STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235296	A. BUILDING _____ B. WING _____	05/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDILODGE OF SOUTHFIELD	26715 GREENFIELD RD SOUTHFIELD, MI 48076

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to: follow Centers for Disease Control and Prevention (CDC) guidelines for infection control for COVID-19 (Coronavirus Disease 2019), ensure adequate monitoring of residents, changing of isolation gowns and/or lab coats between caring for those residents positive for COVID-19 on the 1 South unit and then caring for residents without COVID-19 on the same unit, consistent donning of eye protection, gloves, and/or a gown when caring for residents with COVID-19, ensuring personal protective equipment (PPE) was changed following care for residents positive for COVID-19 prior to entering other areas of the building, and ensure signage was utilized to indicate transmission based precautions for residents positive for COVID-19. This deficient practice affected twenty-nine residents (R#701, R#702, R#703, R#704, R#705, R#706, R#707, R#708, R#710, R#711, R#712, R#713, R#714, R#715, R#716, R#717, R#718, R#719, R#720, R#721, R#722, R#723, R#724, R#725, R#726, R#727, R#728, R#729, R#730) of twenty nine residents reviewed for infection control on the 1 South unit and two of two residents(R#731 and R#732) reviewed for infection control on the 2 North unit, resulting in an immediate jeopardy to the health and safety of all residents residing at the facility due to the facility's infection control practices placing all residents at risk for serious harm and/or death due to the increased likelihood of transmission of COVID-19. Findings include: The Immediate Jeopardy (IJ) started on 4/27/20. The Immediate Jeopardy was identified on 4/27/20 at 12:30PM. The Administrator was identified of the Immediate Jeopardy via telephone and electronically on 4/29/20 at 12:30PM. The immediacy was removed on 5/1/20. Although the immediacy was removed, the facility remained out of compliance at the scope of widespread and a severity of potential for more than minimal harm that is not immediate jeopardy due to sustained compliance that has not been verified by the State Agency. An onsite survey was conducted on 4/27/20-5/4/20. On 4/27/20 at approximately 9:50AM, the facility's Administrator indicated the 1 South unit was being utilized as the COVID unit. 2 North Unit: On 4/27/20 at 10:22 AM, R#731 was observed in a wheelchair out of the door of their room on a non-COVID designated unit. The resident was not observed to be wearing a facemask. At 10:26 AM, the resident was observed out in the hallway not wearing a mask. Shortly after, the resident was observed using their wheelchair and moving down the hallway on the unit the resident resided. Review of the clinical record for R#731 revealed the resident was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of documented temperatures per the resident's electronic medical record for the month of April 2020 revealed the following: 4/22/20: 98.0 F (Fahrenheit), 4/15/20: 97.8F, and 4/1/20: 98.0F. No additional documentation of the resident's temperatures was observed per the electronic vital sign recording of temperature for the month of April 2020. On 4/27/20 at approximately 10:41 a.m., R#732 was observed sitting in their wheelchair on the two North unit in a common area without any type of personal protective equipment covering their face. R#732 was admitted to the facility on [DATE] and had [DIAGNOSES REDACTED].#732's MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/13/20 revealed R#732 needed assistance from facility staff with their activities of daily living. A review of R#732's recorded temperatures revealed only one documented temperature on 4/21/20 for April 2020 and only one documented temperature on 3/25/20 for March 2020. A review of R#732's oxygen saturation rates revealed the last documented saturation rate was on 12/10/19. Review of the CDC's, Preparing for COVID-19, Long-term Care Facilities, Nursing Homes revealed, in part, 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 . 1 South Unit: On 4/27/20 at approximately 10:56 a.m., PTA (Physical Therapy Assistant) G was observed coming out of R#729's room (Covid-19 designated room) without any isolation gown on. PTA G was observed to be wearing gloves in the hallway and seen walking down the designated COVID-19 unit, leaving the unit and entering the facility therapy gym. PTA G was queried if they had worn any personal protective equipment while treating R#729 in their room and they indicated they wore their lab coat, gloves and mask. PTA G was queried if they had worn an isolation gown while treating R#729 and they indicated they hadn't. On 4/27/20 at 11:16 AM, the set of double doors to the 1 South unit was observed, and one side of the double door was open. Upon entry to the unit, there was no visible notification (signage on resident room doors near entry to unit to indicate precautions) for those entering the unit to indicate a division in which rooms were being used to care for residents positive for COVID-19 versus which rooms were being utilized for residents without a [DIAGNOSES REDACTED].