STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075069	A. BUILDING _____ B. WING _____	08/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
REGALCARE AT GREENWICH	**1188 KING STREET GREENWICH, CT 06831**

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 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of the clinical record, facility documentation, facility policy, and interviews for 1 resident (Resident #1) reviewed for behaviors, the facility failed to notify the physician when the resident exhibited the ongoing behavior of leaving the exposed cohort and entering the negative cohort, and the ongoing behavior of not properly wearing a mask for source control when out of his/her room, potentially exposing the residents on the negative cohort to Covid 19 infection. The findings include: Resident #1 was admitted to the facility on [DATE], to A wing on the exposed cohort. [DIAGNOSES REDACTED]. Review of the care plan dated 8/5/20 identified Resident #1 was at risk for infection with interventions that included to follow facility protocol for Covid-19 screening and precautions. Observation on 8/12/20 at 9:10 AM identified Resident #1 in the wheelchair sitting in the hallway on A wing in the negative cohort with a blue surgical face mask underneath his/her chin. The observation identified that NA #1 attempted to redirect Resident #1 back to his/her room and to properly reapply the surgical mask over the resident nose and mouth, however, Resident #1 refused. Interview with NA #1 on 8/12/20 at 9:20 AM identified Resident #1 has been non-compliant with quarantine protocols since Thursday 8/6/20 last week, 6 days. NA #1 indicated Resident #1's behavior has escalated and the resident is very difficult to redirect back to the exposes cohort or his/her room. NA #1 indicated Resident #1 would usually have his/her surgical face mask underneath his/her chin and would start yelling, screaming and using profanity towards the staff when they attempt to redirect. NA #1 indicated the DNS, and other facility staff were aware of Resident #1's behavior of not properly wearing the mask and of yelling, screaming, and using profanity toward the staff. Observation on 8/12/20 at 9:35 AM identified Resident #1 propelled him/herself to the nurse's station on the negative cohort. NA #1 attempted to redirect Resident #1 back to the exposed cohort, but Resident #1 refused and started yelling. NA #1 was observed to walk away at that time. Observation at 9:40 AM identified Resident #1 propelled him/herself around the nurse's desk in front of room A-16 (negative cohort) where another resident was sitting in a wheelchair in front of room A-16. Resident #1, who was wearing a surgical mask was within 3 feet of the other resident. Nursing staff attempted to redirect Resident #1, however the resident started yelling and screaming. At 10:00 AM, LPN #1 encouraged and assisted Resident #1 back to the exposed cohort and into his/her room and remained with the resident. Subsequent to surveyor inquiry, the ADNS placed Resident #1 on 1:1 monitoring at 11:15 AM. Observation on 8/12/20 at 11:40 AM identified Resident #1 was again on A wing in the negative cohort in the hallway with the surgical mask underneath his/her chin and holding on to the railing. The resident was being monitored by 1:1 monitor and the Administrator was present. Resident #1 was approximately 3 feet away from another resident who was sitting in the hallway in front of room A-16. The Administrator explained and redirected Resident #1 to properly place the surgical mask over the mouth and nose, which the resident allowed. The Administrator redirected the resident back to the recreation room. Observation on 8/12/20 at 12:00 PM identified Resident #1 in the recreation room with the 1:1 monitor sitting at the table watching television at this time. Observation on 8/12/20 at 12:30 PM identified Resident #1 was again in the hallway on A wing in the negative cohort. The 1:1 monitor was present. When staff attempted to redirect Resident #1, he/she yelled leave me alone. At 12:45 PM, Resident #1 was redirected into the recreation room and lunch was provided. Interview and review of the clinical record with LPN #2 on 8/12/20 at 1:48 PM identified she was aware of Resident #1's non-compliant behaviors with morning care and throughout the shift the first week at the facility, although the resident would take his/her medications. LPN #2 indicated Resident #1 started being non-compliant with coming out of his/her room last week. LPN #2 identified Resident #1 would yell, scream, curse and become aggressive towards the staff when being redirected, and staff would walk away. LPN #2 indicated Resident #1's behavior has been increasing every day. LPN #2 indicated Resident #1's behavior was like this yesterday (8/11/20) in the morning, and staff encouraged the resident to take a shower and the behavior decreased a little bit. LPN #2 indicated