STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235322	A. BUILDING _____ B. WING _____	05/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OAKRIDGE MANOR NURSING & REHAB CENTER LLC	3161 HILTON RD FERNDALE, MI 48220

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
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** This citation pertains to Intake # MI 804: Based on observation, interview and record review the facility failed to institute and operationalize appropriate infection control principles and practices per the Centers for Disease Control Prevention (CDC) safety measures to prevent the exposure/transmission of residents to 2019 Novel Coronavirus (COVID-19) for 18 (R#'s 702, 703, 705, 706, 708, 709, 710, 711, 712, 713, 714, 716, 717, 718, 720, 721, 723 and 724) out of 27 residents reviewed for cohorting (sharing a room) with COVID-19 positive or presumed positive residents and follow the correct procedure to clean and disinfect the glucometer devices, resulting in the increased likelihood of transmission of COVID-19 and putting all residents who receive glucose monitoring at risk for the likelihood of serious harm or death by contracting a bloodborne illness. The failure to follow current CDC recommendations for COVID-19 resulted in an Immediate Jeopardy (IJ) to the health and safety of all residents, many of whom were at high risk due to age and co-morbidities, to be exposed and/or develop COVID-19, given the high risk of spread once COVID-19 enters a nursing home, facilities must take immediate action to protect residents, families, and healthcare personnel (HCP) from resulting in serious health complications from COVID-19 hospitalization s, and death. Findings include: The IJ began on [DATE]. The IJ was identified on [DATE]. The Administrator was notified of the IJ on [DATE] at 1:43 PM and a plan to remove the immediacy was requested. Although the immediacy was removed on [DATE], the facility remained out of compliance at a 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. Review of a complaint filed with the State Agency on [DATE] included an allegation that the facility failed to follow current guidance related to infection prevention and control, related to cohorting residents. An onsite investigation into the above complaint and a COVID-19 Focus survey was conducted on [DATE] to [DATE]. On [DATE] at 9:10 AM, the Administrator was queried about the facility's residents and whether testing for COVID-19 had been conducted and reported all residents were tested and most were positive. When asked if the local health department and State Agency had been contacted for those residents with positive results, the Administrator reported, When tested all residents, reported to county health. On [DATE] at 10:05 AM, Licensed Practical Nurse (LPN) E was observed working on the first floor (where the residents that are negative for COVID-19 resided), preparing paperwork to send a resident out to the hospital. Continued observations were conducted as follows: At 10:09 AM, a resident (later identified as R#712) was observed walking into the hallway and near the nursing station (on the non COVID-19 unit) without the nose or mouth covered. When asked about simple questions, R#712 did not respond and proceeded to walk throughout the hallway. At that time, Certified Nursing Assistant (CNA H) was observed exiting another room and redirected R#712 back to her bed. CNA H proceeded to pick up the resident's oxygen tubing (which had been observed directly on the floor) and attempted to secure the tubing to the resident's face/nose without replacing or cleaning the tubing. When asked about the resident's use of oxygen and whether a pulse ox could be completed, CNA H reported she did not do vitals and would need to follow up with Nurse (name of Licensed Practical Nurse/LPN E). At that time, R#712 began to cry and stated Please Please repeatedly to CNA H. At approximately 10:12 AM, LPN E was observed at the nursing station and when queried about R#712's status reported, I'm sending her out right now. She won't keep oxygen on. At 10:25 AM, observation of the first floor elevator doors and stairwell door which lead to the facility's designated COVID-19 unit (all residents on second floor were on droplet precautions) included a document which read, ATTN: (Attention) You must be in full PPE (Personal Protective