STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235293	A. BUILDING _____ B. WING _____	04/28/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDILODGE OF FARMINGTON	34225 GRAND RIVER AVE FARMINGTON, MI 48335

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 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 observation, interview, and record review, the facility failed to: perform employee /visitor screening assessments for the COVID-19 virus prior to entry into the facility, ensure the appropriate use of personal protective equipment (PPE) for residents in droplet isolation including residents in isolation for COVID-19, ensure appropriate isolation of residents in droplet isolation for COVID-19, ensure appropriate signage was in place to indicate a droplet isolation room, and ensure increased clinical assessments were completed for residents with a positive or suspected case of COVID-19 for 25 residents, (R#s 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, and 725) of 25 residents reviewed for infection control practices, resulting in an immediate jeopardy to the safety and health of all residents in the facility when the facility's infection control practices put all residents at risk of serious harm and/or death due to the actual and potential spread of the COVID-19 virus. Findings include: The Immediate Jeopardy (IJ) started on [DATE]. The IJ was identified on [DATE] at approximately 10:30 AM. The Administrator was notified of the IJ via telephone and electronically on [DATE] at 4:50 PM. The immediacy was removed on [DATE] at 7:00 PM, based on the facility's implementation of an acceptable plan of removal as verified both off-site and on-site by the survey team. Although the immediacy was removed, the facility remained out of compliance at the scope of widespread and a severity of potential for more than minimal harm that is not immediate jeopardy due to sustained compliance that has not been verified by the State Agency. On [DATE]-[DATE] a COVID-19 Focused Survey was conducted. On [DATE] at 8:45 AM, an interview with the facility's Administrator and Director of Nursing (DON - who was identified as the facility's Infection Control Preventionist - ICP) was conducted. During the interview, they reported they considered both hallways (1 West and 1 East) on the first floor as well as the 2 East [MEDICAL CONDITION] (trach) unit on the second floor as designated units for COVID-19 residents. When queried about how they designated the units and how residents were assigned to rooms, they indicated the first floor had confirmed positive cases of COVID-19 as well as multiple other residents they were treating as positive but had not received a swab for the test, due to not being able to obtain the testing swabs. They also indicated that on [MEDICAL CONDITION] there was one resident with a positive COVID-19 diagnosis, and one resident being treated as positive, but was asymptomatic and a swab had not been ordered. When queried about the residents they referred to that had not been swabbed, it was explained that those residents had been exposed to someone who had tested positive for COVID-19 at some point, but remained asymptomatic, so swab tests were not ordered for those residents but they were 'presumed positive' related to exposure to other residents who had tested positive. The DON reported all residents on the first floor and [MEDICAL CONDITION] on the second floor were on droplet precautions (isolation precautions to prevent transmission of pathogens transmitted by respiratory droplets). The DON reported staff were to wear a gown, gloves, an N95 respirator mask, and goggles or a face shield when entering the droplet precaution rooms. When queried about PPE availability, the DON reported the facility was doing good as far as access to PPE and the supplies were counted daily, passed on to the corporate office, and the corporate office would get the facility what they needed. The DON reported that the facility had access to COVID-19 tests and that results were received much quicker now (within ,[DATE] hours). The DON reported the facility's protocol for screening visitors and staff for COVID-19 was to take their temperature and ask screening questions at the door. If a staff member had a fever, they were sent home and could not return until they went 72 hours without a fever and no fever reducing medications. The DON also reported that anyone with a sore throat, cough, or body aches was not permitted to enter the facility and were sent home. On [DATE] at approximately 10:15 AM, during an observation of the first-floor units, no staff were observed to be positioned at the rear entrance. No signage was observed to direct those who entered to check in for screening. A clipboard with a screening log and a temporal artery thermometer was observed to be placed on the ledge of the nurse's station. At approximately 10:20 AM, Physician L entered the facility through the rear entrance. There was no staff present at the door to screen Physician L. Physician L proceeded to go behind the desk at the nursing station where two staff members