around 3:00 PM, Resident #1 propelled his/her self to the negative cohort and began yelling, screaming and cursing when redirected. The DNS was aware of Resident #1's behavior yesterday (8/11/20) and non-compliance with remaining on the exposed cohort or his/her room. The DNS attempted to educate and redirect the resident at that time. LPN #2 indicated she was aware of Resident #1's behaviors. LPN #2 indicated she did not notify the physician or the conservator of the resident's behaviors. Interview with RN #1 on 8/12/20 at 2:00 PM identified he was aware of Resident #1's non-compliance with refusing care in the morning and throughout the shift. RN #1 indicated Resident #1 was difficult and hard to approach at the beginning, would not accept care and remained in his/her room. RN #1 indicated last week Resident #1 started coming out of his/her room, off the exposed cohort, and onto the negative cohort. RN #1 indicated he and the other staff would constantly educate and redirect the resident but the resident would refuse. RN #1 indicated Resident #1 would sometimes yell and scream at the staff. Interview and record review with the Administrator on 8/12/20 at 2:10 PM identified she was aware that Resident #1 refused to stay in his/her room since his/her admission, however, she was not aware of Resident #1's non-compliant behaviors until today. Interview and record review with the ADNS on 8/12/20 at 3:30 PM identified she was not aware of Resident #1's behaviors and non-compliant behavior with care, yelling, screaming and cursing at the staff. The ADNS indicated she notified the psychiatrist at today at 12:40 PM of Resident #1's behavior, and a new order for [MEDICATION NAME] 0.5 mg (antipsychotic medication) one time dose was obtained. Additionally, the ADNS indicated the psychiatrist would be in to assess Resident #1 today. Interview with NA #2 on 8/13/20 at 9:17 AM identified Resident #1 has been verbally abusive, yelling, screaming and using foul language towards the staff. NA #2 indicated Resident #1 constantly propels him/herself to the negative cohort at the nurse's station and sits there with the surgical mask underneath his/her chin. When staff attempt to redirect Resident #1, he/she would yell and curse at the staff. NA #2 indicated the DNS, ADNS and the supervisor are aware of Resident #1's behaviors. They will attempt to redirect Resident #1 and they can't because he/she would start yelling and screaming and they would walk away. Interview with NA #3 on 8/13/20 at 9:24 AM identified on Monday 8/10/20, Resident #1 was sitting on A wing in the negative cohort at the nurse's station in the morning. NA #3 identified the breakfast truck came to the wing and she explained to Resident #1 to follow her back to his/her room, and Resident #1 started yelling and screaming. RN #1 redirected and escorted the resident to his/her room to have breakfast. Interview with Housekeeper #1 on 8/13/20 at 10:08 AM identified this is the second time he has been assigned to A wing on the exposed cohort. Housekeeper #1 indicated he observed vomit and spit in Resident #1's room on the floor. Additionally, Housekeeper #1 indicated he observed spit on the floor where Resident #1 was sitting in the hallway on the exposed cohort and by the nurse's desk. Housekeeper #1 indicated he would clean and disinfect the areas. Housekeeper #1 indicated he notified the nursing staff and his supervisor. Interview and clinical record review with LPN #1 on 8/13/20 at 10:14 AM identified he was not aware of Resident #1's non-compliant behaviors. LPN #1 indicated he was aware of Resident #1's behavior of propelling to the negative cohort at the nurse's station. LPN #1 identified the staff will attempt to redirect and resident will refuse. LPN #1 indicated 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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) nurses did not document Resident #1 behavior in the clinical record. Interview and clinical record review with the DNS on 8/13/20 at 11:00 AM identified she was not aware of Resident #1 behavior until Tuesday 8/11/20. The DNS identified Resident #1 was at the nurse's station yelling and cursing and indicated she educated and attempt to redirect Resident #1 back to the exposed cohort. Interview with NA #1 on 8/13/20 at 11:45 AM identified Resident #1 refused morning care, and refused to have the bed linen changed for over a week, and Resident #1 would yell and curse at the staff. NA #1 indicated on Tuesday 8/11/20 after multiple attempts Resident #1 agreed to take a shower. NA #1 indicated LPN #2 and all the facility staff were aware of Resident #1 refusal of care. The facility failed to ensure the physician was made aware of Resident #1's ongoing behaviors that put residents on the negative cohort at risk for covid 19 infection.