Equipment) at all times when entering this unit no exceptions!!! At 10:30 AM, further observations on the designated COVID-19 unit included all the doors to the resident's rooms were opened, not closed and there were several residents observed walking in the hallway, and/or accessing the shared bathroom without their nose or mouth covered. At 10:35 AM, Maintenance Staff A was observed walking throughout the designated COVID-19 floor with only a face mask. There was no other PPE worn. Also at 10:35 AM, LPN E was then observed caring for the residents on the second floor (which is the facility's designated COVID-19 unit), following observations of LPN E working on the first floor approximately 30 minutes earlier. Per review of the CDC long term care (COVID-19) guidance, which documented in part .Dedicate space in the facility to care for residents with confirmed COVID-19 . Assign dedicated HCP (health care professionals) to work only in this area of the facility . At 10:39 AM, the Social Service Tech (Staff B) was observed to exit the second floor elevator (located in the center of the COVID-19 designated floor), wearing a winter jacket, and face mask while carrying an insulated cup in one hand and two face masks in the other hand. Staff B proceeded to walk throughout the unit, towards the office located on the second floor and was stopped by a resident seated just inside a doorway of one of the rooms. Staff B then proceeded to head towards the office. There was no other PPE donned. At 10:43 AM, MDS Nurse L (who was not assigned to work the second floor) was observed to exit an office wearing full PPE. When queried about the facility's nurse staffing for the day, MDS Nurse L reported CNA (Certified Nursing Assistant) G) is the only CNA here today (on the COVID-19 floor) and the Nurse is (name of LPN E). At 10:44 AM, a resident was observed standing in the hallway with the door opened and the resident did not have the nose or face covered. Nurse L identified this resident as R#714 and further reported this resident and another on first floor (R#712) had wandering behaviors and required constant redirection to stay in their rooms. At 10:45 AM, Certified Nursing Assistant (CNA) G was queried on working on the COVID designated unit alone when the nurse is downstairs on the first floor (non-COVID unit) caring for those residents and how they would immediately contact the nurse if there was a crisis on the COVID unit, CNA G stated in part, .I don't really feel good about it. I would pick up the phone and call for her . At 10:47 AM, LPN E was queried on how they felt having to work both the first and second (COVID unit) floors LPN E stated That is a problem . LPN E was then asked how the facility was doing on providing staff with the necessary supplies and stated in part .We have ran out of hand sanitizers and disinfectant wipes . When asked what the nurses were using to clean the glucometers between each use, LPN E opened the glucometer kit and said Alcohol, this alcohol prep patch . (While pointing to an alcohol prep pad). The glucometer devices are required to be cleaned and disinfected per facility policy and manufacturer instructions to prevent the spread of infections. The facility policy titled Cleaning and Maintenance of Resident Equipment with a revision date of February 13, 2020 documented in part, .Glucometer, before/after each use, Disinfect- Bleach-based cleaner .Do not use alcohol. Allow 5 minutes to dry . At 10:49 AM, LPN E was observed at the medication cart on the second floor. LPN E had a face shield and face mask, there was no other PPE in use. At 10:53 AM, CNA G confirmed she was the only assigned CNA for the COVID-19 floor (facility census of 26 with seven residents on first floor and 19 on second floor) and was queried about the opened resident rooms and reported Usually doors stay open. When asked what was done for residents that required the use of a mechanical lift with sling, CNA G reported If I need help, I'll ask the nurse. When asked if there was a resident that required two people (such as use of mechanical lift) or a resident was in distress and the nurse was not available on the floor (due to working on another unit at same time) what would be done, CNA G reported, If I couldn't do it myself, I'd call on phone overhead. At 11:00 AM, R#718 was observed self propelling in a wheelchair from the shared bathroom (accessed in the hallway on the COVID-19 designated floor) to the room without the nose or face covered. The door to the room remained open. At 11:55 AM, R#717 was observed self propelling a wheelchair in the hallway toward the nursing desk, asking