were seated, including Nurse E. Physician L asked the staff members if there were any new rules to which Nurse E replied there was not. Physician L proceeded to enter the elevator and go upstairs to the second floor. No screening of Physician L was observed. On [DATE] at 10:35 AM, Physician L reentered the first-floor unit. When queried about why they did not get screened prior to going upstairs to see residents, Physician L reported that they asked, and nobody instructed them to be screened. At that time, Ward Clerk F was observed to screen Physician L prior to them leaving the facility. When queried about the process for screening employees and visitors who entered the facility through the rear entrance, Ward Clerk F reported that staff could fill out their own screening and there was usually a manager present to screen people when Ward Clerk F was not present. On [DATE] at 10:55 AM, Maintenance Staff G was observed entering the facility through the rear entrance and punched in at the time clock. There was nobody at the door to screen for COVID-19. Maintenance Staff G entered through the double doors and proceeded to step all the way into the elevator. When queried about screening, prior to closing the door on the elevator, Maintenance Staff G identified they were maintenance staff and just arrived for their shift. On [DATE] at 11:00 AM, the Administrator was interviewed about the facility's protocol for screening staff and visitors for COVID-19. The Administrator reported that physicians were educated on the need to be temped (temperature taken) and asked the screening questions. The Administrator reported that Medical Records Staff H was assigned to screen all staff leaving and entering the facility through the rear entrance from 6:30 AM until 7:45 AM and then the log and thermometer was taken to the nurse's station. The Administrator reported a charge nurse would be responsible for ensuring staff were being screened and if the charge nurse was not present, Staff should do it on their own. The Facility provided a Plan of Removal via email on [DATE] that detailed how the Facility would ensure the immediacy would be removed. On [DATE] at 9:15 AM, upon entrance to the facility through the rear entrance, Medical Records Staff H proceeded to take the State Surveyors temperatures. No screening questions were asked by Medical Records Staff H and the State Surveyors were permitted to enter the facility. On [DATE] at 9:30 AM, during an interview with Medical Records Staff H, the Staff Vitals/Screening Log for [DATE] was reviewed. Next to the State Surveyors' names the Temp. on entrance was filled in, as well as the following: New onset Cough yes/no: No New onset Sore throat yes/no: No New/Unusual SOB (Shortness of Breath): No Travel outside of the US within last 14 days: No Contact with any suspected or confirmed [DIAGNOSES REDACTED]. When queried about why the answers were filled in for the State Surveyors when they were not asked the screening questions upon entrance, Medical Records Staff H reported they were notified that the State Surveyors were in the facility the previous day and the questions did not need to be asked again. When queried about how Medical Records Staff H would have known in the Surveyors had any new onset symptoms such as cough, sore throat, or shortness of breath, Medical Records Staff H stated, That's what I was told to do. When queried about the process for screening staff who were also in the building the previous day, Medical Record Staff H did not offer a response. On [DATE] at approximately 9:35 AM, the Administrator was interviewed regarding the screening process. The Administrator reported that all screening questions should be asked for every staff member or visitor that enters the building. R#'s 707 and 708 On [DATE] at approximately 9:30 AM, an observation of the second floor 2 [MEDICAL CONDITION] was conducted. During the

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 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 1) observation, it was observed R707 and R708 shared a room. A sign outside of the door indicated the room was on droplet isolation precautions, requiring the use of a gown, gloves, face mask, and facial shield. At approximately 9:40 AM, the DON was queried about the second floor and they indicated all residents on [MEDICAL CONDITION] were on droplet isolation precautions and that one of the residents (R707) had tested positive for COVID-19. When queried about the other resident in the room (R708) the DON explained they were not positive, but because they had been exposed to their roommate prior to testing positive, they were treated as being positive as well, so the two continued to room together. On [DATE] A review of R707's clinical record was conducted and revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. A social service progress note dated [DATE] in R707's record read, .family has put discharge on hold since resident has tested positive for COVID 19. Review of R707's physicians orders indicated that droplet isolation was ordered on [DATE]. A review of R708's clinical record