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 resident (Resident #1) who received an antipsychotic medication and was reviewed for behaviors, the facility failed to ensure the resident's behaviors were identified and monitored, and failed to ensure a psychiatric consultation was obtained according to the physician's orders [REDACTED].#1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The admission physician's orders [REDACTED]. Review of the nurse's note dated 8/1/20 through 8/11/20 failed to reflect documentation regarding Resident #1 non-complaint behaviors with quarantine protocol, refusing care, or yelling, screaming and cursing at staff. A physician's orders [REDACTED]. The care plan dated 8/5/20 identified Resident #1 uses [MEDICAL CONDITION] medications. Interventions included to administer medications as ordered by the physician, and monitor for side effects and effectiveness every shift. Additionally, monitor/record occurrence of for target behavior symptoms (Specify: pacing wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others, etc.) and document per facility protocol. Review of the August 2020 behavior monthly flow sheet for 8/1/20 through 8/31/20 failed to reflect documentation of target behaviors or monitoring of such. Interview and review of the clinical record with the DNS on 8/13/20 at 11:30 AM identified she was not aware the licensed nurses were not monitoring and documenting Resident #1's behaviors on the flow sheet. Observation on 8/12/20 at 9:10 AM identified Resident #1 in the wheelchair sitting in the hallway on A wing in the negative cohort with a blue surgical face mask underneath his/her chin. The observation identified that NA #1 attempted to redirect Resident #1 back to his/her room and to properly reapply the surgical mask over the resident nose and mouth, however, Resident #1 refused. Interview with NA #1 on 8/12/20 at 9:20 AM identified Resident #1 has been non-compliant with quarantine protocols since Thursday 8/6/20 last week, 6 days. NA #1 indicated Resident #1's behavior has escalated and the resident is very difficult to redirect back to the exposed cohort or his/her room. NA #1 indicated Resident #1 usually has the surgical face mask underneath his/her chin and will start yelling, screaming and using profanity towards the staff when they attempt to redirect. NA #1 indicated the DNS, and other staff were aware of Resident #1's behavior of not keeping the mask on properly and yelling, screaming, and using profanity toward the staff. Observation on 8/12/20 at 9:35 AM identified Resident #1 propelled him/herself to the nurse's station on the negative cohort. NA #1 attempted to redirect Resident #1 back to the exposed cohort, but Resident #1 refused and started yelling. NA #1 was observed to walk away at that time. Observation at 9:40 AM identified Resident #1 propelled him/herself around the nurse's desk in front of room A-16 (negative cohort) where another resident was sitting in a wheelchair in front of room A-16. Resident #1, who was wearing a surgical mask was within 3 feet of the other resident. Nursing staff attempted to redirect Resident #1, however the resident started yelling and screaming. At 10:00 AM, LPN #1 encouraged and assisted Resident #1 back to the exposed cohort and into his/her room and remained with the resident. Observation on 8/12/20 at 11:40 AM identified Resident #1 was again on A wing in the negative cohort in the hallway with the surgical mask underneath his/her chin and holding on to the railing. The resident was being monitored by 1:1 monitor and the Administrator was present. Resident #1 was approximately 3 feet away from another resident who was sitting in the hallway in front of room A-16. The Administrator explained and redirected Resident #1 to properly place the surgical mask over the mouth and nose, which the resident allowed. The Administrator redirected the resident back to the recreation room. Observation on 8/12/20 at 12:30 PM identified Resident #1 was again in the hallway on A wing in the negative cohort. The 1:1 monitor was present. When staff attempted to redirect Resident #1, he/she yelled leave me alone. At 12:45 PM, Resident #1 was redirected into the recreation room and lunch was provided. Interview and review of the clinical record with LPN #2 on 8/12/20 at 1:48 PM identified she was aware of Resident #1's non-compliant behaviors with morning care and throughout the shift the first week at the facility, although the resident would take his/her medications. LPN #2 indicated Resident #1 started being non-compliant with coming out of his/her room last week. LPN #2 identified Resident #1 would yell, scream, curse and become aggressive towards the staff when being redirected, and staff would walk away. LPN #2 indicated Resident #1's behavior has been increasing every day. LPN #2 indicated Resident #1's behavior was like this yesterday (8/11/20) in the morning, and staff encouraged the resident to take a shower and the behavior decreased a little bit. LPN #2 indicated around 3:00 