STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235514	A. BUILDING _____ B. WING _____	04/24/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
IMPERIAL, A VILLA CENTER	26505 POWERS AVE DEARBORN HEIGHTS, MI 48125

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** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation pertains to Intake MI 389 Based on observation, interview and record review the facility failed to operationalize, implement, and maintain components of a comprehensive Infection Control program, including Covid-19 infection, comprised of documentation, collection and analysis of surveillance data to identify and track trends and patterns of Residents and employee infection as well as identify infection and implement Transmission Based Isolation Precautions in a timely manner for 10 (#'s 701, 702, 703, 704, 705, 706, 707, 708, 710, 711) Resident's reviewed for infection control and 172 additional facility Residents resulting in delayed identification of Covid-19 infection, spread of the infection, lack of appropriate Personal Protective Equipment (PPE) use, spread and transmission of Covid-19 within the facility and the potential for additional infections. Findings include: An interview was conducted with the facility Administrator on [DATE] at 9:15 AM. When queried regarding Covid-19 infection within the facility, the Administrator stated, We have 70 positive Covid (Residents). When asked if all 70 Residents had confirmed Covid-19, the Administrator indicated they thought all Residents had been tested . When queried regarding confirmed and/or suspected Resident placement within the facility, the Administrator stated, The Covid Unit is the Memory Unit B. No one is a new positive there. The C unit as well. The Administrator then stated, Prior to this weekend, A unit was always clean (no confirmed/suspected Covid-19). When asked, the Administrator revealed, We just did more tests on D unit and will move them (positive results) to C unit. When queried regarding new admissions to the facility, the Administrator disclosed the facility was accepting admissions and new admissions are going to the B or C unit. With further inquiry, the Administrator stated, People from the hospital were placed on D unit. We tested them yesterday and some came back positive. When asked if D unit was an isolation unit, the Administrator replied, It is an in-between unit as of a couple days ago. When queried regarding facility policy/procedure pertaining to Covid-19 and Resident room placements, the Administrator replied, Every morning we come in and make determinations. Residents are moved after lunch. With further inquiry pertaining to facility policy/procedure for Covid-19, the Administrator stated, We started on [DATE]th. Our first true positive was on [DATE]th. When asked about PPE and precautions in place within the facility, the Administrator revealed the facility had an ample supply of PPE and all staff is wearing PPE all the time. When what asked PPE staff were wearing, the Administrator replied, Gown, mask, and face shield in Resident care areas. The Administrator further revealed the B and C units of the facility were closed off by a fire door and a zippered tarp. When queried regarding staff illnesses, the Administrator indicated staffing had improved and proceeded to state, The Assistant Director has Covid. Only have four staff who actually tested positive. Facility Infection Control Program policies/procedures and data from [DATE] to [DATE], including Covid-19 infection data, were requested at this time. Observation of the B and C wing entrance area of the facility occurred at 10:00 AM on [DATE]. Double doors leading into the unit were closed and a table with hair covers, shoe covers, goggles, gloves, and individually packaged raincoats were present near the door. No facility staff were present in the area. A sign on the door door indicated, Contact and Droplet Precautions were required. Registered Dietician B approached the table at 10:05 AM. Registered Dietician B was wearing a colored face mask. When queried regarding PPE required to enter the unit, Registered Dietician B revealed the raincoats were being used as gowns. After donning PPE, including the raincoat which snapped in the front, and opening the doors, a tarp with a center zipper was noted. Unit C was entered through the tarp with Registered Dietician B. Registered Dietician B did not have eye protection in place upon entering the unit. When queried regarding their mask, Registered Dietician B revealed they brought their own mask from home. The Resident room doors in the C unit were observed to be open with multiple Residents sitting in the doorway of their rooms without masks. Upon entering the B unit of the facility, dedicated Covid-19 isolation unit, on [DATE] at 10:10 AM, five Residents were observed sitting in wheelchairs near the nursing station. Three of the Residents were sitting directly next to each other, without masks or any other PPE, and were touching each others arms. One Resident was coughing. An interview was attempted to be completed with the Residents at this time. All the Residents were unable to state their name when asked and/or provide meaningful answers to questions. A Resident was observed sitting in a standard chair in the hallway