STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145714	A. BUILDING _____ B. WING _____	04/27/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OAK PARK OASIS	625 NORTH HARLEM OAK PARK, IL 60302

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 -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This deficiency resulted in two deficient practice statements: 1. Based on the coronavirus global pandemic that resulted in the Presidential declaration of a State of National Emergency dated [DATE], the Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) Memo QSO-,[DATE] revised on [DATE] and QSO-,[DATE]-NH dated [DATE], Nursing Home guidance from the Centers for Disease Control (CDC) and observation, interview and record review the facility failed to follow appropriate standard and transmission based infection control practices to prevent spread of COVID 19 for three (R1, R2, and R3) of three residents exposed to COVID 19 positive residents in the sample of five. These failures resulted in an Immediate Jeopardy to the health and safety of all residents in the facility. The IJ began on [DATE] at 4:20pm when the Social Service Designee (SSD) was observed to deliver R1's lunch tray to his room without proper PPE (Personal Protective Equipment). R1 was currently on standard and transmission based precaution. The SSD only had a mask and gloves on. The SSD was also observed to remove her gloves inside R1's room without performing hand hygiene, exited the room and donned a new pair of gloves outside R1's room. Shortly thereafter, Nurse Aide1 (NA1) was observed to enter R1's room with R2's (roommate of R1) lunch tray without PPE. NA1 only had a mask and gloves on. The facility had 10 residents positive for COVID-19 that were currently hospitalized and was located in a county with sustained community transmission, with many active COVID-19 cases and deaths. Findings include: According to the Centers for Disease Control and Prevention (CDC), 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 severe infections, hospitalization s, and death .Recent experience with outbreaks in nursing homes has also reinforced that residents with COVID-19 may not report typical symptoms such as fever or respiratory symptoms; some may not report any symptoms. Unrecognized asymptomatic and pre-symptomatic infections likely contribute to transmission in these settings .In addition to the actions described above, these are things facilities should do when there are COVID-19 cases in their facility or sustained transmission in the community. Healthcare Personnel Monitoring and Restrictions: Because of the higher risk of unrecognized infection among residents, universal use of all recommended PPE for the care of all residents on the affected unit (or facility-wide depending on the situation) is recommended when even a single case among residents or HCP is identified in the facility; this should also be considered when there is sustained transmission in the community . On [DATE] at approximately 10:30am, during the entrance conference with the Administrator and the Director of Nursing (DON), both were asked whether the facility had confirmed cases of COVID-19. The Administrator answered, Yes, we have 10 residents who tested positive for COVID-19 but they're in the hospital now. When asked if they have residents currently on isolation, the DON responded, Yes, we have few residents on isolation and most were roommates of the residents who tested positive for COVID-19. The DON explained, We put them on contact and droplet precautions that's why you see those isolation cart set-up outside their rooms. When asked about the facility's personal protective equipment inventory, the Administrator replied, We do not have problems with our inventory. We are fully stocked. During a tour with E2 at 4:30pm in the facility's Central Supply room. E2 stated, Look these are our gowns, masks and gloves over there (while pointing to a stack of boxes) I told you we are good. 1. Review of R3's electronic health record (EHR) revealed R3 (age 73) had [DIAGNOSES REDACTED]. R3 was on standard and transmission based precaution after she was exposed to her roommate (R5) who was diagnosed with [REDACTED]. Further review of R5's EHR under Progress Notes revealed R5 was transferred to the hospital on [DATE] via ambulance wherein she was tested positive for COVID-19. On [DATE] at approximately 11:20am, E1 was observed exiting R3's room with gloves and mask on. E1 failed to remove his gloves upon exiting R3's room. E1 then proceeded to