PM, Resident #1 propelled his/her self to the negative cohort and began yelling, screaming and cursing when redirected. The DNS was aware of Resident #1's behavior yesterday (8/11/20) and non-compliance with remaining on the exposed cohort or his/her room. The DNS attempted to educate and redirect the resident at that time. Interview with RN #1 on 8/12/20 at 2:00 PM identified he was aware of Resident #1's non-compliance with refusing care in the morning and throughout the shift. RN #1 indicated Resident #1 was difficult and hard to approach at the beginning, would not accept care and remained in his/her room. RN #1 indicated last week Resident #1 started coming out of his/her room, off the exposed cohort, and onto the negative cohort. RN #1 indicated he and the other staff would constantly educate and redirect the resident but the resident would refuse. RN #1 indicated Resident #1 would sometimes yell and scream at the staff. Interview and record review with the Administrator on 8/12/20 at 2:10 PM identified she was aware that Resident #1 refused to stay in his/her room since his/her admission, however, she was not aware of Resident #1's non-compliant behaviors until today. Interview and record review with the ADNS on 8/12/20 at 3:30 PM identified she was not aware of Resident #1's behaviors and non-compliant behavior with care, yelling, screaming and cursing at the staff. The ADNS indicated she notified the psychiatrist at today at 12:40 PM of Resident #1's behavior, and a new order for [MEDICATION NAME] 0.5 mg (antipsychotic medication) one time dose was obtained. Additionally, the ADNS indicated the psychiatrist would be in to assess Resident #1 today. Interview with NA #2 on 8/13/20 at 9:17 AM identified Resident #1 has been verbally abusive, yelling, screaming and using foul language towards the staff. NA #2 indicated Resident #1 constantly propels him/herself to the negative cohort at the nurse's station and sits there with the surgical mask underneath his/her chin. When staff attempt to redirect Resident #1, he/she would yell and curse at the staff. NA #2 indicated the DNS, ADNS and the supervisor are aware of Resident #1's behaviors. They will attempt to redirect Resident #1 and they can't because he/she would start yelling and screaming and they would walk away. Interview with NA #3 on 8/13/20 at 9:24 AM identified on Monday 8/10/20, Resident #1 was sitting on A wing in the negative cohort at the nurse's station in the morning. NA #3 identified the breakfast truck came to the wing and she explained to Resident #1 to follow her back to his/her room, and Resident #1 started yelling and screaming. RN #1 redirected and escorted the resident to his/her room to have breakfast. Interview with Housekeeper #1 on 8/13/20 at 10:08 AM identified this is the second time he has been assigned to A wing on the exposed cohort. Housekeeper #1 indicated he observed vomit and spit in Resident #1's room on the floor. Additionally, Housekeeper #1 indicated he observed spit on the floor where Resident #1 was sitting in the hallway on the exposed cohort and by the nurse's desk. Housekeeper #1 indicated he would clean and disinfect the areas. Housekeeper #1 indicated he notified the nursing staff and his supervisor. Interview and clinical record review with LPN #1 on 8/13/20 at 10:14 AM identified he was not aware of Resident #1's non-compliant behaviors. LPN #1 indicated he was aware of Resident #1's behavior of propelling to the negative cohort at the nurse's station. LPN #1 identified the staff will attempt to redirect and resident will refuse. LPN #1 indicated the nurses did not document Resident #1 behavior in the clinical record. Interview and clinical record review with the DNS on 8/13/20 at 11:00 AM identified she was not aware of Resident #1 behavior until Tuesday 8/11/20. The DNS identified Resident #1 was at the nurse's station yelling and cursing and indicated she educated and attempt to redirect Resident #1 back to the exposed cohort. Interview with NA #1 on 8/13/20 at 11:45 AM identified Resident #1 refused morning care, and refused to have the bed linen changed for over a week, and Resident #1 would yell and curse at the staff. NA #1 indicated on Tuesday 8/11/20 after multiple attempts Resident #1 agreed to take a shower. NA #1 indicated LPN #2 and all the facility staff were aware of Resident #1 refusal of care. Review of the Psychoactive Medication Use policy identified to ensure that

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F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) psychoactive medications are utilized appropriately, episodes of behaviors such as continuous crying out, screaming, yelling or pacing if these behaviors cause an impairment in the resident's functional capacity must be quantitatively (length of episode) documented. The facility failed to ensure behaviors were identified and monitored and that the physician's orders [REDACTED].