of the facility near room [ROOM NUMBER] and other Residents were walking in the halls without staff assistance. Resident room doors were noted to be open. An interview was conducted with Nurse E on [DATE] at 10:15 AM. When queried regarding Residents with Covid-19 infection on the B unit of the facility, Nurse E revealed they were aware at least seven Residents had tested positive and stated, My understanding is they were all suspected. When asked who the Residents were sitting in wheelchairs near the nurses station, Nurse E revealed they were not familiar with the Residents because they do not frequently work with them. On [DATE] at 10:20 AM, Nursing Assistant I was observed exiting a Resident's room on the B Unit (Covid-19 Isolation Unit) of the facility. Nursing Assistant I was wearing a raincoat (PPE gown) with the front of the gown open and their scrubs exposed. Nursing Assistant I was wearing an N95 mask but the mask was incorrectly positioned on their face and they did not have eye protection on. Nursing Assistant I was observed walking down the hall and entering another Resident room. On [DATE] at 10:30 AM, Nursing Assistant C was observed in the hall of the B Unit (Covid-19 Isolation Unit) with a Resident who had previously been ambulating unassisted. Nursing Assistant C did not have eye protection PPE. On [DATE] at 10:35 AM, Social Worker D was observed in the B unit (Covid -19 Isolation Unit) of the facility. Social Worker D was walking in the hall and then entered a Resident's room without eye protection in place. An interview was completed with Nursing Assistant C and Social Worker D on [DATE] at 10:40 AM. When queried regarding facility policy/procedure pertaining to PPE and eye protection including goggles or a face shield, both Nursing Assistant C and Social Worker D revealed they were supposed to wear eye protection. Nursing Assistant C stated, Oh I forgot and Social Worker D stated, I'm so sorry. I forgot it. An interview was conducted with Nurse F on [DATE] at 10:45 AM in the B Unit (Covid-19 Isolation Unit). When asked who the Residents were sitting at the nurses station without masks, Nurse F revealed they usually work on a different unit and had worked on Unit B in a long time and were not aware of the Resident's names. Nurse F was noted to have long, painted fingernails. Nurse F was observed removing medications from the medication cart without wearing gloves and then entering a Resident room ,with confirmed Covid-19, to administer medications. Nurse F did not perform hand hygiene when they entered the Resident's room and administered the medications without wearing gloves. Nurse F then exited the room without performing hand hygiene, returned to the medication cart, and began to prepare medications for another Residents. When queried regarding facility policy/procedure pertaining to hand hygiene and glove use during medication administration to Residents with confirmed Covid-19, Nurse F did not provide a response. On [DATE] at 10:55 AM, Nursing Assistant G was observed in the hall of the B Unit (Covid-19 Isolation Unit). Nursing Assistant G was wearing a procedural mask (does not provide protection against airborne particles) and not an N95 mask (N95 respirator masks are used to prevent the the spread of infectious airborne particles). When queried what Residents on the unit had Covid-19, Nursing Assistant G replied, All positive. When queried regarding their mask, Nursing Assistant C stated, I left the better one at home. With further inquiry, Nursing Assistant G revealed all staff took their masks home after working. When asked about the protection provided by a procedural mask, Nursing Assistant G indicated it was better than nothing. No further explanation 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 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) provided. On [DATE] at 11:00 AM, Nursing Assistant H was observed pushing a Resident out of their room, (in the B -Covid-19 Isolation Unit) into the hallway and positioning the Resident's wheelchair near the nurses station. Nursing Assistant H was not wearing eye protection PPE. Multiple Residents, without masks, remained seated in wheelchairs near the nurses station. The Resident was not wearing a mask that was not an N95 mask. An interview was conducted with Nursing Assistant H at this time. When queried regarding the Resident they took out of their room and positioned near the nurses station, Nursing Assistant H stated, I get them up when they about to get out of bed. When asked if the Resident had Covid-19, Nursing Assistant H replied, Everyone does. Nursing Assistant H was then observed touching the front of the outside of their mask without wearing gloves and touching a Resident's hand who was ambulating in the hallway of the facility without performing hand hygiene. Nursing Assistant H was asked about touching their mask without gloves and/or performing hand hygiene and indicated they had not realized they had touched their face. When asked about their mask, Nursing Assistant H stated, My friend gave it to me. When queried if they were provided N95 masks by the facility, Nursing Assistant H replied, They gave me another one. On [DATE] at 11:05 AM, Nursing Assistant I was observed walking in the fall of the facility with the front of their