STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265159	A. BUILDING _____ B. WING _____	07/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MARY, QUEEN AND MOTHER CENTER	7601 WATSON ROAD SHREWSBURY, MO 63119

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	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review and in accordance with Centers for Disease Control and Prevention (CDC) guidelines for 2019 Novel Coronavirus disease 2019 (COVID-19, an infectious disease caused by severe acute respiratory syndrome coronavirus 2 ([DIAGNOSES REDACTED]-CoV-2). Common symptoms include fever, cough, fatigue, shortness of breath, and loss of smell and taste), the facility failed to protect residents in the facility by not following acceptable infection control practices for COVID-19. The facility placed a resident (Resident #3) who had an increased risk of infection, was receiving [MEDICAL CONDITION], had tested negative for COVID-19 and did not meet the definition to be placed on the COVID-19 unit per facility policy, on the Veronica Hall COVID-19 unit. During meal service, staff failed to remove potentially contaminated gloves and gown after entering a room of a resident positive for COVID-19 (Resident #5) and before entering the room of Resident #3. Three residents (Residents #12, #10 and #11) tested positive for COVID-19 and were transferred to Veronica Hall between the dates of [DATE] and [DATE], when the facility transitioned the Veronica Hall into the COVID-19 unit. A resident (Resident #8) was a resident on Veronica Hall prior to it becoming the COVID-19 unit, was negative for COVID-19 at the time Veronica Hall was transitioned to the COVID-19 unit and was not moved off the unit. He/she later tested positive for COVID-19. The resident expired on [DATE]. The facility failed to ensure a resident (Resident #9), identified as a person under investigation (PUI) for COVID-19, remained off of the positive COVID-19 unit while test results were pending. The resident never tested positive for COVID-19 and remained on the unit from [DATE] until [DATE]. In addition, the facility failed to follow acceptable infection control practices when they failed to post notice of contact precautions for one resident (Resident #1) with [MEDICAL CONDITION] ([MEDICAL CONDITION], a bacterium that causes diarrhea) which resulted in a staff person entering the room without the required personal protective equipment (PPE) and failed to follow proper infection control practices when checking a resident's blood sugar level (Resident #4). At the time of the survey, the Veronica Hall COVID-19 unit contained 13 residents. Of those 13 residents, four had not been identified as positive for COVID-19 on the facility's COVID-19 tracking log as of [DATE]. This failure had the potential to affect all residents determined by the facility to be PUI. The resident sample was 12. The census was 98. The administrator was notified on [DATE] at 2:25 P.M. of an Immediate Jeopardy (IJ) which began on [DATE]. The IJ was removed on [DATE], as confirmed by surveyor onsite verification. Review of the CDC.gov website, updated [DATE], showed Preparing for COVID-19 in Nursing Homes: -These recommendations supplement the CDC's Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings and are specific for nursing homes, including skilled nursing facilities; -If extended use of gowns is implemented as part of crisis strategies, the same gown should not be worn when caring for different residents unless it is for the care of residents with confirmed COVID-19 who are cohort in the same area of the facility and these residents are not known to have any co-infections (e.g., [MEDICAL CONDITION]); -Identify space in the facility that could be dedicated to care for residents with confirmed COVID-19. This could be a dedicated floor, unit, or wing in the facility or a group of rooms at the end of the unit that will be used to cohort residents with COVID-19: -Identify health care providers who will be assigned to work only on the COVID-19 care unit when it is in use; -Have a plan for how residents in the facility who develop COVID-19 will be handled: -Residents in the facility who develop symptoms consistent with COVID-19 could be moved to a single room pending results of [DIAGNOSES REDACTED]-CoV-2 testing. They should not be placed in a room with a new admission nor should they be moved to the COVID-19 care unit unless they are confirmed to have COVID-19 by testing. While awaiting results of testing, health care providers should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown when caring for these residents. Cloth face coverings are not considered PPE and should only be worn by health care providers for source control, not when PPE is indicated. Review of the facility's COVID-19 Action Plan, dated [DATE], showed: -Policy statement: As of today, the following action plan captures the most up to date information enabling the facility to be proactive in adopting practices to keep our residents, staff, and visitors safe. The practices are based on infection prevention and control recommendations from the CDC and World