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility documentation, facility policy, and interviews for 1 resident (Resident #1) reviewed for behavior, the facility failed to implement measures to address the residents behavior of leaving the exposed cohort and entering the negative cohort, and the behavior of not properly wearing a mask for source control when out of his/her room, potentially exposing the residents on the negative cohort to Covid 19 infection. The findings include: Resident #1 was admitted to the facility on [DATE], to A wing on the exposed cohort. [DIAGNOSES REDACTED]. Review of the care plan dated 8/5/20 identified Resident #1 was at risk for infection with interventions that included to follow facility protocol for Covid-19 screening and precautions. Observation on 8/12/20 at 9:10 AM identified Resident #1 in the wheelchair sitting in the hallway on A wing in the negative cohort with a blue surgical face mask underneath his/her chin. The observation identified that NA #1 attempted to redirect Resident #1 back to his/her room and to properly reapply the surgical mask over the resident nose and mouth, however, Resident #1 refused. Interview with NA #1 on 8/12/20 at 9:20 AM identified Resident #1 has been non-compliant with quarantine protocols since Thursday 8/6/20 last week, 6 days. NA #1 indicated Resident #1's behavior has escalated and the resident is very difficult to redirect back to the exposed cohort or his/her room. NA #1 indicated Resident #1 usually has the surgical face mask underneath his/her chin and will start yelling, screaming and using profanity towards the staff when they attempt to redirect. NA #1 indicated the DNS, and other staff were aware of Resident #1's behavior of not keeping the mask on properly and yelling, screaming, and using profanity toward the staff. Observation on 8/12/20 at 9:35 AM identified Resident #1 propelled him/herself to the nurse's station on the negative cohort. NA #1 attempted to redirect Resident #1 back to the exposed cohort, but Resident #1 refused and started yelling. NA #1 was observed to walk away at that time. Observation at 9:40 AM identified Resident #1 propelled him/herself around the nurse's desk in front of room A-16 (negative cohort) where another resident was sitting in a wheelchair in front of room A-16. Resident #1, who was wearing a surgical mask was within 3 feet of the other resident. Nursing staff attempted to redirect Resident #1, however the resident started yelling and screaming. At 10:00 AM, LPN #1 encouraged and assisted Resident #1 back to the exposed cohort and into his/her room and remained with the resident. Subsequent to surveyor inquiry, the ADNS placed Resident #1 on 1:1 monitoring at 11:15 AM. Observation on 8/12/20 at 11:40 AM identified Resident #1 was again on A wing in the negative cohort in the hallway with the surgical mask underneath his/her chin and holding on to the railing. The resident was being monitored by 1:1 monitor and the Administrator was present. Resident #1 was approximately 3 feet away from another resident who was sitting in the hallway in front of room A-16. The Administrator explained and redirected Resident #1 to properly place the surgical mask over the mouth and nose, which the resident allowed. The Administrator redirected the resident back to the recreation room. Observation on 8/12/20 at 12:30 PM identified Resident #1 was again in the hallway on A wing in the negative cohort. The 1:1 monitor was present. When staff attempted to redirect Resident #1, he/she yelled leave me alone. At 12:45 PM, Resident #1 was redirected into the recreation room and lunch was provided. Interview and review of the clinical record with LPN #2 on 8/12/20 at 1:48 PM identified she was aware of Resident #1's non-compliant behaviors with morning care and throughout the shift the first week at the facility, although the resident would take his/her medications. LPN #2 indicated Resident #1 started being non-compliant with coming out of his/her room last week. LPN #2 identified Resident #1 would yell, scream, curse and become aggressive towards the staff when being redirected, and staff would walk away. LPN #2 indicated Resident #1's behavior has been increasing every day. LPN #2 indicated Resident #1's behavior was like