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)

for water. The resident did not have the nose or face covered and staff did not offer the resident the use of a face mask. At 5:25 PM, the Administrator and Director of Nursing were queried on what disinfectant the nurses are supposed to utilize on the glucometers between each use and the Administrator stated in part, .It's a bleach mixture that we made. They should be using that . Resident #703, #720 & #721 Review of the census record revealed R#703 and R#721 became roommates on [DATE] and continued as such until [DATE]. Resident #703 Review of the clinical record revealed R#703 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. A Nurses Note dated [DATE] at 4 pm, documented in part, Lethargic all morning. CNAs said she ate a little lunch . A Nurses Note dated [DATE] at 3 pm, documented in part, Slept through breakfast. Ate very little lunch . A Nurses Noted dated [DATE] at ,[DATE] (exact documented time), documented in part, Nonproductive cough noted . A Nurses Note dated [DATE] at 11 pm, documented in part, . dry cough, T- (temperature) 99.3) . A Nurses Noted dated [DATE] at 4 pm, documented in part, .(doctor name redacted) notified of cough. New orders received for Stat (immediate) CXR (chest x-ray) today and for CBC (complete blood count) CMP (comprehensive metabolic panel) next lab draw on [DATE] . A Nurse Practitioner (NP) note dated [DATE] documented in part, . Following up on this patient after a report from staff 2 days ago the patient started coughing .assist in care, good bp (blood pressure) control, pt (patient) will need ,[DATE] (24 hours and 7 days a week) care, assistance and supervision . A review of R#703's [DATE] vital signs revealed the following: ,[DATE] morning (temperature)- 99.4 ,[DATE] AM (temp)- 99.1 ,[DATE] PM temp- 100.4 ,[DATE] AM temp- 99.6 and cough noted ,[DATE] PM temp- 99.1 ,[DATE] AM temp- 101.6 A facility discharge list provided by the Administrator documented R#703 was transferred to the hospital on [DATE]. On [DATE] the Director of Nursing informed the surveyor that R#703 was positive for COVID-19. During the above dates resident #703 remained roommates with R#721 (until [DATE]) and roommates with R#720 (from [DATE] until [DATE]), despite having displayed signs and symptoms related to COVID-19. CDC's guidance for (COVID-19) in long term care documented in part, .Actively monitor all residents upon admission and at least daily for fever (T-100.0 F) and symptoms of COVID-19 (shortness of breath, new or change in cough, sore throat, muscle aches). If positive for fever or symptoms, implement Transmission-Based Precautions .Older adults with COVID-19 may not show typical symptoms such as fever or respiratory symptoms. Atypical symptoms may include new or worsening malaise .Identification of these symptoms should prompt isolation and further evaluation for COVID-19 . Resident #721 Review of the clinical record revealed R#721 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. A Nurses Note dated [DATE] (no time noted) documented in part, .Resident observed with temp of 100.4 this shift .SPO2 (oxygen saturation) 89% . A Nurses Note dated [DATE] at 5 am, documented in part, .B/P (blood pressure) ,[DATE], P (pulse) 128, Resp (respirations) 28, SPO2 70, Temp 102 .send to (hospital name redacted) . During the above dates resident #721 remained roommates with R#703 (who was showing signs and symptoms of COVID- 19) until [DATE]. On [DATE] the Administrator and DON confirmed that R#721 was diagnosed with [REDACTED]. Resident #720 Review of the clinical record revealed R#720 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the census record revealed R#720 and R#703 (exposed resident) became roommates on [DATE]. Review of the CDC long term care (COVID-19) guidance, which documented in part .Residents with known or suspected COVID-19 do not need to be placed into an airborne infection isolation room (AIIR) but should ideally be placed in a private room with their own bathroom. Residents with COVID-19 should, ideally, be cared for in a dedicated unit or section of the facility .As