STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105399	A. BUILDING _____ B. WING _____	**08/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SEA BREEZE REHAB AND NURSING CENTER	**3663 15TH AVE VERO BEACH, FL 32960**

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 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to accommodate the needs for 2 of 2 sampled residents with voiced concerns, Residents #11 and #12. The facility failed to provide a remote control in a timely manner for one of one sampled resident, to allow Resident #11 to watch TV independently. The facility failed to provide a functional bed for one of one sampled resident, Resident #12, for two days, until intervention by the surveyor. The findings included: 1. During an interview on 07/30/20 at 10:54 AM, Resident #11 explained she was moved into her current room (105A) last week because of [MEDICAL CONDITION] (COVID-19), and she has been unable to independently use the TV (television) until yesterday (07/29/20). Resident #11 explained the facility finally gave her a remote yesterday, but it only changes the channels. The resident was unable to turn the TV on or off, and was unable to adjust the volume. Resident #11 explained that when she got to the room, her roommate told her the TV belonged to the previous resident who took the remote with her. Resident #11 confirmed the TV had been in the room, but they were unable to control it. The resident demonstrated her inability to adjust the volume or turn the TV on and off. Resident #11 confirmed staff were aware of the issue as they have had to work the TV using the button on the set itself for the past week, and she had voiced her concerns to the staff. During this conversation Resident #11 stated her niece calls her every day to check on her. The resident stated she also told her niece about the TV, her niece talked to staff, but nothing happened with the TV for a week. Resident #11 voiced frustration with the inability to control the TV for the past week, explaining that it was the only thing she had to do while being stuck in this room because of [MEDICAL CONDITION] (COVID-19 pandemic). Review of the record revealed Resident #11 was move to room [ROOM NUMBER]A on 07/22/20. Review of the current Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #11 had a Brief Interview for Mental Status (BIMS) score of 15, on a 0 to 15 scale, indicating she was alert and oriented. Review of the current care plan initiated on 06/09/20 documented it was important for Resident #11 to engage in daily routines and activities of her preference. One intervention included when the resident chooses not to participate in organized activities, she prefers to spend leisure time engaged in independent activities such as watching TV. During an interview on 07/30/20 at 12:51 PM, Staff E, a Licensed Practical Nurse (LPN), was asked about the TV for Resident #11. The LPN confirmed Resident #11 was unable to work the TV independently until yesterday when the facility finally provided her with a remote. The LPN explained the TV in that room was a private TV and the owner would not give up the remote. The LPN confirmed she or other staff had to manually work the TV for the resident for the past week. 2. During an interview on 07/30/20 at 11:44 AM, Resident #12 stated he was OK except he has been stuck in this position for 15 hours now. Observation revealed the resident was in an upright position in the bed, between a 45 and 90 degree angle. Resident #12 explained his bed broke last night (07/29/20) at about 8 PM. The resident explained that the maintenance man can fix it, as it had happened before. He explained there was a wire underneath the bed that occasionally comes loose, and they just super glue it back in place. When asked if he spoke with anyone about it, the resident stated he told everyone last night, but the maintenance guy was not here and no one did anything. On 07/31/20 at 10:10 AM, Resident #12 was noted in the same upright position in bed. When asked about the bed, the resident stated it was still broken. Resident #12 stated someone came in yesterday evening, was unable to fix the bed, and promised him a new one. Resident #12 stated he never heard another word about it. During an interview on 07/31/20 at 10:19 AM, Staff D, the Registered Nurse (RN) for Resident #12 was asked about maintenance at the facility. The RN stated the Maintenance Director left about 3 weeks ago and it has been just the assistant since then, but she hasn't seen him the past few days. The RN was told about the broken bed for Resident #12, stated she was unaware of it, stated it's frustrating and walked away. During an interview on 07/31/20 at 11:30 AM, the Administrator was asked if she knew about the broken bed for Resident #12, that had been stuck in the same upright position since Wednesday (07/29/20) evening. The Administrator stated she had not heard about it, but they had extra beds and she would switch them out. During an interview on 07/31/20 at 11:55 AM, the Maintenance Assistant, stated he was unaware of the current broken bed for Resident #12. The Maintenance Assistant confirmed the bed had broken in the past and all he needs to do is super glue the wire. He stated the resident puts items under his bed and when he raises it, the wire hits the items and sometimes gets pulled apart. The maintenance man stated the bed is just fine and he can go fix it now. When asked the process for repairs, the Maintenance Assistant explained the nurses will just call him when needed, and denied the use of any type of maintenance request or log.