was conducted and revealed a re-admission date of [DATE] with [DIAGNOSES REDACTED]. Continued review of R708's clinical record indicated they received COVID-19 swabs on [DATE] and [DATE] and both tests had been negative. A review of R708's physician's orders was conducted and revealed two active orders dated [DATE] and [DATE] that indicated R708 was placed on droplet precautions. It was noted R708 had two negative COVID-19 swabs, had been placed on droplet precautions, and remained roommates with R707, who had tested positive for [MEDICAL CONDITION]. On [DATE] at approximately 9:55 AM, Certified Nursing Assistant (CNA) K was observed working on the 2 East unit. CNA K was wearing a blue plastic gown, goggles that they verbalized were too big and falling off their face, and an N95 respirator mask with a surgical mask underneath the N95. CNA K reported they were instructed to stay gowned up and when they go on break, they remove the gown and reapply the same gown when going back to work. CNA K reported they did not know of any residents in the facility who were positive for COVID-19. R#'s 701, 702, 703, and 715 On [DATE] at approximately 10:05 AM, a tour of the first floor 1 East unit was conducted. During the tour, R#'s 701, 702 and 703 were observed in their beds, sharing the same room. A sign was observed on the door that indicated the room was a droplet isolation room. On [DATE] a review of R701's clinical record was conducted and revealed an admission date of [DATE] and a re-admission date of [DATE] with [DIAGNOSES REDACTED]. A nursing note dated [DATE] read, .Notified .NP (Nurse Practitioner) regarding resident running 101 degree fever, resident complains of dry cough .Orders received for chest x-ray .influenza (flu) test, and covid-19 swab. It was noted there were no nursing notes prior to [DATE] that addressed R701's fever beginning on [DATE], or any increased monitoring of vital signs when the COVID-19 swab had been ordered. Continued review of R701's record revealed a consult note from Infectious Disease NP 'M' dated [DATE] that read, .Following for Acute [MEDICAL CONDITION] syndrome likely due to COVID-19 . A review of R701's physician's orders was conducted and an order dated [DATE] read, Droplet precautions-for suspected Covid-19. Please isolate patient to private room to prevent further spread . A review of R701's laboratory result for COVID-19 dated [DATE] indicated they had tested positive for [MEDICAL CONDITION]. On [DATE] a review of R702's clinical record was conducted and revealed an admission date of [DATE] and re-admission date of [DATE] with [DIAGNOSES REDACTED]. A review of R702's physician's orders did not indicate R702 had orders for droplet isolation precautions. On [DATE] a review of R703's clinical record was conducted and revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Continued review of R703's record did not include an order that indicated R703 was on droplet isolation precautions, and a
Nurse Practitioner's note dated [DATE] read, .No evidence of COVID-19 infection at this time, patient doesn't exhibit any symptoms of fever/cough/sob/malaise or fatigue . R#715 On [DATE] a review of R715's clinical record was conducted and revealed a re- admission into the facility on [DATE] that included: COVID-19, [MEDICAL CONDITION], shortness of breath, diabetes, and end stage [MEDICAL CONDITION] requiring [MEDICAL TREATMENT]. It was noted R715 readmitted to a two-bed
room they did not share with a roommate. Further review of R715's record included a review of their physician's orders, it was noted the first order in the record to place R715 on droplet precautions was dated [DATE], six days after their re-admission from the hospital with a COVID-19 diagnosis. On [DATE] at approximately 3:30 PM, an interview was conducted with the Facility's Administrator and Director of Nursing. They were queried why R701, 702, and 703 remained roommates when R701 tested positive for COVID-19, but neither 702 or 703 had been tested or exhibited any signs and symptoms. They indicated that because R702 and R703 had been exposed to R701 they had been presumed positive. When further queried why R701 (COVID-19 [DIAGNOSES REDACTED]. At that time, they were also asked that if a resident was placed in droplet isolation precautions, should there be a physician's order for the isolation, and it was indicated there should be an order. R#'s 709, R710, 724, and R715 On [DATE] at approximately 10:05 AM, R709 and R710 were observed sharing a room on the 1 East Unit. There was signage on their door that alerted to the residents being placed on droplet precautions. An isolation caddy was located on the door of the residents' room and did not contain any gowns. CNA N who was wearing a yellow isolation gown in the hallway was interviewed and reported R710 tested positive for COVID-19, but their roommate (R709) did not. CNA N reported they wore the same gown for all residents on the unit, including R710 and R709 because everyone was in droplet precautions. A review of R710's clinical record on [DATE] revealed the following: R710 was admitted into the facility on [DATE] and readmitted on [DATE]. R710 resided in the same room since their admission in 2014 on the 1 East Unit. R710 had [DIAGNOSES REDACTED]. A review of progress notes revealed R710 had a fever and congestion on [DATE] and was assessed by the NP. An Infectious Disease Progress Note dated [DATE] documented, .Acute [MEDICAL CONDITION] Syndrome likely due to COVID-19 . A progress note written on [DATE] documented R710 was placed on droplet precautions related to COVID-19. Physicians