roommates of residents with COVID-19 might already be exposed, it is generally not recommended to place them with another roommate until 14 days after their exposure, assuming they have not developed symptoms or had a positive test . A lab report dated [DATE] at 9:12 pm, revealed R#720 was positive for the Coronavirus. Resident #705, #723 & #724 Review of the census record revealed R#'s 705, 723 and 724 all became roommates on [DATE] and continued until [DATE]. Review of the clinical record revealed R#705 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the documentation of monitored vitals documented by the nurses revealed the following for R#705 in [DATE]: ,[DATE] AM & Midnights- Cough ,[DATE] PM- T (temperature)- 99.9 ,[DATE] PM- T- 99.5 ,[DATE] PM- T- 99.2 ,[DATE] AM- T- 99.6, PM- 99.4 ,[DATE] AM- T-100.8 A Nurse Practitioner (NP) note dated [DATE] documented in part, .patient was noted to have poor p.o. (by mouth) intake the past 3 days. Patient also have not been drinking fluids and appeared to be weak . A review of a COVID test result document with a reported date of [DATE] at 8:11 pm, revealed R#705 was positive for the COVID 19. Despite having displayed signs and symptoms related to COVID as indicated above R#705 remained room mates with R#'s 723 & 724 until [DATE]. Resident #723 Review of the clinical record revealed R#723 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the document of monitored vitals (documented by the nurses) revealed the following for R#723 in [DATE]: ,[DATE] PM- BP (blood pressure) ,[DATE], T- 99.2 ,[DATE] PM- T- 99.2 Review of the census revealed R#723 was transferred to unit one (a non-covid unit) and placed with another room mate (R#717). On [DATE] R#723's previous room mate (R#705) test result confirmed that they were positive for COVID-19. Further review of R#723's clinical record revealed the following: ,[DATE] PM- P (pulse)- 120, T- 103, midnight T- 99.8 A Nurses Note dated [DATE] at 9 pm, documented in part, .SPO2 (oxygen saturation) 76% . oxygen was administered via nasal cannula. A Nurses Note dated [DATE] at 9:05 pm, documented in part, .New order given to transfer to (hospital name redacted) . On [DATE] at 9:32 AM, the administrator confirmed that R#723 was currently admitted into the hospital for respiratory difficulty. Resident #724 Review of the clinical record revealed R#724 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the paper document of monitored vitals (documented by the nurses) revealed the following for R#724 in [DATE]: ,[DATE] AM- T- 100.6 ,[DATE] PM- T- 99.3 ,[DATE] PM- T- 99.1 ,[DATE] Midnight- 99.3 A review of the clinical record revealed R#724 was diagnosed with [REDACTED]. Resident #706, #709 & #710 Review of the census record revealed R#706, R#709 and R#710 became roommates on [DATE]. Review of the clinical record revealed R#706 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the documentation of monitored vitals (documented by the nurses) revealed the following for R#706 in April of 2020: ,[DATE] MN (midnight)- 99.3 ,[DATE] PM- T- 99.3 ,[DATE] MN- T- 99.1 A Nurses note dated [DATE] at 10 pm, documented in part In bed the entire shift. Took fluids only for dinner . A hospital consult dated [DATE] at 1301 (1:01 pm) documented in part, .patient was found to be hypoxic at 60%, tachypenic (fast breathing), HR (heart rate) 108, Temp 108 .Was found to be staring into space and appearing lethargic which promoted this admission . On [DATE] at 11:39 AM, test results of the COVID-19 test completed at the hospital revealed .COVID- 19 Result- Detected . Despite being symptomatic, R#706 remained roommates with R#'s 709 and 710. Resident #709 Review of the clinical record revealed R#709 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the documentation of monitored vitals (documented by the nurses) revealed the following for R#709 in March and April of 2020: ,[DATE] MN- T- 99.0 ,[DATE] AM- blood pressure ,[DATE], pulse 102 and T- 99.0 ,[DATE] PM- T- 99.0 ,[DATE] AM- T- 99 ,[DATE] MN- T- 99.5 R#709 remained roommates with R#'s 706 and 710, until [DATE] when R#709 was discharged to another facility (Despite being symptomatic and being roommates with another symptomatic resident R#706 who four days later tested positive for COVID-19). Resident #710 Review of the clinical record revealed R#710 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the census