this yesterday (8/11/20) in the morning, and staff encouraged the resident to take a shower and the behavior decreased a little bit. LPN #2 indicated around 3:00 PM, Resident #1 propelled his/her self to the negative cohort and began yelling, screaming and cursing when redirected. The DNS was aware of Resident #1's behavior yesterday (8/11/20) and non-compliance with remaining on the exposed cohort or his/her room. The DNS attempted to educate and redirect the resident at that time. Interview with RN #1 on 8/12/20 at 2:00 PM identified he was aware of Resident #1's non-compliance with refusing care in the morning and throughout the shift. RN #1 indicated Resident #1 was difficult and hard to approach at the beginning, would not accept care and remained in his/her room. RN #1 indicated last week Resident #1 started coming out of his/her room, off the exposed cohort, and onto the negative cohort. 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They will attempt to redirect Resident #1 and they can't because he/she would start yelling and screaming and they would walk away. Interview with NA #3 on 8/13/20 at 9:24 AM identified on Monday 8/10/20, Resident #1 was sitting on A wing in the negative cohort at the nurse's station in the morning. NA #3 identified the breakfast truck came to the wing and she explained to Resident #1 to follow her back to his/her room, and Resident #1 started yelling and screaming. RN #1 redirected and escorted the resident to his/her room to have breakfast. Interview with Housekeeper #1 on 8/13/20 at 10:08 AM identified this is the second time he has been assigned to A wing on the exposed cohort. Housekeeper #1 indicated he observed vomit and spit in Resident #1's room on the floor. Additionally, Housekeeper #1 indicated he observed spit on the floor where Resident #1 was sitting in the hallway on the exposed cohort and by the nurse's desk. Housekeeper #1 indicated he would clean and disinfect the areas. Housekeeper #1 indicated he notified the nursing staff and his supervisor. Interview and clinical record review with LPN #1 on 8/13/20 at 10:14 AM identified he was not aware of Resident #1's non-compliant behaviors. LPN #1 indicated he was aware of Resident #1's behavior of propelling to the negative cohort at the nurse's station. LPN #1 identified the staff will attempt to redirect and resident will refuse. LPN #1 indicated the nurses did not document Resident #1 behavior in the clinical record. Interview and clinical record review with the DNS on 8/13/20 at 11:00 AM identified she was not aware of Resident #1 behavior until Tuesday 8/11/20. The DNS identified Resident #1 was at the nurse's station yelling and cursing and indicated she educated and attempt to redirect Resident #1 back to the exposed cohort. Interview with NA #1 on 8/13/20 at 11:45 AM identified Resident #1 refused morning care, and refused to have the bed linen changed for over a week, and Resident #1 would yell and curse at the staff. NA #1 indicated on Tuesday 8/11/20 after multiple attempts Resident #1 agreed to take a shower. NA #1 indicated LPN #2 and all the facility staff were aware of Resident #1 refusal of care. Review of the Limiting Transmission of Covid-19 policy identified it is the procedure of this facility to follow the guidelines of CMS and the CDC for limiting the transmission of Covid-19. Also, if possible, dedicate a unit/wing exclusively for any residents coming or returning from the hospital. This can serve as a step-down unit where they remain for 14 days with no symptoms (instead of integrating as usual on short-term rehab floor or returning to long-stay original room). Review of the Admission Criteria (Covid-19) policy identified to protect individuals at risk for adverse outcomes from Covid-19, including healthcare personnel who are in a recognized risk category, new admissions who have not been previously tested or come from the community will be assumed exposed and will be placed in a private room. The resident will be cohorted for 14 days or until they have no symptoms. The facility failed to adequately address Resident #1's behaviors and ensure the resident did not gain access to the negative cohort to prevent the possible transmission of Covid 19 infection to the residents on the negative cohort.