F 0561 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents' choice and preference for bathing were accommodated for 3 of 3 sampled residents who voiced concerns. Residents #2 and #3 were not provided a shower, and Resident #11 was not provided a bed bath. The findings included: 1. On 07/30/20 at 10:18 AM, peri-care (the process of cleaning private area) observation was conducted on Resident # 3 by Staff A, a CNA (certified nursing assistant). While the CNA was in the process of providing the peri-care, she stated to Resident # 3 today you are scheduled to receive a bath and it will be done later after lunch. Resident # 3 replied I will be glad to finally receive a bath. At this time, the surveyor asked the CNA if it was going to be a shower or bed bath, and the CNA revealed it was going to be a bed bath. At 11:00 AM, the surveyor returned to the resident's room and the resident indicated he has not received a bed bath or shower in three weeks. He revealed he has been receiving 'peri-care only' for three weeks. He expressed to the surveyor he would like to receive a shower. Resident #3 was alert and oriented and able to make his needs known. The quarterly minimum data set (MDS) reference date 06/13/20 revealed he needed staff assistance for all his personal hygiene needs. The MDS showed evidence of a brief interview for mental status (BIMS) score of 13 indicated the resident was cognitively intact. His care plan indicated he required assist of 1 staff with bed mobility, transfers, dressing, toileting, eating, locomotion, bathing, and personal hygiene. One of the interventions documented included: Please give me my shower/bath as per my bath schedule and if needed give me a sponge bath on non-shower days. Review of the generated shower schedule for all the rooms on B-1 hall (room [ROOM NUMBER]-210), revealed Resident # 3's room number was on the list to receive shower on Mondays and Thursdays on the 3 PM - 11 PM shift. On Friday, 07/31/20 in the presence of the DON, Resident # 3 voiced he had not received a shower yesterday. On 07/31/20 at 9:39 AM, an interview was held with Staff B, a CNA, who confirmed she observed Resident # 2 and # 3 had received a bed bath on Thursday 07/30/20, not a shower. Furthermore, there was no evidence recorded in the shower book of whether a shower was given to Resident #3 on 07/30/20. On 07/31/20 at 9:53 AM, an interview and a side by side record review was conducted with the Director of Nursing (DON), and he was not able to find evidence of documented shower for Resident #3 for 07/30/20. 2. On 07/30/20 at 11:05 AM, an interview was held with Resident #2, and he revealed the facility hasn't given him bed baths or showers in 3 weeks. He expressed he would be glad to receive a shower

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 0561 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) or bed bath. He added the staff only provides peri-care. Resident #2 was alert and oriented and able to make his needs known. The annual minimum data set (MDS) reference date 07/09/20 revealed he needed staff assistance for all his personal hygiene needs. The MDS showed evidence of a brief interview for mental status (BIMS) score of 13 indicated the resident was cognitively intact. His care plan indicated he required assist from staff with activity of daily living (ADLs) care. One of the interventions included: Please give me my shower/bath as per my bath schedule and if needed give me a sponge bath on non-shower days. Review of the shower schedule for all the rooms on B-1 hall (room [ROOM NUMBER]-210), revealed Resident # 2's room number was on the list to receive shower on Mondays and Thursdays on the 7 AM - 3 PM shift. On Friday, 07/31/20, a follow up interview in the presence of the DON. was held with Resident # 2. He voiced he did not receive a shower yesterday. On 07/31/20 at 9:39 AM during an interview with Staff B, a CNA, who confirmed she observed Resident #2 and #3 had received a bed bath on Thursday 07/30/20, not a shower. There was no evidence recorded in the shower book of whether a shower was given to Resident #2 on 07/30/20. On 07/31/20 at 9:53 AM, an interview and a side by side record review was conducted with the DON, and he was not able to find evidence of documented shower for Resident #2 for 07/30/20. 