Health Organization (WHO) and is based on the currently limited information available about COVID-19. The information is subject to change as more information becomes available; -Background: [MEDICAL CONDITION] that causes COVID-19 places residents at senior living and skilled nursing communities at the highest risk. The incubation period is two to 14 days and there are reports of transmission before a patient is symptomatic. Current symptoms have included mild to severe respiratory illness with fever, cough, and difficulty breathing. It has also been determined older adults and individuals with severe chronic medical conditions, such as heart, lung or kidney disease are at higher risk. Person to person transmission most commonly occurs during close exposure to a person infected with COVID-19, primarily via respiratory droplets produced when the infected person coughs or sneezes. Droplets can land in the mouths, noses or eyes of people who are nearby or possibly be inhaled into the lungs of those within close proximity. It may also be possible that a person can get COVID-19 by touching a surface or object that has [MEDICAL CONDITION] on it and then touching their mouth, nose or possibly their eyes; -Definitions: -Standard Precautions: Infection prevention practices that apply to all residents, regardless of suspected of confirmed [DIAGNOSES REDACTED]. Standard precautions are based on the principle that all blood, body fluids, secretions, excretions except sweat, regardless of whether they contain visible blood, non-intact skin, and mucous membranes may contain transmissible infectious agents; -Transmission based precautions: The second tier of basic infection control are to be used in addition to standard precautions for patients who may be infected of colonized with certain infectious agents for which additional precautions are needed to prevent infection transmission; -Contact precautions: Procedures that reduce the risk of spread of infections through direct or indirect contact. Transmission occurs with physical contact of the infected patient or handling of a contaminated object in the infected patient room; -Droplet precautions: Refer to actions designed to reduce/prevent the transmission of pathogens (harmful microorganisms) spread through close respiratory or mucous membrane contact with respiratory secretions; -PPE: Protective items or garments worn to protect the body or clothing from hazards that can cause an injury and to protect residents from cross-contamination. This includes but is not limited to gloves, gowns, goggles, facemasks or respirators; -Cohort: Practice of grouping residents infected with the same infectious agent together to confine their care to one area and prevent contact with susceptible residents. During outbreaks, healthcare staff may be assigned to a specific cohort of resident to further limit opportunities for transmission; -Hand hygiene: Cleaning one's hands that substantially reduces potential pathogens on the hands. Hand hygiene is considered a primary measure for reducing the risk of transmitting infection among patients and health care personnel. Hand hygiene procedures include the use of alcohol based hand rubs (ABHR, containing 60 percent (%)-95% alcohol) and hand washing with soap and water; -Proactive approach to keep residents, staff and visitors safe: The infection preventionist (IP) will provide education on hand hygiene, use of PPE to include donning (placing on) and doffing (removal), utilization of standard precautions; -Preventing the spread of COVID-19: In an effort to prevent the potential spread of the disease, the following will be implemented for each skilled nursing facility

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) (SNF): -Transition area: Each community will develop a plan that includes an identified area or group of rooms that will be utilized for all residents that have been newly admitted or readmitted to the community and their COVID-19 status is negative or unknown and for current residents that have had a sudden onset of fever greater than 100.0 degrees and/or respiratory symptoms, but have not tested positive for COVID-19; -Recovery area: Each community will develop a plan that includes an identified area or group of rooms that will be utilized for residents that are admitted or readmitted to the community that have been tested and are COVID-19 positive or are current residents that have been tested and are COVID-19 positive; -These two areas will be in separate areas within each community; -A plan for consistent staffing for each of these SNF units will be developed to the best ability of the community; -Suspected COVID-19 positive (sudden onset of fever above 100 degrees and/or respiratory symptoms): -Move the resident to the transition area (private room if available, otherwise cohort with others with like symptoms or diagnoses); -Immediately place the resident on droplet precautions; -Provide isolation set up with gown, facemasks with shield or goggles, gloves and door signage; -Notify the medical provider of the change in condition; -Staff request an influenza (flu) swab, chest x-ray, blood