record revealed R#710 shared a room with R#'s 706 and 709 until [DATE] and then again on [DATE] until discharged to the hospital on [DATE]. Resident #714, #717 & #718: A review of the clinical record revealed R#714 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the clinical record revealed R#718 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the clinical record revealed R#717 was admitted into the facility on [DATE] and recently moved from the second floor (COVID unit) to the first floor (non COVID unit) on [DATE] with [DIAGNOSES REDACTED]. A review of the documentation provided by the facility included a form which read, COVID Resident Tracking and included a list of names for six residents that had been hospitalized between [DATE] and [DATE] (which included R#713 and R#716). On [DATE] when queried about the multiple room changes identified during the survey for many of the residents, the Administrator reported all residents were moved to the second floor to attempt to maintain adequate staffing. However, once facility COVID-19 testing was conducted on [DATE] and most of the residents tested positive, those residents that were negative were moved back down to the first floor. When asked about what process was implemented for those residents that had been exposed to positive COVID-19 residents and/or staff, despite negative testing, and relocated to the non-COVID-19 floor, the Administrator reported they were monitoring vitals every shift and offered no further explanation. Resident #712, #713 & #716 Review of census records revealed R#712, R#713, and R#716 all shared a room on the first floor between [DATE] to [DATE]. Since then, all three residents had been confirmed COVID-19 positive either by the facility testing, or upon hospitalization . According to the documented census information, R#716 had been hospitalized on [DATE]; R#712 had been hospitalized on [DATE]; and R#713 had been hospitalized on [DATE]. Facility Administration reported that both R#713 and R#716 were now deceased . Resident #711, #702 & #708 Review of the census records revealed R#711, R#702 and R#708 shared a room as of [DATE]. Since then, all three residents had been confirmed COVID-19 positive either by the facility testing, or upon hospitalization . Resident #711 & #712 Review of the census records revealed R#711 and R#712 first began sharing a room on [DATE] on the non COVID-19 unit.

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 2) Both residents had been confirmed COVID-19 positive either by the facility testing, or upon hospitalization and exhibited ongoing respiratory signs and symptoms within 14 days of readmission on [DATE]. Resident #711: A review of the clinical record revealed R#711 was admitted into the facility on [DATE], was transferred to another room on [DATE], hospitalized on [DATE], and readmitted into the facility on [DATE] with [DIAGNOSES REDACTED]. According to the hospital documentation dated [DATE], R#711 .COVID-19 positive per state testing at ECF (extended care facility) . Review of R#711's progress notes on [DATE] revealed R#711 had loss of appetite and a temperature of 102.7. On [DATE] at 2:45 PM, R#711 was noted to have a temperature of 100.2. On [DATE], R#711 was noted to be extremely tired, had no appetite, had temperature of 100.2 and was sent to the hospital at approximately 12:15 PM. There was no documented evidence that the facility had placed R#711 on isolation precautions when symptoms first appeared, and R#711 continued to share a room with other residents (R#702 and R#708) despite testing positive for COVID-19. Review of the physician/physician extender progress notes since February included three consults dated [DATE], [DATE] and [DATE]. The entry on [DATE] read, .Here to follow-up patient after report from staff that patient has confirmed COVID positive infection .patient is febrile with T-max of 101.8 .Assessment/Plan Lethargy, acute mental status change secondary to confirmed COVID positive infection. Attempted to start IV (intravenous) fluids however secondary to decreased po (oral) intake, will send patient to ER (emergency room) for further eval (evaluation) . Review of the vital sign documentation provided by the facility on [DATE] at 3:45 PM revealed blank documentation for vital signs on [DATE] for all shifts, [DATE] AM shift, PM shift only had temperature - no respiratory