the housekeeper's cart in the hallway where he discarded the soiled gloves. Review of R3's Nursing Progress Notes dated [DATE] 15:59pm, revealed, Note text: Resident received in bed .observed experiencing dyspnea and confusion. Lungs were congested with sounds of wheezes. Writer assessed resident. vitals were ,[DATE] (blood pressure), 48% (oxygen saturation), 152bpm (beats per minute), 53rr (respiratory rate), 97.5 (tempearture) .immediately call 911 .upon arrival 911 refused to come into the facility stating that we had to bring the bed ridden resident down in a wheelchair ot in her bed. they also stated that they did not wish to come inside because they would have to put all of their gear on just to come inside. despite the emergent situation, 911 remained in the lobby forcing writing and other assisting staff members to have to bring her down in her bed .Resident was admitted to ICU (Intensive Care Unit) . Review of an email correspondence from the DIrector of Clinical Services (DCS) dated [DATE] 1:06pm indicated, .Today the Village Fire Chief notified us that resident (R3) was retested later and tested positive (COVID19). Hospital did not notify us of this. We are trying to verify . Review of an email correspondence from the Administrator dated Friday, [DATE] 2:19pm revealed, Resident is now deceased . Review of an email correspondence dated [DATE] 2:22pm from the DCS indicated, She (R3) expired same day she was taken to hospital. R3's hospital records were requested from the facility. There were no hospital records received prior to the survey's exit. 2. Review of R1's electronic medical record (EHR) revealed R1 (age 97) was admitted to the facility with [DIAGNOSES REDACTED]. R1 was moved to room ,[DATE] when his roommate R4 tested positive for COVID-19 and was transferred to the hospital. R1 then was placed on droplet precautions. Review of R4's (age 68) EHR revealed R4 had [DIAGNOSES REDACTED]. Further review of R4's EHR under Progress Notes revealed, XXX[DATE] .at approximately 1200 CNA (Certified Nurse Assistant)reported that resident was not acting himself. Writer went in to access. Resident was very confused, not able to follow simple commands, and had a constant shaking. Resident's vitals were as follows ,[DATE] (blood pressure), 100 (pulse rate), 22 (respiratory rate), 84% (oxygen saturation) RA (room air), 99.3 (temperature). Writer applied 2L O2 NC (2 liters of oxygen per nasal canula). O2 went up to 95. MD (name of physician) paged at 1215 . Review of the facility's list titled Residents tested COVID and Presumptive dated [DATE] provided by the facility revealed R4 was tested positive for COVID19 on [DATE] and was currently hospitalized . Review of an email correspondence with the Administrator on [DATE] at 1:32pm revealed R4 shared a room with R1 and R2 prior to his transfer to the hospital. On [DATE] at 12:10pm, the Social Service Designee (SSD) was observed delivering R1's lunch tray (R1 was on standard and transmission based precaution) to his room. The SSD did not have an isolation gown, only had her gloves and mask on. While inside the room, the SSD was observed to reposition R1's over bed table next to his bed. R1 did not have a mask on (for source control). On her way out the SSD removed her gloves and exited R1's room without performing hand hygiene. The SSD then retrieved a new pair of gloves from the infection control cart outside R1's room. The cart was observed to be fully stocked with PPEs (masks, isolation gowns and gloves). 3. Review of R2's EHR revealed R2 (age 66) had [DIAGNOSES REDACTED]. R2 was moved into room [ROOM NUMBER] and was on standard and transmission based precaution after he was exposed to his former roommate (R4) who tested positive for COVID-19 and was currently in the hospital. On [DATE] at approximately 12:15pm, Nurse Aide1 (NA1) was observed to deliver R2's (R1's roommate) lunch tray. NA1 only had her mask and gloves on. NA1 repositioned the over bed table while touching R2's bed and curtain in the process. R2 did not have a mask on (for source control). The Director of Nursing (DON) who observed the occurrence immediately asked NA1, Why are you not wearing an isolation gown? NA1 responded, I thought we are only using isolation gowns during resident cares. The DON replied to NA1 that staff should don complete PPE including gown when

