by the window; and name plates outside the door indicated the same. Interview on [DATE] at 2:01 PM with Recreation Assistant (RA) 35 and RA36 revealed they were the ones who transported both R8 and R7 from the Serenity Unit to the Valor Unit on [DATE]. Both RAs stated they knew the residents very well. The RAs stated they first brought R8 to the Valor Unit and placed his bed in room V8 by the window and then brought R7 and placed his bed in room V8 by the door as instructed by the Valor unit's ward clerk. RA35 stated he remembers R8 talking and asking where he was being moved too. Interview on [DATE] at 10:10 AM, the DON revealed on [DATE] Licensed Practical Nurse (LPN) 33 assigned to room V8 called Registered Nurse Supervisor (RNS) 32 to come pronounce a resident as deceased . The DON stated LPN 33 reported to the RNS 32 the resident who had expired was R8 when in fact it was R7 who had expired. The DON also stated the RNS 32 identified the resident who she pronounced as R8 based on the identification name outside of the room's door and the residents hard copy medical record, which both had R8 as being in the bed by the window. The DON also stated LPN 33 assigned to the resident also failed to recognize the resident that was deceased was not the correct name and both the RNS 32 and LPN 33 were not familiar with either resident in room V8. Continued interview with the DON revealed neither resident wore ID bands since both residents came from the Serenity Unit. The DON stated that most residents on the dementia unit will frequently remove them. The DON further stated the facility's practice of correctly identifying residents was for staff to look at the ID bands on the resident and staff who were not familiar with the resident should have familiar staff verify who the name of the resident. When asked about picture identification, the DON stated pictures of residents were only located in the resident's Medication Administration Record [REDACTED]. When asked if staff have been re-educated since the event that took place on [DATE] when a deceased resident was not correctly identified, the DON stated she had not had the time to do any education yet. The DON confirmed the wrong resident was identified as deceased , and R7 went to the wrong funeral home and was almost cremated instead of buried per his wishes. Interview on [DATE] at 11:05 AM, with RN 12 revealed if she found a resident unresponsive, she would check the resident's ID band for the resident's name and if she was not familiar with the resident, she would call a staff person who was familiar with the resident to verify who the name of the resident. Interview on [DATE] at 11:15 AM, with LPN37 revealed if he was to find a resident unresponsive, he would check the resident's ID band to verify the resident's name and if he was unfamiliar with the resident, he would request someone familiar with the resident to come verify the name of the resident. Interview on [DATE] at 11:46 AM, LPN33 stated on the morning of [DATE] there was a lot of confusion related to the relocation of residents and that it was a very stressful shift. Continued interview revealed on the morning of [DATE], LPN 33 was notified by a CNA that the resident in room V8W may have passed away. LPN 33 stated that when he went into the room, he checked the name on the door and when he checked the resident for an ID band, the resident was not wearing an ID band. LPN 33 also stated that after he assessed the resident, he pulled the chart (hard copy medical record) for the resident in the bed by the window and the chart indicated the resident in the bed by the window was R8. LPN33 stated he notified the RNS 32 to come pronounce R8 deceased . LPN 33 stated that he made the resident a new ID band and placed it on the resident prior to the funeral home's arrival. When asked if he had looked in the resident's MAR indicated [REDACTED]. When asked had he received any education related to identifying residents, LPN 33 stated that he returned to work the next day and did not receiving any education regarding the identification of residents. Interview on [DATE] at 12:00 PM, RNS 32 stated that on [DATE], LPN33 notified her that R8 had expired. The RNS 32 stated that when she arrived at the Valor Unit, CNA 39 told her the resident was R8 in room V8W. RNS 32 stated that the sign outside of room V8W indicated R8 was in the bed by the window. RNS 32 indicated that the unit's roster also indicated that R8 was in the bed by the window. RNS 32 confirmed that the resident was not wearing an ID band. The RNS 32 stated that because the CNA confirmed the resident was R8, LPN 33 confirmed the resident was R8, the name outside the door indicated the resident in the window bed was R8, and the chart indicated the resident was R8, he did not look at the resident's picture in the MAR. Observation on [DATE] at 12:50 PM of the Serenity Unit revealed three residents in the day room did not have ID bands on their person. Continued observation revealed the residents' rooms were not marked with a D or a W by the names of residents to clearly identify the residents' bed location. Interview on [DATE] at 1:08 PM, RN 13 revealed that three residents in the day room were not wearing an ID bands, and that the residents had taken their ID band off and staff had placed the ID band in the resident's hard copy medical record. RN 13 confirmed that none of the residents' bedroom on the Serenity Unit were marked with a D or a W. Observation on [DATE] at 1:30 PM of the N Wing revealed rooms 102, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116 missing the W for window bed and that D was identified on the name plate outside of the residents' bedroom doors.