raincoat (PPE) open, mask improperly positioned, and no eye protection in place in the B Unit (Covid-19 Isolation Unit). An interview was completed at this time. When queried regarding their raincoat (PPE) being open in the front, Nursing Assistant I stated, It doesn't fit. When asked it other PPE was available, Nursing Assistant I indicated they were not aware of any other gowns being available for staff use. When queried regarding the N95 being incorrectly positioned on their face and if they had been trained regarding proper mask placement and wear, Nursing Assistant I replied, Not really. When queried if they were supposed to wear eye protection per facility policy/procedure, Nursing Assistant I indicated they were and stated, It got dirty and I didn't get a new one today. A tour of the C Unit, Covid-19 Isolation Unit of the facility was completed on [DATE] at 11:15 AM. During the tour, Resident room doors were noted to be open to the hall. Several rooms had Droplet isolation signs hanging on the doors. An interview was conducted with Nursing Assistant J on [DATE] at 11:20 AM. When queried regarding Covid-19 Residents within the facility, Nursing Assistant J stated, Just started separate Covid from Non-Covid Residents two weeks ago. We lost six Residents in two days and we just had a man die Sunday. With further inquiry, Nursing Assistant J revealed They (Residents) are sick before (facility nursing staff/administration) do anything. When asked what they meant, Nursing Assistant J revealed Residents were not put on isolation precautions when they first got sick and then it spreads to everybody else. On [DATE] at 11:30 AM, Nursing Assistant K was observed in the C (Covid-19 Isolation) Unit of the facility. Nursing Assistant K had their face shield positioned upside down on their head so the shield was not covering their face and their N95 mask was upside down and incorrectly positioned with a cloth face mask under the N95 mask. An interview was completed with Nursing Assistant K at this time. When asked why they had a cloth mask under their N95 mask, Nursing Assistant K indicated they were unaware it made a difference if they wore the N95 over the cloth mask. When asked about the N95 mask being upside down and if they had received training pertaining to use of the mask, Nursing Assistant K revealed they had not really been taught how to put it on. When asked about their face shield being upside down, Nursing Assistant K indicated they had turned the shield but did not provide further explanation. An interview was completed with Licensed Practical Nurse (LPN) L on [DATE] at 11:39 AM. LPN L was not wearing eye protection and their N95 mask was noted to only have one strap. When asked why some Resident rooms had droplet precaution signs outside of the doors and some rooms did not, LPN L replied, We don't have enough of the Precaution things to let everyone know and further revealed they had put the signs on the Resident rooms before to signal the Residents in those rooms had confirmed Covid-19 but they had not worked in a while and were unsure if the signs were still accurate in regards to positive Residents. When queried regarding their N95 mask, LPN L stated, It only has one strap. When asked if they were supposed to wear eye protection per facility policy/procedure, LPN L indicated they were and stated, I have my glasses (personal eye glasses) on. An interview was conducted with the Administrator on [DATE] at 12:13 PM. When queried regarding facility policy/procedure pertaining to N95 mask storage and disposal, the Administrator replied, The duck masks (style of N95 mask) get tossed and the hard masks are kept. When queried if staff take the hard style N95 masks home, the Administrator replied, They can take them home. When asked if staff are supposed to appropriately wear N95 masks and eye protection, either goggles or a face shield in the B and C Covid-19 Isolation Units of the facility, the Administrator replied, Yes. When queried regarding observations of facility staff wearing PPE inappropriately and/or not wearing PPE, the Administrator stated, They (staff) know they are supposed to wear it (PPE). We have it available and it they need something different, they just need to ask. When queried if Residents room doors are supposed to be closed or open, the Administrator stated, It's really whatever the Resident wants, especially on B wing. The Administrator then revealed the Covid-19 infection started on B unit. With further inquiry, the Administrator stated, (Resident #703) was patient zero. By the time we found it, other (Residents) had it. The Administrator then indicated Resident #703 may not have been the first Resident and stated, Maybe it was (Resident #701) and then (Resident #705). (Resident #705's) was the first one who's swab (Covid Test) came back first. We started by making a part of B wing contained off (Dementia Unit) with a tarp but they (Residents) tore it down. The Administrator then provided a paper document of Residents with Covid-19 infection. When asked, the Administrator indicated the document was what the facility was utilizing to keep track of Covid-19. The document contained the following columns: -Swabbed Positive in House- 66 Residents -admitted Positive- 22 Residents -Swabbed Negative in House - 38 