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 -** Some	(continued... from page 1) entering an isolation room especially when there were identified positive cases in the facility. On [DATE] at approximately 1:05pm, the DON was asked about the observations. The DON confirmed staff should have donned mask, gown, and gloves before entering the room even if they were only passing trays. The DON was asked about the isolation signage on the door. The DON went out of the conference room and viewed the isolation signage posted outside the rooms. The signage was only for droplet precaution. The DON stated, Honestly, this is the first time I've seen this. This is not the same signage we had yesterday. It should be for both. When asked what she meant by both. The DON explained, It's for contact and droplet. The DON continued, Regardless, staff should don complete PPE (mask, gown, gloves) when entering isolation rooms and that included wearing a gown. That's why we have the isolation cart set up right outside. When asked about the lack of hand hygiene in between glove changes, the DON confirmed the SSD should have performed handwashing or used alcohol gel prior to exiting the room and before donning a new pair of gloves. On [DATE] at approximately 3:30pm, the DON stated It's different if we have shortage of PPE but we do not- so no excuse at all (referring to staff not using the isolation gowns). On [DATE] at approximately 12:05pm, NA2 was observed delivering a lunch tray inside room [ROOM NUMBER] an isolation room. NA2 had a gown and mask on but did not have gloves. In addition, NA2 exited the room without first removing his isolation gown. When asked whether he had training about proper PPE usage, NA2 stated that he had attended one last week. When asked why he did not have gloves on and why he did not remove his isolation gown prior to exiting the R2's room, NA2 did not provide an answer. When asked if he followed the proper use of PPE when entering and exiting an isolation room, NA2 just shook his head and walked towards 1 pavilion's nurse's station. On [DATE] at approximately 12:20pm the Director of Clinical Services (DCS) was informed of the observation. The DCS stated, They just have (sic) their training and there's a sign posted on the door as guide. The DCS verbalized that not using the available PPE defeated the purpose of having a fully stocked isolation cart set up outside the isolation rooms. On [DATE] at approximately 12:50pm during unit observations with the RNC the following were observed: A. On the second floor NA3 and NA4 were observed standing next to each other in front of the dining cart. Both failed to observe the six feet social distancing recommendations. B. On the second floor a dietary aide (DA) was observed in the hallway carrying two plates of food with only his mask and gloves on. The DCS stopped the DA and asked the DA why he was not wearing his gown per their protocol. After the dialogue with the dietary aide, the DCS verbalized, They've been in-serviced and reminded. C. On the first floor E3 was observed to remove her isolation gown right in the hallway and placed the used gown on top of the isolation set up cart. E3 then took a new gown from the isolation cart and donned a new gown. The RNC stopped E3. E3 then asked the RNC what was the concern. The DCS explained to E3 the proper sequence in donning and doffing PPEs. Review of the facility's [MEDICAL CONDITION] Policy revised on [DATE] revealed under Policy: This policy is to educate, prevent, identify and treat the Coronavirus .Coronavirus in humans can cause the common cold and range to severe respiratory infections even leading to death. Symptoms: Generally manifest within ,[DATE] days after being infected .Signs/symptoms of lower respiratory illnesses: Fever, Cough, Shortness of Breath, Sometimes Pneumonia and [MEDICAL CONDITION] .Respiratory germs prevention spread WITHIN your facility: Make sure PPE, including gowns, gloves, masks, eye protection are available immediately outside door. Review of the facility's Infection Control policy dated ,[DATE] under Standards revealed, .14. All facility personnel are required to routinely wash hands and use appropriate barrier precautions to prevent transmission of infections. 15. All facility personnel shall adhere to the Infection Control Program in the performance of their daily assignments. Employees disregarding the facility's policies and procedures shall be retrained as necessary, disciplined, and may be discharged for repeated non-compliance. 16. The facility shall assure that necessary training, equipment and supplies are maintained to carry out an effective Infection Control Program. 