F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, observations, review of facility policy, and record review, the facility failed to develop an effective procedure to identify presumptive positive COVID-19 residents from COVID-19 positive residents resulting in the nursing and housekeeping staff's failure to follow infection control guidelines in four of 12 sampled residents (Resident (R) 1, R2, R3, and R4). This failure had the potential to affect all 235 residents in the facility. In addition, the facility failed to cancel communal activities and dining on the dementia unit resulting in COVID-19 positive residents (R9, R10, R11, and R12) interacting with residents with an unknown COVID-19 status. The dementia unit had a census of 32 residents. On 04/21/20 at 3:40 PM, the Administrator, the Clinical Assistant Administrator, and the Non-Clinical Assistant Administrator were notified that the failure to develop an effective procedure to identify presumptive positive COVID-19 residents from COVID-19 positive residents resulted in the nursing and housekeeping staff's failure to follow infection control guidelines and the failure to cancel group activities and dining on the dementia unit constituted immediate jeopardy at F880. The facility presented an acceptable plan for removal of the immediate jeopardy at F880 on 04/22/20 at 6:15 PM. The removal plan included obtaining additional PPE, changing the signage to include a red STOP sign to indicate COVID-19 positive residents and a yellow STOP sign to indicate those residents with pending COVID-19 test results, and educating nursing, housekeeping, dietary, and environmental services staff on appropriate use of PPE and the color coded signage. To ensure all staff were educated, any staff that did not attend the in-services would be educated prior to the beginning of their shift. The removal plan included closing and sanitizing the dayroom on the dementia unit. Staff was educated on promoting social distancing for the residents who continued to wander out of their rooms. Housekeeping was educated to clean and sanitize high touch surfaces in the dementia unit. The facility provided a plan to monitor the burn rate of Person Protective Equipment (PPE) to assist in ordering an adequate amount of PPE. The removal plan was validated through observations, interviews of staff and record review of inservice records. Observations revealed the red and yellow STOP signs were placed on the residents' room doors according to the COVID-19 status of the residents. Observations were made of the amount of PPE on each nursing unit. Interviews of staff validated that the amounts of PPE available had improved and an understanding of the color-coded signage. Observations of the dementia unit validated that the dayroom was closed, most residents were in their rooms, those residents in the hall were monitored by staff for social distancing, and the residents were served their meals in their rooms. The survey team notified the Clinical Assistant Administrator that the immediate jeopardy at F880 was removed on 04/22/20 at 6:45 PM. Findings include: During the entrance conference on 04/19/20 at 10:45 AM, the Director of Nursing (DON) stated, Every unit has one wing for positive residents. Positive residents are moved to the designated unit. Their roommates are tested due to exposure. The residents that have pending test results stay on the other wing on the unit. The STOP sign on the door means the resident is positive. The DON stated that the nursing staff follows infection control procedures by providing care for the residents who are negative for COVID-19 first, then provides care to the residents awaiting test results, and lastly provides care to the residents who are positive for COVID-19. The DON stated that this procedure was to extend the use of PPE, in particular gowns, by providing care to the residents who are positive for COVID-19 last. During an interview on 04/19/20 at 2:00 PM, Registered