3. During an interview on 07/30/20 at 10:54 AM, Resident #11 stated I've been lying in this bed for a week without a bed bath. The resident further explained the staff have been providing personal care when she is incontinent, but she hasn't had a bath for over a week because they are short staffed. When asked if she had been provided a washcloth for her face or received a bath or shower, the resident again said no and shook her head to the negative and explained she preferred a bath to a shower at this time. When asked how she knows they are short staffed, Resident #11 stated they tell her so. The resident explained the staff tell her they only have 3 CNAs for the unit. Resident #11 stated her niece calls her every day to check on her. The resident explained she told her niece about her issues, the niece talked to staff, but she still hasn't gotten a bath. On 07/30/20 at 11:27 AM, Staff G, a Certified Nursing Assistant (CNA) went into Resident #11's room with a small bag of linens. A few washcloths and a towel could be seen through the clear bag. The CNA came out of the room at 11:34 AM. Staff G confirmed he had provided only peri-care (personal care for an incontinent episode). Review of the record revealed Resident #11 was moved to her current room on 07/22/20. Review of the current Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #11 was alert and oriented with a Brief Interview for Mental Status score of 15, on a 0 to 15 scale, which indicated the resident was alert and oriented. Further review of this MDS documented Resident #11 needed extensive to total assistance for personal hygiene and bathing. Review of the Electronic Medical Record (EMR) lacked any evidence of the provision of any type of bathing. During an interview on 07/30/20 at 12:00 PM, Staff D, a Registered Nurse (RN) on the same unit, confirmed there were 38 current residents. The RN stated they have been usually working with four CNAs on the day shift, but there should be five. The RN stated the residents should be getting showers twice weekly or as they request. If the resident refuses, the CNA is to tell the nurse as she can sometimes encourage the resident to get a shower. The RN stated the residents should get a bed bath daily. During an interview on 07/30/20 at 12:11 PM, Staff E, a Licensed Practical Nurse (LPN), stated Resident #11 received a bed bath on Monday or Tuesday of that week. Staff E further stated, Staffing is horrible . the CNAs are always running short. During an interview on 07/30/20 at 12:35 PM, Staff F, a Certified Nursing Assistant (CNA) stated they are always running short (with CNAs), yet they expect the same work. Staff F stated they are unable to give the same care and services compared to when they are fully staffed. During an interview the next day on 07/31/20 at 9:48 AM, Staff G, the same CNA that cared for Resident #11 on 07/30/20, stated he gave the resident a bed bath yesterday late afternoon or evening, as he worked a double. During an interview on 07/31/20 at 9:50 AM, Resident #11 stated, I don't know why they are telling you that. I did not get a bed bath yesterday and I would not tell you a lie. On 07/31/20 at 10:40 AM, a 'Shower Book' was noted at the nurse's station. The most current page in book was for the week of 07/06/20. Interviews with both CNAs, Staff F and Staff G, revealed the process was to document either a bed bath or shower next to the room on the 'shower sheets' on the day of their scheduled shower day or if requested by the resident, and then sign their name. The CNAs were unable to find a current page. When asked if they had been documenting any baths or showers, the CNAs stated they had not. Staff D, the RN on the unit, was unable to locate any documentation and agreed with the concern. On 07/31/20 at 11:10 AM, upon leaving the unit, Resident #11 was observed on the phone through the open door. The resident waved the surveyor into the room and handed the surveyor the phone and said, Here talk to my niece. The niece spoke at length, stating her aunt was older, but her mind was very clear. The niece confirmed she had voiced concerns to the staff regarding her aunt's care and services with regards to the short staffing and the current pandemic. The aunt stated she was assured by staff that her aunt was receiving proper care and services but stated Resident #11 continues to voice issues with the care. Review of the Resident Census and Condition report, dated 07/30/20, documented of the 79 residents, 58 were totally dependent upon staff and 20 needed the assistance of one or two staff members for bathing.