17. The facility shall inform the public of the IL State Department of Health's Universal Precautions Rule by posting same in a location accessible to the public, residents and staff. The notice shall also be included in the resident admission informational packet. 18. Handwashing is essential. Alcohol based hand rubs/gels is the Gold Standard of Prevention. 19. Contact precautions in addition to standard precautions will be initiated as specified in the specific isolate policy . Based on the CMS QSO ,[DATE]-NH dated [DATE] revealed under Guidance fo limiting the transmission of COVID-19 for Nursing Homes .1. Cancel communal dining and all group activities, such as internal and external group activities .3. Remind residents to practice social distancing and perform frequent hand hygiene. Review of an article from CDC (Centers for Disease Control) revealed under In addition to the actions described above, these are things facilities should do when there are COVID-19 cases in their facility or sustained transmission in the community .these are things facilities should do when there are COVID-19 cases in their facility or sustained transmission in the community . Resident Monitoring and Restrictions: Encourage residents to remain in their room. If there are cases in the facility, restrict residents (to the extent possible) to their rooms except for medically necessary purposes . If they leave their room they should wear a cloth face covering or facemask, perform hand hygiene, limit their movement in the facility, and perform social distancing (stay at least 6 feet away from others) . Remind residents to practice social distancing and perform frequent hand hygiene . Educate residents and families including, information about COVID-19; actions the facility is taking to protect them and/or their loved ones, including visitor restrictions; and actions they can take to protect themselves in the facility, emphasizing the importance of social distancing, hand hygiene, respiratory hygiene and cough etiquette, and wearing a cloth face covering . https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhealthcare-facilities%2Fprevent-spread-in-long-term-care-facilities.html#cases-in-community In addition under Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings dated [DATE] reveaeld under Recommendations .2. Adhere to Standard and Transmission-Based Precautions .Personal Protective Equipment .The PPE recommended when caring for a patient with known or suspected COVID-19 includes: Respirator or Facemask (Cloth face coverings are NOT PPE and should not be worn for the care of patients with known or suspected COVID-19 or other situations where a respirator or facemask is warranted) Eye Protection - Put on eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face) upon entry to the patient room or care area, if not already wearing as part of extended use or reuse strategies to optimize PPE supply. Gloves - Put on clean, non-sterile gloves upon entry into the patient room or care area. Change gloves if they become torn or heavily contaminated. Remove and discard gloves when leaving the patient room or care area, and immediately perform hand hygiene. Gowns - Put on a clean isolation gown upon entry into the patient room or area. Change the gown if it becomes soiled. Remove and discard the gown in a dedicated container for waste or linen before leaving the patient room or care area. Disposable gowns should be discarded after use . https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Finfection-control%2Fcontrol-recommendations.html The immediacy was removed on [DATE] at 4:41pm when the facility implemented the following: 1. The facility re-educated all staff on general infection control with emphasis on proper PPE use, accurate donning and doffing procedure and hand hygiene in between gloving. 2. Revised and replaced isolation door signage as appropriate 3. Revised its plan for staffs' gown distribution 4. Assigned the DON to be ultimately responsible in the close monitoring of staff in the first floor and the ADON in the second floor to ensure direct care staff followed appropriate PPE protocol 5. Both the DON and the Administrator will consistently monitor new memorandum and guidelines daily from CDC, DHHS and CMS and disseminate the information timely as needed. 