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 2) Nurse (RN) 5 stated, This morning we handed out one blue (isolation) gown and one yellow poncho to each Certified Nursing Assistant (CNA) for the day shift. During an interview on 04/19/20 at 2:15 PM, the DON verified that each CNA was provided one isolation gown and one plastic poncho for their shift. During an interview on 04/20/20 at 10:00 AM, RN 6 stated, On one side (wing) of the unit are all COVID positive residents. The L side is COVID positive and K side is pending results. During an interview on 04/20/20 at 10:20 AM, RN8 stated, Both wings (L and K) have some positive COVID 19 and some pending. During an interview on 04/19/20 at 12:15 PM on the L-wing near the nurses' station, CNA 18, 19, 20, and 21 stated that the facility supplied them with one disposable gown and one plastic poncho to place over their gown per shift. These CNAs stated that the PPE provided by the facility was not enough to follow isolation precautions. The CNAs stated that all residents negative for COVID-19 were to have care first, then the residents who were presumptive (test pending or exposed) COVID-19, and last to have care were the residents who were positive for COVID-19 to help mitigate the spread of [MEDICAL CONDITION]. When asked how they would know which residents are pending test results and which residents are COVID-19 positive, the CNAs stated that the STOP sign on the residents' doors indicated that both residents were positive for COVID-19 or one resident was positive and the other had pending test results. The CNAs were unable to state which resident was positive and which was presumptive. The CNAs stated that they treat both residents with a STOP sign on the residents' bedroom door as positive increasing the exposure to COVID-19 to the resident awaiting test results. Continued interview on 04/19/20 at 12:45 PM, CNAs 17, 18, 20, and 21 revealed that once the last resident on their assignment received care, the plastic poncho would be discarded. The CNAs stated that they would wear the same isolation gown minus a poncho for the rest of the shift while providing care to the residents regardless if they are COVID-19 positive, presumptive, or negative. During an interview on 04/19/20 at 12:45 PM on the K wing, CNA17 stated that she was given one isolation gown and one plastic poncho per shift to wear while caring for the residents on her assignment. CNA17 stated her assignment includes both COVID-19 negative and positive residents. CNA17 stated that the STOP sign on the residents' bedroom doors indicated that both residents were positive for COVID-19 so it didn't matter which resident was given care first. During an interview on 04/19/20 at 1:00 PM on the M wing, CNAs 22, 23, and 24 stated that they are provided one isolation gown and one plastic poncho or apron as PPE for the shift. These CNAs were unable to state which residents in the rooms with the STOP sign were positive and which were presumptive. These CNAs stated that all residents in the rooms with the STOP sign were treated as positive during care. During an interview on 04/19/20 at 2:35 PM on the V wing, CNA25 stated that she was provided with one isolation gown and two plastic ponchos for the shift. CNA25 stated, I go to the negative residents first. I throw away the 'poncho' when all of the residents on my assignment have received their care. When I go back later to provide care, I use the second 'poncho.' I have only the gown to wear when caring for the residents. During an interview on 04/20/20 at 10:05 AM on the L wing, CNA21 stated that the STOP sign on the residents' bedroom door means all the residents in the room are positive for COVID-19. When asked which resident would receive care first in the room with the STOP sign CNA21 stated, I do the resident on the window side first then door side. When asked if it mattered if one resident is pending or one was positive when deciding to provide care, CNA21 stated, I treat both as positive. When asked who would receive care first in a room where there is a STOP sign on the residents' bedroom door, CNA21 stated, The window bed. Review of R2's paper medical record April 2020 physician's orders [REDACTED]. Review of R1's paper medical record April 2020 physician's orders [REDACTED]. R1's test results were pending as of 04/20/20. CNA21 verified that she provided care to R2 first based on her understanding that the STOP sign meant both residents were COVID-19 positive. Observation on the N wing on 04/20/20 at 10:30 AM, revealed CNA29 wearing an isolation gown with a thin plastic gown over it preparing to go into R3 and R4's room. The door of the room had a STOP sign. CNA29 stated that the STOP sign meant both residents are positive for COVID-19. CNA29 stated that since both residents