monitoring, [DATE] MN (midnight) shift was blank for all residents, [DATE] AM, PM and MN (Midnight) shifts were blank, [DATE] AM, PM, and MN shifts were blank, and ,[DATE] AM shift was blank and had documentation for PM shift only. Resident #712: A review of R#712's census information included: clinical record revealed R#712 was admitted into the facility on [DATE] , was hospitalized on [DATE], readmitted on [DATE], hospitalized on [DATE], readmitted on [DATE], hospitalized on [DATE], readmitted on [DATE] (to a room with R#711), and hospitalized on [DATE] for increased signs and symptoms of respiratory distress. Further review of the clinical record revealed R#712 had [DIAGNOSES REDACTED]. Review of R#712's discharge hospital paperwork indicated that a test for COVID-19 had been completed on [DATE] but also documented, Can the Post-Acute Care Setting Provide care for patient with Transmission-Based Precautions?. An X was marked by Yes, (which indicated) May Transfer Patient. Review of the clinical record revealed there was no documented evidence that any isolation precautions or transmission-based precautions had been implemented. The resident was not isolated from other residents as well despite exhibiting symptoms consistent with COVID-19. Review of R#712's hospital documentation included a COVID-19 test completed on [DATE] which documented, Detected!!. Review of the documentation provided by the Director of Nursing (DON) who also acted as the Infection Control Preventionist included an Infection Surveillance Report Line Listing [DATE] which identified R#712 as having change in oxygen saturations, shortness of breath or respirations greater than 25, fever and was treated with [MEDICATION NAME] 200 mg (milligrams) 2 tabs) 400 mg x 1 day, [MEDICATION NAME] 500 mg x 1 day on [DATE]. Review of the clinical record further documented on [DATE] at approximately 6:15 AM, R#712 was found unresponsive, Cardiopulmonary Resuscitation (CPR) had been initiated successfully and the resident was transferred to the hospital. Review of the progress notes included an entry on [DATE] at 2:30 PM which indicated R#712's readmission. The portion of the note which read, .VS (vital signs) at time of admission were blank. There were no documented vital signs. The next entry was on [DATE] at 10:15 AM that the nurse was called to the room and R#712 did not have oxygen on at the time, was non-compliant with putting on, had pulse ox of 91% and complained of shortness of breath and abdominal pain and was sent to the hospital. Review of the additional vital sign documentation provided by the facility which included monthly and every shift revealed the Monthly Vital Sign and Weight Form had vital signs without a date or time of when obtained, and the Active Screening of Residents form did not include R#712. Resident #713 A review of the clinical record revealed R#713 was admitted into the facility on [DATE], discharged to hospital on [DATE], readmitted on [DATE], discharged to hospital on [DATE], readmitted on [DATE], discharged to hospital on [DATE], readmitted on [DATE] (to a room shared with R#712 and R#716) and discharged to hospital on [DATE] with [DIAGNOSES REDACTED]. Per Administration, R#713 was now deceased . According to the census information, R#713 remained on the first floor throughout these dates mentioned above. A review of additional documentation provided by the facility included a log titled, COVID Resident Tracking that identified six residents as positive COVID-19 and included dates the state agency was contacted. This list of residents included R#713 which was reported to the state on [DATE]. Additionally, review of a facility's Infection Surveillance Report Line Listing for [DATE] documented R#713 with respiratory symptoms on [DATE] with notations by change in oxygen saturation, fever, and mental status changes. Review of the progress notes included: An entry on [DATE] at which read, Resident started feeling sick unable to give writer symptoms .2A (2:00 AM) B/P (blood pressure) ,[DATE], P (Pulse) 110, R (Respirations) 18, T (Temperature) 96.7 .4A Resident restless request to go to the hospital .Send resident to ER, T 96.7, P - 148, R-20, B/P ,[DATE] . The next documented entry in the progress notes provided was an entry on [DATE] at 1:00 AM which read, .B/P (Blood Pressure) ,[DATE], P (Pulse) 69 .Resp (Respirations) 26, SpO2 83%. She appeared pale, slunched <sic> over and her breaths were short with poor depth. Her lungs were crackling in all 4 quadrants .she stated she felt like something was sitting on her chest. 