F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** Based on interviews, record reviews, and observations, the facility failed to demonstrate sufficient staffing levels were maintained to allow staff to consistently perform daily functions. These functions included: activities of daily living (Refer to F561), maintenance of resident equipment (Refer to F558) and environment, responding to phone calls to the facility from family/interested parties, and updating families/interested parties timely on the facility's COVID 19 status (Refer to F885). Interviews were conducted with multiple family members, residents, and staff members throughout the duration of the survey which revealed concerns related to insufficient staffing. Several attempts were made to reconcile daily staffing schedules with employee timecards since the establishment of the COVID 19 hall on 7/13/2020 and the establishment of the COVID 19 unit on 07/22/20. An accurate reconciliation of staffing could not be completed due to discrepancies between all sources provided by the facility. The findings included: 1. Staff interviews were conducted beginning on 07/30/20, which included department heads, 5 of 7 licensed nursing staff, and 8 of 12 certified nursing assistants (CNAs). Interviews with CNAs revealed staffing has been short lately on both the COVID 19 unit and the non-COVID 19 unit. The CNAs interviewed expressed concerns such as: 'Some residents have had to wait a while, especially with showers; When there are only two CNAs, we can't shower residents because we need another CNA on the floor'; 'We were down to 2 CNAs; We don't have back up when others are out sick; The staff on the isolation unit have to stay there so the rest of us are left for the other hallways; We are overworked'; 'We have been short staffed for months especially since COVID'; 'We are always running short but are expected to do the same work and are unable to give the same care and services'; 'We usually have 3-4 CNAs for a unit but now we have 1-2, The nurses help out as much as they can but we can't get the work done'; 'Staffing was horrible, At the time of the outbreak many of the aides quit, We also had to do the housekeeping too;' and 'We have been short lately, I can provide basic care but can't go that extra mile with the residents'. The licensed nursing staff interviewed also expressed staffing concerns such as: 'Things take longer when we are short staffed'; 'Staffing has been horrible. My relief yesterday was late, Last weekend there was only one aide on nights'; 'They have been short on weekends, They called agency staff one time and the person did not show up', and 'We have been short staffed sometimes, You should have a choice over which unit you work on.' Interview with 3 of 6 family members revealed multiple complaints that they had not been able to reach residents in the facility due to problems with the phone lines, staff not answering the phones, and/or staff being too busy. Family members stated that they are not receiving timely updates regarding the status of the facility during the pandemic and have had to make multiple calls to find out information regarding their loved one. Multiple family members reported instances of residents expressing staffing shortages. Interviews with alert and oriented residents revealed residents have not received regular showers or bed baths (refer to F561). An interview was conducted on 07/31/20 at 11:19 AM with the Staffing Coordinator. She stated the COVID-19 unit started on B1 on 07/13/20 and staff were dedicated to work only on that unit. When Unit A was converted to a COVID 19 unit, the staff that previously worked on Unit A became dedicated staff. Dedicated staff stay on their units and do not interact with staff on the non-COVID-19 units. She stated staffing was rocky at first but is fine now. She stated she has not received complaints about staff shortages. She explained she has agency staff that she can call as a backup and facility staff have also worked double shifts or worked 12 hour shifts to compensate if staff are out. A copy of the master schedule, for 07/09-30/20, was provided at the beginning of the survey on 07/30/20. The new Administrator, who started at the facility on 07/27/20, stated to her knowledge this schedule reflected the final schedule of which staff worked each shift. On 07/31/20, copies of the daily posted schedules for licensed nurses and CNAs were requested beginning 07/15/20. A