Residents -Negative in Hospital - Eight Residents -Positive in Hospital -14 Residents -Pending in Hospital- One Resident -Pending Swab in House - 11 Residents -Expired in House - No Swab- 14 Residents -treated for [REDACTED]. The colors were: yellow= expired, pink = hospitalized , blue = treated as suspected to have Covid-19 not tested , and green = discharged . The colors were scattered in each column of the document. An interview was conducted with the Director of Nursing (DON) (also the Infection Control Nurse) on [DATE] at 12:43 PM. When asked who the first Resident with Covid-19 was in the facility, the DON stated, It was room [ROOM NUMBER], (Resident #701). When asked, the DON revealed Resident #701's first symptom was an elevated temperature. When queried what unit the Resident was in at that time, the DON replied, That is C Unit. When queried if Resident #701 had a room mate at that time, the DON replied, (Resident #707) was room mate. We swabbed (Resident #707) and it was negative then they went out (to hospital) a couple weeks later for respiratory distress. With further inquiry regarding the spread of Covid-19 within the facility, the DON stated, The next Resident was on the B Unit, (Resident #705). (Resident #705) is the biggest wanderer in the facility. When asked about their first symptom, the DON stated, They spiked a temp. The DON was asked if Resident #705 had a room mate when they became symptomatic with Covid-19 and replied, (Resident #711) was their room mate. (Resident #711) was positive and they passed. When queried regarding actions taken by the facility to prevent transmission and further spread of Covid-19, the DON stated, We noticed a lot of other Residents on that unit (B Unit) were sick. The whole unit is droplet precautions now. When queried regarding the first positive Resident being on the C Unit of the facility, the DON indicated that was correct and stated, Then on B unit there were enough people that had suspected signs and symptoms so we mad that our Covid Unit. The DON further revealed, We swabbed ten bed bound people on the B Unit hoping they would be negative. We got three negatives. We moved two of those Residents to the same room on the D Unit and one to a room on the C Unit. With further inquiry regarding what occurred next, the DON stated, We went a while where there was a whole bunch of bad[***]happening on B Unit. All of B (Unit) was struggling. We ran IV's (Intravenous therapy- fluid replacement through a vein) on a lot of (Residents). When queried regarding infection control within the facility including how the facility was monitoring for Covid-19 infection, the DON indicated the facility was using signs and symptoms of Covid-19 as indicators. The DON stated, We run a Vital Sign report and follow up with anyone who had a temp. Some Docs choose to treat based on signs and symptoms, D-Dimer (blood test typically used to identify blood clots and may also be elevated in a variety of other clinical conditions) and ferritin level (blood test to determine the amount of iron in blood). When asked about admissions to the facility, the DON stated, At one point we only took (Covid-19) positive admits but then we started having temps show up on C and D (Units). We aren ' t taking any (admits) for a couple days now. With further inquiry regarding infection control including surveillance and tracking, the DON provided a binder which included daily printouts of Resident temperatures and a map of the facility for each day with different colored highlighting on Resident room numbers. When asked what the colors signified, the DON revealed they were not sure as the Administrator had completed the colors on the map. When asked why the Administrator was completing the infection mapping when they were not a Registered Nurse, the DON indicated the Administrator was helping out. With further inquiry regarding the daily vital sign monitoring including where the report data was pulled from in the EMR, the DON revealed the vital sign report data came from documentation in the EMR but were not sure where. When queried how they would know if a Resident had abnormal vital signs if the information was documented in a different section of the EMR than where the report data was generated and if the report included information if a Resident's vital signs had not been documented, the DON revealed the report would not include data not documented in other areas of Resident medical

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) records and did not indicate if vital signs were not completed. When asked if an audit was being conducted to ensure vital signs were being documented, the DON replied, No and revealed there not a system in place to verify vital signs had been obtained and/or documented. The Covid-19 Resident document provided by the Administrator was reviewed with the DON at this time. When asked how many facility Residents had died related to Covid-19 infection, the DON revealed the document and revealed, 15 positive Covid-19 and four suspected of having Covid-19 but who had not been swabbed died in the facility and seven positive Covid-19 and three suspected had died in the hospital. When asked, the DON confirmed 29 facility Residents had passed related to Covid-19 infection. When queried regarding the number of