work and perform in house COVID-19 testing; -While waiting for the results of laboratory values and COVID-19 testing, the resident will remain in the transition area; -If the resident's COVID-19 test is positive the resident will immediately be moved to the recovery area; -Staff perform respiratory assessment including vitals every shift; -CDC guidance for PPE: Gowns summary: -Extended use of isolation gowns (disposable or cloth), such as the same gown is worn by the same health care provider (HCP) when interacting with more than one patient know to be infected with the same infectious disease when these patients housed in the same location (COVID-19 patients residing in an isolation cohort). This can be considered only if there are no additional co-infection [DIAGNOSES REDACTED]. Review of the facility's hand hygiene policy, dated [DATE], showed: -Policy: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents and visitors. This applies to all staff working in all locations within the facility; -Definitions: -Hand hygiene: is a general term for cleaning your hands by handwashing with soap and water or the use of antiseptic hand rub or ABHR; -Policy explanation and compliance guidelines: -Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice; -ABHR is the preferred method for cleaning hands in most clinical situations. Wash hands whenever hands are visibly dirty, before eating and after using the restroom; -The use of gloves does not replace hand hygiene. If the task requires gloves, staff should perform hand hygiene prior to donning gloves and immediately after removing gloves. 1. Review of Resident #3's medical record, showed the following: -[DIAGNOSES REDACTED].M., the resident left the facility for a [MEDICAL CONDITION] appointment; -On ,[DATE] through [DATE], no documentation of a coronavirus screenings noted; -On [DATE] at 8:52 A.M., the resident noted to have a temperature (T) of 99.1 (normal range is 97XXX,[DATE].8) Fahrenheit (F), the nurse practitioner (NP) was notified, no new orders received; -At 11:32 A.M., a nasal swab was obtained for COVID-19; -At 1:14 P.M., a call was received from the resident's NP and a new order to test the resident for COVID-19 ordered; -At 3:40 P.M., the resident was moved to the Veronica hall COVID-19 unit. Review of the resident's electronic physician order [REDACTED]. Notify the physician of any acute changes. Further review of the resident's progress notes, showed: -On [DATE] at 8:40 P.M., the laboratory called with critical low hemoglobin (HGB, indicator of [MEDICAL CONDITION]) level. The resident's HGB was 6.9, the physician was notified, and an order received to send the resident to the hospital. At 8:35 P.M., the resident left by ambulance to go to the hospital; -On [DATE] at 7:51 P.M., the resident readmitted to the facility and arrived by ambulance and in route to the Veronica Hall COVID-19 unit in a wheelchair. The resident admitted with a left shoulder fracture and a sling to left shoulder on and intact. Circulation and sensation intact. Diagnosis: [REDACTED]. Review of the resident's hospital discharge summary of care, dated [DATE], showed: -[DIAGNOSES REDACTED]-COV-2 (Covid-19) test: none detected; -an order for [REDACTED]. Four cycles of [MEDICAL CONDITION]. Each cycle of [MEDICAL CONDITION]: 21 days of Capecitabine with seven days off. Start date: [DATE]; -Diagnosis: [REDACTED]. Side effects that are common, occurring in greater than 30% of patients included low white blood cell count. This can put the patient at increased risk for infection. Side effects occurring in about ,[DATE]% of patients included fever. During an interview on [DATE] at 8:35 A.M., Licensed Practical Nurse (LPN) E said the Veronica hall is the unit with residents who have tested positive for COVID-19 or are considered PUI. Review of Resident's #5's medical record, showed: -Resided on the Veronica Hall since [DATE]; -[DIAGNOSES REDACTED].M., showed the resident's Covid-19 test results are negative; -The resident's census report, showed the resident remained on the Veronica Hall during the time it transitioned to the COVID-19 unit; -A progress note, dated [DATE] at 12:03 P.M., a nursing note: A nasal swab obtained for COVID-19 with the resident's consent. The specimen ready for pick up; -Review of the COVID-19 laboratory report, showed: -COVID-19 sample collected on [DATE] at 9:43 A.M.; -Reported results: Positive; -Further review of the progress notes, showed on [DATE] at 1:14 P.M., the facility received the resident's COVID-19 test results. The resident tested positive. Observation on [DATE] of the Veronica hall COVID-19 unit, showed: -At 8:39 A.M., the fire doors closed and four signs posted on the outside of the fire doors: -An 8 x 11 inch laminated paper stated Stop, contact and droplet precautions in addition to standard precautions; -A sign Stop droplet precautions. Everyone must clean hands before and after entering and exiting rooms. Make sure eyes, nose and mouth are covered before room entry and remove face protection before room exit; -A sign All staff must wear N95 mask at all times in patient care areas; -A picture display