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F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) review of staffing schedules and interviews with staff revealed the master schedule was inaccurate as were the daily schedules. A request was made on 08/03/20 for updated schedules for 6 sampled dates in July for all shifts and the timecards for the staff who were reported to have worked those days. Review of the second set of daily schedules versus staff timecards that were provided showed discrepancies. Additional attempts to reconcile the daily schedules with staff timecards showed discrepancies. Interviews with staff members, residents, and family members also revealed concerns related to the resident equipment and environment, including problems with intermittent hot water and with malfunctioning phone lines. An interview was conducted with the Administrator on 07/30/20 which revealed the facility's previous Maintenance Director left on 07/08/20 and had not been replaced. The Maintenance Director from a sister facility was called in this week to make repairs. An interview was conducted on 07/30/20 at 12:37 PM with the acting Maintenance Director. He stated the facility has one Maintenance Technician that has been taking care of repairs and two floor technicians who can assist with maintenance tasks such as changing light bulbs in addition to their other assigned environmental task. The acting Maintenance Director stated he was called into the facility this week to install a new hot water tank. At this time, he was unable to access the electronic workorder system to verify when the hot water issue first began or when other repairs were made. The Maintenance Technician has access but is off today. An interview was conducted on 07/31/20 at 11:31 AM with the Maintenance Technician. He stated he has worked at the facility for six months and his first supervisor left in May 2020. The previous Maintenance Director came and worked for two weeks. The Maintenance Technician stated he was able to handle things to an extent. He stated the process is if staff notice something they put an order in the electronic workorder system and it goes to Maintenance. He stated he did not see a work order for the hot water and did not know when the issue started. He explained that previous problems with the phone lines were the result of workers from an outside company accidently cutting the phone lines. He was off yesterday and was not in the facility to repair Resident #12's bed (refer to F558). 2. Resident #11 voiced she had been in her room for over a week with the inability to independently control her TV. Interviews and record review revealed the facility failed to provide a remote for a week, and the remote that was finally provided only changed the channels. Resident #12's bed broke, leaving him in an upright position for more than two days, until surveyor intervention. Refer to F558 for specifics. 3. Interviews with Residents #2, #3, and #11, all three of whom were determined to be alert and oriented, revealed concerns with bathing. Interviews and record reviews revealed showers were not provided to Residents #2 and #3 as per their request and bed baths were not provided to Resident #11. Refer to F561 for specifics. 4. Both residents and family members voiced concerns with the lack of notification of the facility's COVID-19 status. Interviews and record review revealed the facility failed to update resident's and family members on a weekly basis of the number of residents and staff members that had positive COVID-19 results. Refer to F885 for specifics.
F 0885 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents, their representatives, and families of residents residing in the facility were notified of positive COVID-19 results by 5 PM the next day upon receipt of positive results, for 7 of 7 days reviewed (06/20/20, 07/04/20, 07/09/20; 07/10/20, 07/11/20, 07/12/20, and 07/16/20). The facility also failed to provide cumulative updates for residents, their representatives, and families at least weekly. The finding included: 1. During the entrance conference on 07/30/20 beginning at 9:15 AM, the Administrator (NHA) was asked who was responsible for the notification to residents, representative, and families of the COVID-19 status in the facility. The NHA stated notification to residents was made verbally by social services and the unit manager with a note documented in PCC (Point Click Care, their electronic medical record). The NHA stated notification to representatives and family members was done by the Admissions team. The NHA stated Corporate also sends out blast text messages to family members. The NHA was asked to provide evidence of the text messages that were sent out and the date they were sent. This blast text message was requested a second time on 08/03/20 at 1:14 PM via phone call, and as of the exit date of 08/05/20, the surveyor had not received any evidence of the text blast messages or any representative/family notifications. On 08/04/20 at 8:59 AM, the NHA provided via email information that families were notified of the facility's COVID status by the Assistant Director of Nursing (ADON), Director of Nursing (DON), and Social Worker on 06/22/20, 07/11/20, and 07/22/20. During a phone interview on 08/04/20 at 12:10 PM, the DON confirmed their first positive result for a staff member (Staff J, a Certified Nursing Assistant/CNA) was reported to them on 06/20/20, and the second reported positive staff member (Staff K, a CNA) was on 07/03 or 07/04/20. The DON explained that after the second positive staff member was identified, the facility then started having positive COVID-19 results for residents. During a phone interview on 08/04/20 at 2:34 PM, the Social Services Director (SSD) was asked if she assisted with the notification to residents and or representatives/families