current Residents with Covid-19 infection, the DON replied, 69. The DON was queried regarding the Administrator stating 70 Residents had Covid-19 and indicated they were unsure but there were 69 Residents. When asked how many Residents were suspected of Covid-19 infection related to signs and symptoms, the DON stated, None if going off of signs and symptoms. When asked about the provided list of Covid-19 Residents including a column labeled treated for [REDACTED]. that. With further inquiry regarding the list, the DON stated, The ones (Residents) on the top (31 Residents) had signs and symptoms and the ones (Residents) on the bottom (64 Residents) had elevated D-dimers. The DON then stated, Cooperate wanted us to draw labs on everybody. We started with the C Unit first. The DON was queried regarding when testing stated, and replied, Middle of last week, started having a lot of temps (in C Unit) then moved (Residents) to D (Unit) because we had a couple positives. When asked if staff were consistently assigned to specified units, the DON revealed they try but still have to move staff around the facility and between units. The DON then stated, We still have staff off from the B Unit. When queried regarding monitoring and data related to staff call ins, the DON indicated they did not collect and/or monitor that information. When queried regarding reporting and monitoring of staff call ins for employees contracted by the facility including therapy and laundry, the DON stated, Not monitoring therapy call ins. When queried how Infection Surveillance and Monitoring was completed without comprehensive monitoring of employee call-ins related to illnesses, the DON was unable to provide an explanation. Upon request to review facility infection control tracking and surveillance documentation including line listings for infections for January, February, and March of 2020, the DON revealed they recently assumed the Infection Control role and did not have that documentation. When asked about infection control tracking and surveillance data since they assumed the role, the DON revealed the no infection control surveillance and/or tracking for any infectious diseases other than Covid-19 had been completed. The DON further revealed that Nurse A was recently promoted to the Assistant Director of Nursing (ADON) role and had completed the Covid-19 Resident list provided by the Administrator. An interview was conducted with the Administrator on [DATE] at 2:00 PM. When queried regarding facility infection control data including surveillance and tracking data, the Administrator stated, The line listing was up to date for January. When asked to review the infection control data, the Administrator was unable to provide any surveillance documentation for the requested months of January, February, and [DATE]. When queried regarding the different colors on the maps included with the temperature monitoring reports, the Administrator indicated the different colors indicated different temperatures. On [DATE] at 3:40 PM, an interview was conducted with the DON and the ADON. When queried regarding the list of Covid-19 Residents provided by the facility Administrator, the ADON revealed they had created the document and stated, It was for me to use to keep track. It wasn't meant to go to you. When queried regarding comprehensive tracking and surveillance documentation for Covid-19 infection within the facility, the ADON indicated they were unsure what information needed to be monitored and documented. The ADON and DON were asked if they were familiar with the CDC Long-Term Care (LTC) Respiratory Surveillance Line List example and both revealed they were not. When queried regarding the lack of any documented Infection Control surveillance data for January to [DATE] and who was responsible to complete the surveillance in the facility, both the DON and ADON revealed Corporate staff had been completing the data collection after the previous Infection Control Nurse left employment at the facility in November or [DATE]. The DON then stated, (Cooperate Nurse M) was supposed to come in and do it in February. The ADON added, (The Administrator) was supposed to be working on it with (Cooperate Nurse M). When queried how they were able to quickly identify infections in the facility, including Covid-19 infection without surveillance data, the DON stated, (The Administrator) was tracking through temps (Resident temperatures). When asked how the Administrator was tracking and assessing the data when they are not a nurse and who was reviewing the data, the DON revealed the Administrator and Cooperate Nurse M were looking at the data. When queried how they were made aware of the data, as the acting Infection Control staff in the facility, the DON and ADON revealed the information was relayed to them by the Administrator. When asked about Covid-19 infections within the facility, the ADON indicated they started to become aware of Residents with symptoms on [DATE]rd and stated, I took the Covid symptoms and then I started assessing people. When asked how they became aware of symptoms, the ADON revealed they were told by facility staff. The ADON further elaborated, Housekeeping (staff) was coming to me with information about Residents and so were CNA's (Nursing Assistants). When queried