2. Based on the unprecedented coronavirus global pandemic that resulted in the Presidential declaration of a State of National Emergency dated [DATE], the Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) Memo QSO-,[DATE]-NH revised on [DATE], Nursing Home guidance from the Centers for Disease Control (CDC), interview and record review, the facility failed to 1) establish a facility-wide Infection Control Prevention Program including standards, policies and procedures that are current and based on national standards; 2) develop and implement measures to contain the possible spread of COVID-19, as evidenced by failures to establish a facility-wide surveillance plan that used evidenced-based surveillance criteria to define infections, appropriately track and analyze resident infections to recognize possible trends or outbreaks; and 3) monitor for signs and symptoms to prevent the development of COVID-19 for four residents (R6, R7, R8, and R9) reviewed for infection control. These failures had the potential to affect all 97 residents in the facility. Findings include: Review of the facility's List of residents who tested positive (for COVID-19) provided by the Administrator via email on [DATE] at 12:34pm revealed that the facility had 10 residents who were hospitalized with COVID-19 and 19 residents as PUI (Person Under Investigation) or considered under the presumptive case. A. Review of the facility's Infection Control Summary dated February 2020 revealed that the facility had a census of 119, admitted with two residents with infections, six nosocomial infections, and had an infection rate of 2.3%. There were no additional surveillance logs provided by the facility other than the February 2020 Infection Control Summary. Interview

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) with the DCS (Director of Clinical Services) on [DATE] at 12:24pm, when requested for the Infection Control Surveillance for January, March, and [DATE], the DCS indicated that she will check the DON (Director of Nursing) and ADON (Assistant Director of Nursing) computers and later revealed This is all (referring to the February 2020 Infection Control Summary) I found. I spoke with Nurses on units too and they don't remember anyone else being on isolation this year. In a follow-up interview with the DCS on [DATE] at 9:07am, the DCS stated that the ADON (Assistant Director of Nursing) was responsible in tracking infections and her DON (Director of Nursing) who started this month was doing it, and April is not even done yet. It is usually a month later when it gets to the QA. When asked if the facility had a working and ongoing surveillance tracking and trending, the DCS indicated I cannot answer that because I am not in the facility. I did not find anything. In the same interview when the DCS was asked about the facility's Infection Report and Surveillance Procedures that included the policies and procedures dated [DATE], the DCS confirmed that this was the current policy. Review of the facility's Infection Control Policy dated [DATE] revealed Purpose: To establish methods and criteria, necessary within the facility and its operation, to prevent and control infections and communicable diseases .Policy: It is the policy of 'this facility to maintain an infection control program designed to provide a safe, sanitary and comfortable environment, and to prevent or eliminate when possible the development and transmission of disease and infection .Standards .6. All infection control policies and procedures will be reviewed annually by the Quality Assurance Committee and revised as needed. Department Heads are responsible for assuring personnel are made aware of all revisions to respective policies and procedures .7. The program provides for the recording of each suspected infection and surveillance activities as they relate to individual resident infections. A log is maintained of suspected and actual infections . According to the CMS QSO Memo ,[DATE] NH dated [DATE] revealed .Furthermore, we remind facilities that they are required to have a system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility, and when and to whom possible incidents of communicable disease or infections should be reported (42 CFR 483.80(a)(2)(i) and (ii)) . Review of the article titled The SHEA (Society for Healthcare Epidemiology of America)/APIC (Association for Professionals in Infection Control and Epidemiology) Guideline: Infection Prevention and Control in the Long-Term Care Facility, published in the [DATE] issue of AJIC (American Journal of Infection Control), stated: .To establish baseline infection rates, track progress, determine trends and detect outbreaks, site-specific rates should be calculated .Analysis and reporting of surveillance data: Analysis of absolute numbers is misleading; calculation of