in that room were COVID-19 positive, it did not matter which resident was provided care first. Review of R3's paper medical record April 2020 physician's orders [REDACTED]. Review of R4's paper medical record April 2020 physician's orders [REDACTED]. Observation on the L wing on 04/19/20 at 12:10 PM revealed housekeeping staff 30 was mopping the residents' rooms. Housekeeping staff 30 was asked if he mopped the rooms in any particular order, i.e. COVID-19 negative before COVID-19 positive rooms, and he stated, No. When asked what the STOP signage on the doors to the residents' rooms meant he stated, I have no clue. During an interview on 04/19/20 at 1:00 PM, the Assistant Director of Housekeeping stated, We are short-staffed. He (housekeeping staff 30) usually works in the laundry and on the weekends. I will reeducate him on the order to mop the floors with the COVID-19. Observation and interview on 04/20/20 at 7:30 PM on the secured dementia unit revealed 10 residents seated in the dayroom. The residents were not wearing face masks or social distancing. R9 was identified by the CNA26 as being positive for COVID 19. R9 was observed seated in a chair next to another resident who was identified as being COVID negative. CNA26 stated, What are we supposed to do? This a dementia unit and they (the residents) won't stay in their rooms or wear a mask. Review of R9's paper medical record Aril 2020 physician's orders [REDACTED]. Observation on 04/21/20 at 12:50 PM revealed approximately 15 residents seated in the dayroom on the secured dementia unit. Interview on 04/21/20 at 12:50 PM with CNA27 and CNA28, four of the residents (R9, R10, R11, and R12) in the dayroom were positive for COVID 19. These four residents were not wearing face masks. R9 was observed ambulating throughout the dayroom and was seated next to other residents with an unknown COVID 19 status. R10 and R11 were observed seated at a round table with a resident with unknown COVID 19 status. R12 was observed seated in a wheelchair placed at a rectangular table with three residents with unknown COVID 19 status. CNA27 stated, This is a dementia unit. We can't keep the residents separated because they wander. Review of R10's paper medical record April 2020 physician's orders [REDACTED]. Review of R11's paper medical record April 2020 physician's orders [REDACTED]. Review of R12's paper medical record April 2020 physician's orders [REDACTED]. Interview on 04/21/20 at 1:00 PM on the dementia unit, RN13 stated that the residents were unable to maintain social distancing, wear face masks, or stay in room due to their dementia. RN13 verified that the residents ate their meals and congregated in the dayroom. RN13 stated that the facility did not provide them with additional guidance or policies regarding infection control for the dementia unit. RN13 stated that as of 04/20/20 at 1:00 PM, all 32 residents residing on the dementia unit had been tested for COVID 19. Fourteen residents were COVID-19 positive and 17 residents' results were pending. During an interview on 04/21/20 at 3:00 PM, the Administrator verified that the staff on the dementia unit were educated concerning transmission-based precautions and communal activities following the same guidelines as the other units in the facility. Review of the facility's policy titled, COVID-19 Infection Prevention and Control Program-New Jersey Veterans Homes, dated 04/03/20, revealed . The VMH (Veteran's Memorial Homes) will maintain an active Infection Prevention and Control Program that includes all departments and contracted services, working to ensure the following infection prevention interventions are in place: Communal Activities: The Veterans Home shall cancel all group outings, group activities, communal therapies, and communal dining during the period of the COVID-19 pandemic . Make PPE available to care for residents on transmission-based precautions (as available) . Signage for staff regarding the use of PPE shall be posted in appropriate locations in the facility . Interview with the DON on 04/22/20 at 4:00 PM revealed that as of midnight on 04/21/20, the facility had a census of 239. Out of the 239 residents, 119 residents had been confirmed COVID-19 positive, 46 COVID-19 related deaths, and 148 residents with pending COVID-19 results. These numbers are since the first documented case of COVID-19 in the facility on 03/25/20.