instructing persons how to don and doff a surgical mask and apply hand sanitizer; -At 11:26 A.M., a food cart contained approximately 13 Styrofoam container meals left on the unit just inside the closed fire doors. The top level of the food cart contained beverage pitchers and disposable utensils. The lower level contained multiple pieces of dessert covered with a single sheet of large plastic wrap; -At 11:30 A.M., two certified nurse aides (CNAs) wore N95 masks, approached the meal cart and donned disposable isolation gowns, gloves and a face shield from an isolation PPE cart outside of the first occupied room at the top of the hall and started passing the meals to resident rooms; -The CNAs passed the individual meals, drinks and desserts to eight resident rooms without changing any of their PPE, including gowns and gloves. No hand hygiene performed between the different resident rooms. A CNA entered the room of Resident #5 (positive for COVID-19) and passed the tray. He/she exited the room with the same PPE and without performing hand hygiene, obtained a new food tray from the food cart and passed it to Resident #3 (negative for COVID-19); -At 12:00 P.M., observation of Resident #3's room, showed a sign on the door, which read contact precautions. The door stood open and a three drawer isolation supply container located outside the door. The resident walked without assistance to the doorway and talked to the staff. During an interview on [DATE] at 12:51 P.M., the IP said staff may don droplet PPE on the Veronica unit and pass individual meal trays to residents and wear the same PPE room to room. The staff must doff the worn PPE if the staff touch the resident in the room or provide any care, staff then should perform hand hygiene before leaving the room and then would don PPE before resuming the meal tray pass. The IP then said, at a minimum, all staff should be doffing and donning gloves and performing hand hygiene before entering and exiting any resident room. That is standard infection control practice. The Veronica unit houses both resident's considered PUI and active COVID-19 positive residents. If staff do not wash hands in between room passes that could increase the transmission of COVID-19 among the unit residents. Staff should have completely changed PPE, except the N95 masks, after passing a meal to Resident #5 and before passing a tray to Resident #3. During an interview on [DATE] at 12:20 P.M., the administrator said the residents who are on the Veronica Hall COVID-19 unit have either tested positive or are a PUI. Resident #3 was moved to the unit because he/she had symptoms of COVID-19. Resident #3's COVID-19 test results are pending. When the resident was readmitted to the facility, he/she was readmitted to the Veronica hallway because he/she would be under investigation/observation for 14 days, because the resident had been in the hospital. During an interview on [DATE] at 2:00 P.M., the administrator and the IP said Resident #3 had been moved onto the Veronica unit because he/she was having COVID-19 like symptoms. The resident had a temperature of 99.4 F, and the nurse practitioner ordered a COVID-19 test. Later that day the resident was sent to the hospital for critical labs. While the resident was at the hospital, the hospital obtained a COVID-19 test, and the results were negative and had been reported back to the facility when the resident was readmitted . When the resident was readmitted to the facility, the resident would be considered under investigation because he/she was in the hospital. If space allows, the facility tries to keep those residents who are admitted or readmitted to the facility at the top of the hallway in the rooms on the outside of the fire doors of the Veronica hall for transition or observation. These room are based on availability. When the resident was readmitted , those rooms were occupied, so the resident was admitted on the COVID-19 positive hallway, the Veronica unit/hall, for 14 days. At this time the laboratory had not provided the COVID-19 test results from the test taken at the facility. Typically, it takes 72 hours for the test results to come back. The administrator said the labs are struggling to keep the testing and result reporting timely due to the increase in testing. Anyone who is immunocompromised would be considered high risk for infection, examples included someone with the [DIAGNOSES REDACTED]. Resident daily COVID assessments would be located under