Orders for R710 revealed the following: [DATE] Check temperature every shift [DATE] Droplet precautions related to fever [DATE] COVID-19 nasal swab [DATE] Place peripheral IV (intravenous) for hydration [DATE] Droplet precautions [DATE], a new order for oxygen to maintain SPO2 (oxygen saturation) of 92% or greater. A review of R709's clinical record was conducted and revealed R709 was admitted into the facility on [DATE] and readmitted on [DATE]. A progress note dated [DATE] by the Physician Assistant (PA) documented R709 had congestion. On [DATE], R709 was evaluated by the Infectious Disease physician who documented, .likely COVID-19 . R709 had a negative chest X-ray and a negative influenza test on [DATE]. Results of R709's COVID-19 test were received on [DATE] and was negative. It was noted R709 and R710 remained roommates after R710 had tested positive for the COVID-19 virus. A review of the Midnight Census Reports from [DATE] and [DATE] revealed a third resident (R724) resided in the same room as R710 and R709 until [DATE] when they were discharged to the hospital. On [DATE], R724 was tested for COVID-19 and positive results were received on [DATE]. R724 was transferred to the hospital on [DATE], after a change in condition and expired in the hospital. The DON was interviewed via the telephone on [DATE] at 11:15 AM. When queried about why R709 and R710 resided in the same room, when R710 tested positive for COVID-19 and R709 tested negative, the DON reported it was due to bed availability and, (R709) tested negative before, but could still become positive. On [DATE], a review of the Midnight Census Report For [DATE]-[DATE] was conducted, and it was discovered R710 (positive COVID-19 [DATE]) could have been placed in the same room as R715 (also positive COVID-19), as a bed was available in that room. R#714 On [DATE] at approximately 10:45 AM, a sign outside R714's room indicated the room was a droplet isolation room. The sign indicated staff entering the room should be wearing a gown, gloves, face mask, and eye protection. R714 could be observed from the hallway and was in their bed. At that time, Activity Staff 'B' was observed at R714's bedside providing a one-on-one activity. Activity Staff 'B' was observed to be wearing a gown, face mask, and eye protection. Activity Staff 'B' was not observed to be wearing gloves in the droplet isolation room. On [DATE] at 11:05 AM, Activity Staff 'B' exited the room and an interview was conducted. Activity Staff 'B' was asked what type of PPE was required for a droplet isolation room, and Activity Staff 'B' reported they needed a gown, mask, and eye protection. When queried about the use of gloves, Activity Staff 'B' stated, If I am coming in contact with residents, I put on gloves. A review of R714's clinical record was conducted and revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. A review of R714's physician's orders was conducted and revealed an order dated [DATE] that indicated R714 was placed on droplet precautions related to possible exposure to COVID-19. On [DATE] at 11:45 AM, an interview with the facility's DON was conducted regarding appropriate PPE for droplet isolation rooms. The DON indicated that staff entering droplet isolation rooms should wear a gown, gloves, face mask, and eye protection. At that time, the DON was made aware of the observation of Activity Staff 'B' not wearing gloves in R714's droplet isolation room. R#'s 711, 712, and 713 On [DATE] a review of the second-floor census report was conducted and indicated R711, 712, and 713 shared a three-bed room on the second floor. On [DATE] a review of R711's clinical record was conducted and revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. A review of R711's physician's orders was conducted and revealed an order dated [DATE] for a COVID-19 nasal swab. It was
noted there was no increased monitoring of vital signs ordered upon the suspicion of COVID-19, and the first order for droplet isolation precautions was placed on [DATE], five days after the COVID-19 swab was ordered. On [DATE] a review of R712's clinical record was conducted and revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. A review of Infectious Disease NP 'M's note dated [DATE] was reviewed and read, .No evidence of COVID-19 infection at this time . On [DATE] a review of R713's clinical record was conducted and revealed a re-admission date of [DATE] with [DIAGNOSES