of the COVID-19 status in the facility. The SSD stated she didn't know the status of the facility as far as how many cases, but she told alert and oriented residents that there were positive cases in the building and that they were separating them from the 'negative residents'. The SSD stated she did not remember the couple of dates that she did this, but that they printed out a census and checked off the residents as they told them. The SSD stated she did not document anything in the record. The SSD was asked to locate and provide evidence of the notifications made to the residents that she and the other two managers completed. On 08/04/20 at 4:20 PM and 08/05/20 at 11:34 AM, the surveyor received emails with evidence of notification to residents (as noted by a checkmark) for 06/22/20, 07/11/20, and 07/21/20. Interview and record review revealed the following regarding the lack of notification to residents, representatives and families of the positive COVID-19 results: On 06/20/20, the facility was notified of Staff J's positive COVID-19 results. The facility verbally notified residents on 06/22/20, failing to notify anyone of the positive COVID-19 result by 5 PM on 06/21/20. On either 07/03 or 07/04/20 (as per the DON who did not have the actual results), the facility was aware of Staff K's positive COVID-19 results. The facility failed to notify anyone by 5 PM on 07/05/20. Resident #13 was transferred to the hospital on [DATE] and tested positive for the COVID-19 virus that same day. The facility failed to notify anyone by 5 PM on 07/10/20. Resident #14 was transferred to the hospital on [DATE] and tested positive for the COVID-19 virus that same day. The facility provided evidence of notification to residents on 07/11/20, but not to any representatives or families. Resident #5 was transferred to the hospital on [DATE] and tested positive for the COVID-19 virus that same day. The facility provided evidence of notification to residents on 07/11/20, but not to any representatives or families. Resident #15 was transferred to the hospital on [DATE] and tested positive for the COVID-19 virus that same day. The facility failed to notify anyone by 5 PM on 07/13/20. Residents #16 and #17 were both tested at the facility on 07/14/20 and received positive results reported on 07/16/20. The facility notified residents on 07/21/20, but failed to notify anyone by 5 PM on 07/17//20. During a phone interview on 08/04/20 at 3:46 PM, the Emergency Contact for Resident #8 explained she had heard about the COVID-19 outbreak because she provides direct care at the local hospital. When asked if she was being notified on a weekly basis and with new positive COVID-19 cases, of the COVID-19 status in the facility, the Emergency Contact stated, 'Not at all'. She explained that she has provided the facility with both her home phone number that has an answering machine that staff could leave a message, and has also provided the facility with her cell phone number. The Emergency Contact stated they have never tried to call or text her cell phone. During a phone interview on 08/05/20 at 10:23 AM, when asked if he had received any notification of the COVID-19 status of the facility, the Emergency Contact for Resident #10 responded 'Not at all'. The Emergency Contact stated he was only notified back in June 2020 when they were going to test all the residents, and then when Resident #10 had the positive result. During a phone interview on 08/05/20 at 10:41 AM, when asked if she had received any notification of the COVID-19 status of the facility, the Emergency Contact for Resident #9 stated when they called to let her know that the resident was being moved to another room, she asked the staff member why and the staff told her because they had 38 cases of COVID-19 in the building. The Emergency Contact stated the only other time she was called or notified of anything was a couple of months ago when they had just one case. As of the phone exit conference on 08/05/20 at 3:42 PM, the NHA was asked about the weekly notification of facility COVID-19 status to representatives and families, and the NHA stated she just put that in place upon her arrival to the facility. The NHA officially took over this facility as of 07/27/20, transferring from a sister facility. 2. On 07/30/20 at 11:05 AM, an interview with Resident #2 revealed the facility does not keep him updated on the positive COVID-19 cases in the building. Clinical record review revealed the annual minimum data set (MDS) reference date 07/09/2020 showed evidence of a brief interview for mental status (BIMS) score of 13, indicated the resident was cognitively intact. The record lacked adequate evidence of notifications to the resident and family of the covid-19 status in the building. The only note that was in Resident # 2's record regarding notification was dated for 07/11/20 at 5:52 PM written as follow: notifications made to (Resident #2). The note did not even indicate what type of notifications was made. There were no indications in the records that the resident was updated on the COVID-19 status of the facility.

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