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) the progress notes in each resident chart. Staff should be providing and documenting COVID assessments twice a day. At this time, Resident #3 remained on the Veronica hallway. During a phone interview on [DATE] at 9:32 A.M., the administrator said the Veronica hall is the only hall used to house both COVID-19 positive and PUI residents. For a resident to be able to come off of the Veronica hall, they must first receive two negative COVID-19 test results. During an interview on [DATE] at 12:17 P.M., Physician A, the physician for Resident #3, said he/she had not been aware the resident had been placed on the Veronica hallway, a COVID-19 positive unit. The resident [MEDICAL CONDITION] and is currently receiving [MEDICAL CONDITION]. Both [MEDICAL CONDITION] [DIAGNOSES REDACTED]. When he/she learned that the resident was living on the Veronica unit, he/she emailed the facility infection control nurse on [DATE] and instructed the facility to move the resident out of the unit due to his/her risk level. The resident should not have been placed on an active COVID-19 unit while his/her COVID-19 testing was pending. During an interview on [DATE] at 12:19 P.M., the IP said that Resident #3's physician had emailed him/her on [DATE] and instructed the facility to move the resident off of Veronica hall. The resident had received his/her second negative COVID-19 test shortly before the email had been received from the resident's physician and the resident had been free of symptoms for 72 hours and was already being moved to another unit. The resident will continue to be observed on his/her new unit for the continuation of the 14 day observation period since his/her first negative test result from the hospital. Observation on [DATE] at 12:20 P.M., at the entrance to Veronica Hall, showed a sign posted: Hand Hygiene before you go into a room. Hand hygiene when you come out of the room. This includes passing trays, doing one on one visits, dropping items off, etc. During an interview on [DATE] at 12:24 P.M., the IP said an N95 mask is required on the COVID-19 unit and all other PPE is placed on before entering the resident's room. During an interview on [DATE] at 12:28 P.M., Licensed Practical Nurse (LPN) B said N95 masks and face shields are reused for a week. Everything else is one time use. Gowns can only be worn in one room. 2. Review of information, sent by the facility on [DATE], showed: -Resident #12: -tested for COVID-19 on [DATE], the results returned positive on [DATE]; -On [DATE], transferred to Veronica hall; -Resident #10: -tested positive for COVID-19 at the hospital on [DATE]; -Returned to the facility on [DATE] to the Joachim Hall; -On [DATE], transferred to Veronica hall, the new COVID-19 unit; -Resident #11: -tested for COVID-19 on [DATE], the results returned positive on [DATE]; -On [DATE], transferred to Veronica hall. Review of Resident #8's medical record, showed: -admitted to the Veronica hall on [DATE]; -[DIAGNOSES REDACTED]. -A progress note, dated [DATE] at 11:17 A.M., showed a nasal swab obtained with patient's consent for COVID-19 test; -A progress note, dated [DATE] at 11:14 A.M., showed the facility received the resident's COVID-19 test back and the resident tested negative; -The resident's census report, showed the resident remained on Veronica hall as it was transitioned into the COVID-19 unit; -A progress note, dated [DATE]: -At 8:23 A.M., the resident's physician assessed the resident today. He/she was informed the resident placed on oxygen (O2) at 3 liters per nasal cannula on the night shift. The resident had no fever (afebrile) at 97.3 degrees F, pulse 95, respirations 18, blood pressure ,[DATE] and oxygen saturation (oxygen level in the blood, normal range is ,[DATE]% on room air) at 91% with 3 liters oxygen. The resident's eyes are closed and his/her lungs sounded clear but diminished; -At 8:34 A.M., a physician noted the resident was seen for [MEDICAL CONDITION] (low oxygen level); -At 8:59 A.M., the resident's oxygen saturation at 90% with 3 liters of oxygen applied. His/her lungs sounded diminished and noted a dry cough; -At 9:56 A.M., new orders received for chest x-ray for [MEDICAL CONDITION], retest the resident for COVID-19, apply oxygen to keep oxygen level at 90% or above, monitor oxygen saturation; -At 10:46 A.M., the chest x-ray obtained. The resident noted to lay resting quietly in bed; -At 2:20 P.M., new orders received to obtain a COVID-19 test; -At 3:01 P.M., a physician visit note: The resident assessed related to a change in condition. The facility nurse had reported the resident became hypoxic during the night (O2 saturation in the 80's on room air) and oxygen applied at 3 liters had been initiated. The nurse reported no distress and the resident observed to be lying in bed and staff assisted the resident to eat his/her breakfast. His/her room is currently situated in a hallway with lab confirmed positive COVID-19 patients. The treatment plan noted [MEDICAL CONDITION] and rule out pneumonia and COVID-19 virus infection. Check chest x-ray and nasopharyngeal swab for COVID-19. Adjust oxygen with pulse oximetry to keep oxygen saturation level at 90% or greater; -At 7:06 P.M., a nursing progress note: the resident's chest x-ray results reported to his/her physician. No new orders received; -Review of the resident's COVID-19 laboratory test results, showed COVID-19 test ordered and collected on [DATE] at 12:27 P.M. Results: Positive; -Review of the resident's room census sheet, showed on [DATE] the resident noted as admitted to hospice services and remained on the Veronica hallway; -Review of the progress notes, dated [DATE], showed: -At 9:21 A.M., the resident in bed unresponsive. The head of the bed noted to be elevated. His/her lungs