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 2) REDACTED]. A review Infectious Disease NP 'M's note dated [DATE] was conducted and did not mention any concern for COVID-19. A review of a facility provided Census report dated [DATE] was conducted and indicated that [MEDICAL CONDITION] had two empty rooms available on [DATE], but R712 and R713 both remained in the same room as R711, who was suspected as having the COVID-19 virus. R#'s 716, R717, and R725 On [DATE], R716, R717 and R725's clinical records were reviewed. According to a list of residents who were confirmed positive for COVID-19, pending tests, or transferred to the hospital provided by the DON, R717 had a test ordered, but it was not yet obtained and R716 tested positive for COVID-19 and was in the hospital. R725 was not included on the list. R716's clinical record was reviewed and revealed R716 was readmitted into the facility on [DATE] with [DIAGNOSES REDACTED]. Physician Orders for R716 revealed the following: [DATE] Check temperature every four hours [DATE] Droplet precautions related to fever [DATE] Please complete respiratory assessment and document in a nurse's note. Assess for cough, SOB, rhinitis, lung sounds every 4 hours. [DATE] Oxygen at 2L per minute for 24 hours per day as needed, maintain SPO2 greater than 90% A review of R716's progress notes revealed the following: On [DATE] a Nurse's Note documented, .Denies cough, sore throat, SOB. Covid screen pending. On [DATE] a Nurse's Note documented, .Resident cxr (chest x-ray) positive for slight right upper lobe pna (pneumonia) . On [DATE] a Nurse's Note documented, Resident currently in bed eyes closed. earlier in shift PT (patient) reported body aches and headache .slight cough, no resp. (respiratory) distress noted .B/P (blood pressure) ,[DATE] temp 101.1 HR (heart rate) 22 resp. (respiratory rate) 19 pain 3 . On [DATE], a Nurse's Note documented, Resident is febrile with temperature of 101.6 and show signs of respiratory distress. Vitals taken BP ,[DATE], P 98, RR 19, SPO2 81%. RT (Respiratory Therapist) assessed resident. P.A on site and assessed patient. New order given for 2L (Liters) O2 to maintain saturation above 90% and new ABX (antibiotics) ordered. Resident saturation is now 92%. Will continue to monitor resident . On [DATE], an SOC-Infection note documented, .Resident positive for COVID 19- nasal swab obtained on [DATE] and resulted <sic> [DATE]. Remains febrile at this time. Denies cough or sore throat. C/o (complains of) headache. CXR completed and positive for PNA- remains on ABX at this time .Precaution type: Droplet . On [DATE], an Infectious Disease progress note documented, .Following for [MEDICAL CONDITION] Pneumonia due to COVID-19 XXX,[DATE]: COVID-19 positive XXX,[DATE]: Slight Right Upper lobe pneumonia .1. Acute [MEDICAL CONDITION] Pneumonia due to COVID-19 . On [DATE] at 5:10 PM, a PA progress note documented, .Seen for . tachypnea (increased respiratory rate), BP, [MEDICAL CONDITION] .and for multiple medical conditions requiring monitoring to prevent decline .RR (respiratory rate) 30, O2 83% on 6L+ SOB .Pulmonary: few scattered rhonchi with exp (expiratory) wheezes .[MEDICAL CONDITION] with tachypnea. Will transfer the patient to the hospital for further eval and treatment . R716 resided in the same room with R717 and R725 until [DATE] when they (R716) were transferred to the hospital despite a pending COVID-19 test performed on [DATE] and a confirmed positive result on [DATE]. A review of R725's clinical record revealed R725 was admitted into the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. Physician Orders for R725 documented the following orders: [DATE]-[DATE] Check temperatures every four hours [DATE]-[DATE] Droplet Precautions [DATE]-[DATE] Please complete respiratory assessment and document in a nurse's note. Assess for cough, SOB, rhinitis, lung sounds every 4 hours. [DATE] Please consult ID (Infectious Disease) for recent COVID-19 infection and treatment with continued fevers. [DATE]-[DATE] [MEDICATION NAME] .for COVID-19 positive . A review of R725's MAR (Medication Administration Record) and TAR (Treatment Administration Record) for [DATE] revealed R725 was on droplet precautions until [DATE] when they were transferred to the hospital. The MAR indicated [REDACTED]. The MAR indicated [REDACTED]= 100.8, [DATE] at 1:00 PM = 100.0 and 5:00 PM = 100.1, [DATE] at 5:00 AM = 101.1, [DATE] at 9:00 AM and 5:00 PM = 100.1 and 100.2 at 9:00 PM = 100.2, and [DATE] at 1:00 AM = 100.0. Respiratory Assessments were documented as completed on the MAR indicated [REDACTED]. R725's progress notes were reviewed for the physician ordered respiratory assessments beginning [DATE] (the order was to document the assessments in a nurses note every four hours) and revealed that on [DATE] at 11:47 PM, a blank respiratory note was entered, and two blank respiratory notes were entered on [DATE] at 12:55 PM and 4:40 PM. The next progress in the record was written on [DATE] at 6:55 AM, and documented, Res (resident) temp (temperature) elevated @ 101.1 . It was noted R725's clinical record did not include any progress notes or assessments from [DATE]-[DATE]. On [DATE], two days after the last progress note, a dietary note documented R725 had refused two meals which was rare for that resident. The next progress note was entered on [DATE] and documented, 2pm social worker checking residents when resident c/o DOB <sic>, writer checked patient stated, 'I can't breath, <sic> SPO2 is 88%-90%. 