911 called . Resident #716 A review of R#716's clinical record revealed R#716 was admitted into the facility on [DATE] (to a room shared with R#712) and discharged to the hospital on [DATE]. Per Administration, R#716 was now deceased . According to the face sheet, [DIAGNOSES REDACTED]. R#716's census information included an admission date of [DATE] to a room on the first floor shared with R#712. On [DATE], R#716 was transferred to the hospital. A review of documentation of a COVID Resident Tracking log provided by the facility identified R#716 had been hospitalized on [DATE] and had tested positive for COVID-19 (date of testing was not documented). Per discussion with the Administrator, R#716's positive COVID-19 results were reported to the facility by phone from the hospital. Review of the additional documentation provided by the facility regarding R#716's vital signs for March and [DATE] revealed incomplete, missing (blank) vital signs for: ,[DATE] 11p-7a; ,[DATE] 7a-3p; ,[DATE] 7a-3p; ,[DATE] 11p-7a; ,[DATE] 11p-7a; ,[DATE] 11p-7a; ,[DATE] 11p-7a; ,[DATE] 11p-7a; ,[DATE] 3p-11p. The entries for all three shifts on ,[DATE] read hospital. On [DATE] at 8:57 AM, all COVID 19 related polices and infection controls polices was requested from the Administrator. At 11:07 am, a second request was made to the Administrator and Director of Nursing to provide the policies on contact, droplet and airborne precautions. A policy titled Isolation- Notices of Transmission-Based Precautions with a revision date of [DATE] was provided. At 4:01 pm, the DON was queried on the policy Isolation- Notices of Transmission-Based Precautions and asked if that was the facility's policy on contact, droplet and airborne precautions and stated yes. The policy was reviewed and revealed no guidance for staff to follow regarding the appropriate steps to implement if the facility staff had to initiate contact, droplet or airborne precautions. On [DATE] at approximately 9:30 AM, the Administrator was asked to clarify the facility's decision to cohort residents that were exposed to positive residents and/or readmission from hospitalization following positive COVID-19 diagnosis, the Administrator acknowledged the concern and reason for policy changes since notification of the IJ and offered no further response. A facility policy titled Covid-19 Investigation Guidance dated [DATE] documented in part, . The purpose of this policy is to assure procedures to investigate suspected cases of Covid-19 so that implementation of appropriate protocol will occur . Validation of daily vitals signs, including temperatures and 02 sats . Onset date of symptoms/suspected illness . Isolate resident and implement contact and droplet precautions . Abatement Plan: (Facility name redacted) submits the following Credible Allegation of Compliance outlining the measures it has completed to abate the findings of immediate jeopardy to resident health and safety identified by the survey team regarding the facility's alleged failure to adhere to CDC guidelines and facility policy for Covid-19 residents in nursing homes (Facility name redacted) believes that as of [DATE], the measures it has implemented are sufficient to demonstrate measure to control infection control practices according to CDC guidelines and Facility policy(s). Resident identified to be affected by the alleged deficient practice. Patients on the Covid-19 recovery unit have been re-screened for symptoms consistent with Covid-19 and to assure no cross cohorting of symptomatic/asymptomatic residents. Doors have been closed to rooms on the Covid-19 unit per CDC recommendations. Retesting of all residents previously positive and currently with symptoms will be tested on [DATE]. Active employees will be tested as tests are available. Resident testing negative, physician will be notified, Room changes and treatment protocol will be implemented, based on facility policy and current CDC recommendations. Staff will be in serviced on the appropriate donning/ doffing and appropriate use of PPE to prevent the spread of infection. Identified nurse was also immediately reeducated on appropriate PPE use donning/doffing and PPE use for droplet precaut