are congested and respirations are labored at 30 breaths a minute (normal 12 through 20). Temperature 99.9 degrees F and his/her skin noted to be warm to the touch. Tylenol administered; -At 9:46 A.M., a call placed to the resident's physician and verified [MEDICATION NAME] (narcotic pain medication, can also be used to treat shortness of breath) orders; -At 10:02 A.M., ordered [MEDICATION NAME] administered for labored respirations. The resident's responsible party at the resident's bedside. The resident's oxygen saturation not registering on the pulse oximetry (device used to measure the percentage of oxygen in the blood); -Review of the progress notes, dated [DATE], showed: -At 8:31 A.M., New orders received from the resident's physician for comfort medications and to discontinue all other medications except comfort medications and oxygen. [DIAGNOSES REDACTED]. The resident is receiving hospice services; -At 8:30 P.M., the resident in bed. Head of bed elevated. Oxygen at 3 liters in use. The nurse notified by the CNA that the resident observed not to be breathing. Lungs sounds ceased and no heart rate. Time of death verified with another nurse. Hospice provider notified and the hospice nurse arrived to attend the resident. [DIAGNOSES REDACTED].M., funeral home received the resident remains. During a phone interview on [DATE] at 9:06 A.M., the administrator said Resident #8 had been living on the Veronica hallway for several months. As the facility's COVID-19 positive numbers increased and to help with facility staffing, the Veronica unit was turned into the COVID-19 unit. Resident #8 stayed on the Veronica hall during the transition since his/her room was already there. The Veronica hallway had been transitioned into the COVID-19 unit sometime in mid-June. Resident #8 had tested COVID-19 negative in June, then experienced a change in condition over a week later and had been retested . The facility obtained the test, but the results did not get reported to the facility before the resident's death. Staff presumed the resident had developed COVID-19 after the negative test result due to the symptoms he/she developed. The resident had been on the Veronica hall since [DATE]. 3. Review of Resident #9's medical record, showed: -A face sheet, included [DIAGNOSES REDACTED].M., resident is complaining of pain upon urination and this nurse has called the exchange to leave a message for the doctor; -At 6:30 A.M., received call back from the doctor, new orders for STAT (immediate) urinary analysis (UA, lab to test for urinary tract infection). Orders put in lab, called lab stated they are not picking up STAT UA unless there is blood work; -At 12:05 P.M., urine collected, placed in fridge for pick up tomorrow; -No further documentation to show if the urine sample was picked up, if the resident had a urinary tract infection or other documentation of the UA as late as [DATE]; -A progress note, dated [DATE]: -At 8:57 A.M., no cough, sore throat, shortness of breath, loss of taste or smell, diarrhea, vomiting, fatigue or malaise. Headache, yes. Physician notified. Body aches, yes, arms; -At 8:59 A.M., the resident stated I'm not feeling good. I have a headache and my arms hurt. Vital signs included a temperature of 98.2 degrees F (within normal limits). Call placed to the physician; -At 10:29 A.M., received a call from the physician. Order obtained to do COVID-19 test; -At 12:01 P.M., COVID-19 nasal swab obtained with resident's consent; -At 12:28 P.M., transferred to Veronica hall as ordered; -A census report, showed the resident moved to Veronica Hall COVID-19 unit on [DATE]; -An order dated [DATE], for droplet precautions x14 days or until negative test; -A COVID-19 lab report: -Collected [DATE]; -Result: Negative; -A progress note, dated [DATE] at 12:21 A.M., showed dry cough; -A progress note, dated [DATE] at 5:50 P.M., nasal swab obtained with resident consent for COVID-19 test. Resident test from [DATE] was negative. Patient was re-tested due to symptoms from weekend; -No further documentation of symptoms consistent with COVID-19 through [DATE]; -A progress note dated [DATE] at 9:17 A.M., received the resident's COVID-19 test back and tested negative; -A census report, showed the resident not moved off the Veronica Hall COVID-19 unit until [DATE]. During an interview on [DATE] at 12:28 P.M., LPN B said they currently have two residents on the COVID-19 unit who are negative for COVID-19. One had been positive and is now negative and the other, Resident #9, never tested positive. He/she only had signs and symptoms. Both residents will be transferred off the unit today. During an interview on [DATE] at 2:15 P.M., with the IP and administrator, they said Veronica Hall was transitioned into the COVID-19 unit in mid-June. The resident was placed on the COVID-19 unit for symptoms. He/she was removed today after two negative tests. During an interview on [DATE] at 12:48 P.M., the facility's medical director said he did not assist the facility in creating the COVID-19 action plan and the guidance came from the corporate offices. The facility should follow all infection control policies a