2L is given, still SpO2 is ,[DATE]%. Called NP .ordered to send to hospital . A nurse's note dated [DATE] documented R725 returned from the hospital on 5L of oxygen. Hospital records for R725 were reviewed and revealed the following: A Discharge Summary for R725's hospital stay from [DATE] through [DATE] documented the Discharge [DIAGNOSES REDACTED]. Hospital Course .lives at an ECF (extended care facility) with COVID-19 positive roommates presents to the emergency department with [MEDICAL CONDITION] in the mid 80's prior to arrival .Patient has a cough. No fever. Patient has been breathing at 30 times a minute but this improved with increased oxygen .Initial triage temperature was 100 Fahrenheit . .Per discussion with patient's nurse at (facility name redacted) patient was notably short of breath with O2 saturation ,[DATE] % on 6L (of oxygen) .Pt does not wear oxygen at home per facility .Per discussion, patient has 2 roommates at her facility with recent exposure to COVID-19. She denied any complaints besides shortness of breath .Given [MEDICAL CONDITION] markers despite negative COVID testing patient was treated with current COVID protocol . A COVID-19 test was completed in the hospital on [DATE] and results were negative. An Infectious Disease progress note dated [DATE] documented, COVID-19 [MEDICAL CONDITION] markers are consistent. This coupled with high O2 needs with abnormal CT (computed tomography) of chest, and apparent known exposure highly suspect COVID infection with a false negative test. Maintain COVID isolation . Continued review of the record revealed R725 was readmitted into a room with R717 on [DATE] and both residents were moved to a different room which they also shared, and where they remained until [DATE] when R717 expired and later tested positive for COVID-19. R717's clinical record was reviewed and revealed the following: R717 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. R717 resided in the same room from [DATE] until [DATE], at which time she was moved to the same room with R725. Physician Orders were reviewed and included the following orders: [DATE] Check temperature every four hours [DATE] and [DATE] Droplet precautions Progress notes for R717 documented the following: On [DATE], a physician progress notes [REDACTED]. Upon examination in her room, she admits of having a poor appetite all these days. she does not exhibit any other symptoms for covid- 19 .will monitor for any s/s (signs/symptoms) of covid-19 . There were no other progress notes that documented clinical monitoring of R717. The next progress note in the record was written on [DATE], eight days after the physician's note, and documented, Code Blue called over head. CPR (cardiopulmonary resuscitation) in progress. EMS arrived. A second progress note dated [DATE] documented, Resident seen at around 8:40 AM. Resident was alert and responded to writer. Med administered. Resident found unresponsive at 12:42 PM. EMS called at 12:42 PM. CPR started at 12:42. EMS arrived at 12:56PM. iv placed on left leg .CPR stopped at 1:33 PM. A progress note written on [DATE] documented, Resident COVID results obtained- positive. Health department notified of results and death. Skilled Daily - Cardiopulmonary Assessment forms were completed on [DATE], [DATE] [DATE], [DATE], and [DATE], However; all the above assessments were completed (locked and signed) on [DATE]. The vital signs on all the above assessments were dated [DATE]. An O2 Sats (saturation) Summary for R717 documented on [DATE] at 5:43 PM, O2 Sats were 89 percent on room air. The summary documented all future O2 Sats were assessed with [REDACTED]. It was noted documentation did not address R717's decreased oxygen saturations on [DATE], and also noted there was not a physician's order for oxygen. On [DATE] at 11:22 AM, an interview was conducted with the DON via the telephone. The Midnight Census Reports from [DATE] through [DATE] were reviewed and showed R717 in a different room than where she was on [DATE]. The DON confirmed that R717 resided in the same room as R725 on [DATE] and was moved to a different room with R725 until their (R717) death on [DATE] and that R717, R725, and R716 resided in the same room until [DATE] when R716 was transferred to the hospital. The DON explained the facility conducted a lot of room changes and R717's did not get changed in the electronic system. When queried about why R725 was placed into a room with R717 after returning from the hospital, the DON reported COVID-19 was suspected but not confirmed. The DON reported that the hospital was adamant that R725 was positive for COVID-19 despite a negative test. When queried about the physician ordered respiratory assessments for R725 that were ordered to be documented every four hours in the nurses notes, the DON reported they were not completed as ordered. During the interview, the DON provided a Respiratory Therapy Evaluation dated