rates provides the most accurate information .Infection control data, including rates, then need to be displayed and distributed to appropriate committees and personnel (including administration) and used in planning infection control efforts. The data should lead to specific interventions such as education and control programs. B. Review of the facility's [MEDICAL CONDITION] Policy revised on [DATE] revealed under Policy: This policy is to educate, prevent, identify and treat the Coronavirus .Definition: COVID-19 is a beta coronavirus that rapidly developed into an epidemic centered in China. [MEDICAL CONDITION] is commonly found in bats, rabbits, camels and anteaters. Coronavirus in humans can cause the common cold and range to severe respiratory infections even leading to death. Symptoms: Generally manifest within ,[DATE] days after being infected .Signs/symptoms of lower respiratory illnesses: Fever, Cough, Shortness of Breath, Sometimes Pneumonia and [MEDICAL CONDITION] .Respiratory germs prevention spread WITHIN your facility: Make sure PPE, including gowns, gloves, masks, eye protection are available immediately outside door. Further review of the same policy did not include to actively monitor all residents at least daily for symptoms of COVID-19 (shortness of breath, new or change in cough, sore throat, muscle aches). Review of the document List of Positive Residents (for COVID-19) dated [DATE] revealed: i. R6's onset date of COVID-19 symptoms was on [DATE] and was hospitalized . Review of R6's SPO2 (stands for peripheral capillary oxygen saturation, an estimate of the amount of oxygen in the blood. More specifically, it is the percentage of [MEDICATION NAME] hemoglobin) readings were as follows: XXX[DATE] 12:04am 12:04am 94% room air [DATE] 2:56am 96% room air [DATE] 10:09pm 96% room air [DATE] 2:17pm 96% room air [DATE] 11:47am 98.0% room air . R6's EHR (Electronic Health record) under vital signs revealed that R6's SPO2 was not being monitored every shift since the implementation of the facility's COVID-19 policy on [DATE]. R6's progress notes revealed: [DATE] 4:01pm Social Service .note text: Writer spoke w Note Text: Writer spoke with daughter Elizabeth to provide her with an update regarding positive COVID19 resident in the facility. {Name of R6) is aware to contact the Administrator with any questions/concerns . [DATE] 4:05pm Nursing Progress Note .Resident was experiencing constant productive cough . vitals signs WNL (sic) and as follows ,[DATE], 71, 97.7, 18, 94% MD (physician) was contacted to inform of the change in condition. He ordered to send resident to (name of hospital) for evaluation. Daughter contacted. Nurse consultant aware. endorsed to evening nurse to follow up . [DATE] 5:27pm Nursing Progress Note: Resident is being admitted for UTI and tested positive for Covid-19. all appropriate staff made aware. belongings and meds packed and placed in med room . [DATE] 12:05pm Social Service Note: hospitalization : Resident was transferred to the nursing home due to changes in health. Social service will follow up . [DATE] 4:01pm Nursing Progress Note: Received Resident from (name of hospital) around 12:30 pm per stretcher accompanied by two paramedics of (name of hospital) ambulance in stable condition. Resident is Covid 19 positive per hospital report and is on droplet isolation. Resident also discharged from hospital. Resident noted to be A&O (sic) x ,[DATE] with periods of confusion. Resident's respiration noted to be regular and slightly labored. Bilateral lung fields noted to be moderately diminished. Resident presents no cough at present time. No SOB (sic)or respiratory distress. Resident ate his lunch meal and is currently resting in bed .T 98.8 P 72 R 18 BP ,[DATE] O2 sat 96% on RA (sic) . [DATE] 08:33am Nursing Progress Note .droplet isolation precautions maintained . [DATE] 12:40am Nursing Progress Note .droplet precaution maintained throughout shift . Review of R6's progress notes failed to reveal evidences that R6's respiratory status was being assessed and monitored every shift or at least daily since the implementation of the facility's COVID-19 policy on [DATE]. Review of R6's EMAR (Electronic Medication Administration Record) revealed R6's SPO2, temperatures, respiratory rates, presence of coughing and shortness of breath were only monitored on [DATE], and 23, 2020 since the implementation of the facility's COVID-19 policy on [DATE]. ii. R7's onset date of COVID-19 symptoms was on [DATE]. R7 was hospitalized and expired in the hospital on [DATE]. Review of R7's progress notes revealed: [DATE] 3:08pm Social Service Note .Writer spoke with brother (name of brother) to give update on resident during Shelter in Place Order. No questions or concerns at this time . [DATE] 10:05pm Nursing Progress Note .resident vital sign: 98.7 T, R17, P78, ,[DATE], 99% SAO2 (sic) . [DATE] 2:01pm Nursing Progress Note .Another staff member on unit informed writer that resident was on floor her bedroom. Writer observed resident on all fours next to bed. Vital signs taken: BP: ,[DATE]; P: 108; O2 Sat: 94% on room air; Temp: 96.3; Resp:22. No signs of injury, pain, or distress noted . [DATE] 2:35pm Nursing Progress Note .At about 2:30pm, charge nurse reported to writer that resident is in respiratory distress and hyperventilating at rest upon assessment, Responds to verbal/tactile stimuli, A/Ox2, but falls right back to sleep. She is noted to have general body weakness, her vitals as noted BP: ,[DATE] HR: 105 T: 98.9 RR:29 O2:90%RA .intermittent Non-productive cough/SOB noted. Increased effort in inspiration and expiration. denies any chest pain. diminished lungs sounds to bilateral lower lobes. NP (Nurse Practitioner) notified and gave orders to send to hospital for further eval. (sic) .ambulance called and report called to hospital, spoke to RN (Registered Nurse) facial mask provided to resident. will continue to monitor for any further changes . Review of R7's progress notes failed to reveal evidence that R7's respiratory status was being assessed and monitored every shift or at least daily since the implementation of the facility's COVID-19 policy on [DATE]. Review of R7's EMAR revealed that R7's respiratory rates, presence of coughing and shortness of breath were only monitored on [DATE], 10, 11, and 17, 2020 since the implementation of the facility's COVID-19 policy on [DATE]. iii. R8's onset date of COVID-19 symptoms was on [DATE]. R8 was hospitalized and expired in the hospital on [DATE]. Review of R8's progress notes revealed: [DATE] 3:27pm Social Service Note .Writer called (name of resident representative) to give update on resident during Shelter in Place Order. voicemail left . [DATE] 5:14pm Social Service Note .Writer left voicemail for State Guardian to give her an update regarding positive COVID19 resident in the facility . [DATE] 6:38pm Nursing Progress Note .At about 6pm, staff reported to writer that resident is out of his baseline and didn't eat his lunch nor dinner, upon assessment, his vitals as noted BP:,[DATE] HR;111 T:100.2 RR:20 O2 (sic):94%RA. No cough/SOB noted. denies any chest pain. Md notified and gave orders to send to hospital for further eval. ambulance called and given an ETA (sic) of 30 mins. VM (sic) left for POA (sic) .at about 6:48pm . [DATE] 7:00pm Nursing Progress Notes .2 attendants here to transport resident via stretcher. he remains awake, A/O (sic) x1 . [DATE] 10:14pm Nursing Progress Note .called placed to hospital, resident tested positive for Covid-19 and is being admitted . all belongings and meds packed and placed in med room. all appropriate staff made aware [DATE] 12:01pm Social Service Note .Resident was transferred to the hospital due to changes in health. Social service will follow up . [DATE] 4:25pm Social Service Note .Dr (name of physician) reviewed his records & gave medical ok for readmission. Per Dr (name of physician), pt is not on oxygen [MEDICATION NAME] or chloroquine . [DATE] 08:36am Nursing Progress Note .droplet isolation precautions maintained . Review

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

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 3) of R8's progress notes failed to reveal evidences that R8's respiratory status was being assessed and monitored every shift or at least daily since the implementation of the facility's COVID-19 policy on [DATE]. Review of R8's EMAR revealed that R8's respiratory rates, presence of coughing and shortness of breath were only monitored on [DATE], 18, and 19, 2020 since the implementation of the facility's COVID-19 policy on [DATE]. iv. R9's onset date of COVID-19 symptoms was on [DATE] and was hospitalized . Review of R9's vital signs record revealed that oxygen saturation rate (SPO2) was not being monitored. The last documented SPO2 of R9 was on [DATE]. Review of R9's progress notes revealed: [DATE] 3:57pm Social Service Note .Writer spoke with sister (name of R9's sister) to give update on resident during Shelter in Place Order. No questions/concerns at this time . In addition, review of R9's progress notes dated [DATE] 4:4