regarding facility policy/procedure pertaining to notification and where the notification was documented, the ADON stated, A lot of it probably still needs to be documented. When asked how the facility was tracking infection control data including Resident symptoms if not documented, neither the ADON and DON were able to provide an explanation. The ADON then stated, Every Doctor has different dosages and protocols for Covid-19 infections. When queried if the facility protocol regarding the Covid-19 including signs/symptoms, isolation, and testing followed Centers for Disease Control (CDC) guidelines, the ADON revealed the facility followed a mixture between CDC guidelines and Physician orders. When asked when all facility staff began wearing masks in the facility, the ADON indicated mask use was implemented after the facility received the first confirmed positive on [DATE]. Resident #701 Record review revealed Resident #701 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was rarely/never understood and required extensive to total assistance to complete Activities of Daily Living (ADLs) with the exception of supervision assistance for eating. The medical record further revealed Resident #701 was a full code (wanted all medication treatment/interventions completed to save their life) and expired (died) in the facility on [DATE]. Review of Resident #701's medical record revealed the Resident began running a temperature on [DATE]. Review of temperature documentation on the Medication Administration Record [REDACTED]#701's Electronic Medical Record (EMR) revealed the following additional abnormal, elevated temperatures: -[DATE] at 3:12 PM: 103.0 F -[DATE] at 6:16 PM: 100.4 F -[DATE] at 12:32 AM: 101.0 F -[DATE] at 6:25 AM: 100.0 F -[DATE] at 8:28 AM: 100.0 F -[DATE] at 11:11 AM: 100.0 F -[DATE] at 6:20 PM: 100.7 F -[DATE] at 1:22 AM: 102.2 F -[DATE] at 11:16 AM: 100.4 F -[DATE] at 5:28 AM: 99.0 F -[DATE] at 1:52 AM: 100.9 F -[DATE] at 10:08 AM: 100.8 F Review of Resident #701's SPO2 (oxygen saturation-greater than 92% is considered normal) documentation in the EMR revealed the Resident's SP02 decreased from normal level ranges to 78% on [DATE] during the night shift per the MAR. Review of Resident #701's progress note documentation revealed the following notes: -[DATE]: Weight Change . Res triggering as a significant weight loss X 30 days; CBW (Current Body Weight) 181.6; Comparison Weight [DATE], 191.3 Lbs (pounds), -5.1% , -9.7 Lbs . -[DATE] at 3:52 AM: Health Status Note . Checked (Resident) vitals Temp was 102.7 At 12.10 am. called (Physician). Order (blood laboratory studies), Chest X-ray Stat. Given Tylenol to reduce fever, 98.9 at 1:25am. -[DATE] at 7:27 PM: Health Status Note . Lab results called in (to Physician). New order given for rapid flu testing. Specimen collected and picked up by lab. -[DATE] at 8:57 PM: Health Status Note . results from influenza swab negative for (influenza) A&B. (Physician)was notified of this and gave no new orders at this time . -[DATE] at 5:47 AM: Health Status Note . received Resident alert with confusion (temperature) at this time 99.2 axillary Tylenol given as prescribed . -[DATE] at 7:59 PM: Health Status Note . Resident RSV (Respiratory [MEDICAL CONDITION]) swab results negative with a consistent fever notified (Physician), on shift supervisor and DON (Director of Nursing). Lab order for a STAT COVID-19 Swab was entered, obtained and sent to lab. Awaiting results, oncoming nurse made aware, resident currently on droplet precautions. -[DATE] at 8:16 AM: Health Status Note . Resident received at 1900 (7:00 PM), Isolation precaution in place . Temp 102.0 and 100.0. PRN (as needed) Tylenol given as ordered . [DATE] at 12:02 PM: Social Service Note . notified guardian of room change . [DATE] at 5:19 AM: Health Status Note . Resident found BP (Blood Pressure) less, Pulse less and No O2 sat at 0440 (4:40 AM). Code blue called and CPR started. 911 called. EMS arrived and assessed the resident and declared them Dead at 0500 . From [DATE] to [DATE], no note documentation for Resident #701 was present in the EMR on [DATE], [DATE], [DATE] and [DATE]. Review of Resident #701's Health Care Provider Orders and MAR indicated [REDACTED]. Resident #701's laboratory testing results revealed the laboratory received a Covid-19 testing sample from the facility on [DATE] at 5:36 PM and the positive test result was reported to the facility on [DATE] at 1:02 PM. Resident #701 also had a care plan titled, The Resident requires Droplet Isolation r/t (related to) Covid-19 (Initiated: [DATE]). Review of Resident #701's room census further revealed the Resident had been in three different rooms in the facility from [DATE] to [DATE]. The Resident room placements were as follows: -[DATE]: Moved to Room ,[DATE] -[DATE]: Moved to Room ,[DATE] -[DATE]: Moved to Room ,[DATE] Resident #703 Record review revealed Resident #703 was originally admitted to the facility on [DATE] and

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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 -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 3) readmitted on [DATE] with [DIAGNOSES REDACTED]. Review of the MDS assessment dated [DATE] revealed the Resident was moderately cognitively impaired and required supervision to limited assista