#708, R#710, R#711, R#712, R#713, R#714, R#715, R#716, R#717, R#718, R#719, R#720, R#721, R#722, R#723, R#724, R#725, R#726, R#727, R#728, R#729, and R#730. Resident room doors were observed to be open for the rooms where R#713, R#714, R#715, R#719, R#720, R#721, R#722, R#723, R#724, R#725, R#726, R#727, R#728, R#729, and R#730 resided. It was noted during the onsite survey that residents who were not positive for COVID-19 also resided on the 1 South unit. These residents included the following (as of the morning of 4/27/20): R#701, R#702, R#704, R#705, R#706, and R#707. R#703, who was admitted the evening of 4/27/20, also was not identified as having COVID-19. Review of the clinical record for R#701, R#702, R#703, R#704, R#705, R#706 and R#707 revealed, in part, the following: R#701 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. R#702 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Per a note in the resident's clinical record dated 4/27/20 the resident had been .COVID19 negative x2. R#703 was admitted to the facility on [DATE] and was readmitted on [DATE] with [DIAGNOSES REDACTED]. R#704 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Per a note dated 4/23/20 it was documented the resident had been negative for COVID-19 in the hospital. R#705 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Per a progress note dated 4/20/20 it was documented the resident displayed, no evidence of COVID-19 infection . R#706 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. R#707 was admitted to the facility on [DATE] and was readmitted on [DATE] with [DIAGNOSES REDACTED]. Per physician orders [REDACTED]. On 4/27/20 at 11:20 AM, Licensed Practical Nurse (LPN) 'B' was queried as to what area of the unit was being used for residents positive for COVID, and explained it was the room where R#717 and R#718 resided, then down the hallway (which would include where residents R#717 through R#730 resided, which was different than the list of residents positive for COVID-19 provided by the facility). Per LPN 'B' people who were already clear (without COVID) were on the other part of the hallway. LPN 'B' was queried as to CNA staffing, and explained there were two CNAs (Certified Nursing Assistants) who were working as a team, and LPN 'B' acknowledged the CNAs had the full hallway. Observations of the resident room door for R#727, R#728, and R#729's room revealed a sign present to see the nurse before entering. On the room door for R#730's room was a sign indicating droplet precautions. Signs were not observed on the doors of the rooms where R#717, R#718, R#719, R#720, R#721, R#722, R#723, R#724, R#725, or R#726 resided to indicate if precautions were being utilized for the resident rooms. Review of a staff assignment sheet for CNAs for 4/27/20 for the 7:00 AM to 3:30 PM revealed the following: CNA 'F' was assigned to care for R#701, R#702, R#704, R#705, R#706, R#707 (residents who did not have COVID-19), and also R#708, R#710, R#711, R#712, R#713, R#714, R#715, and R#716 (who were positive for COVID-19) on the 1 South unit. Per the staff assignment sheet, CNA 'E' was assigned R#717, R#718, R#719, R#720, R#721, R#722, R#723, R#724, R#725, R#726, R#727, R#728, R#729, and R#730, all of whom were identified by the facility as positive for COVID-19. On 4/27/20 at approximately 11:30AM, Housekeeper 'C' was observed to enter the room

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 1) where R#715 and R#716 resided. Housekeeper 'C' was observed to be wearing goggles on their forehead while in the resident's room. It was noted R#715 and R#716 were identified as positive for COVID-19 per the facility. Housekeeper 'C' was queried about use of a face shield (eye protection) and said that they knew the COVID wing was farther back (different rooms than where R#715 and R#716 resided). On 4/27/20 at approximately 11:34 a.m., CNA E was observed walking from the back end of the designated COVID-19 unit wearing a yellow isolation gown and was seen entering the Non COVID-19 section of the hallway and enter R#704 and 705's room (a non-COVID-19 room). On 4/27/20 at approximately 11:38 a.m., CNA E was observed coming out of R#710 and R#711's room (a designated COVID-19 room) wearing the same yellow isolation gown and was seen walking down the COVID-19 unit hallway to the clean linen cart (located on the hallway of the COVID-19 unit). CNA E was observed to reach their hand into the linen cart and retrieve new linen and subsequently enter R#713 and R#714's room (COVID-19 designated room). On 4/27/20 at approximately 11:52 a.m., CNA E was queried regarding which residents they were providing care for that day. CNA E indicated there were only two aides including them, so they didn't have room numbers assigned. CNA E reported they and CNA F were taking care of the whole hallway. CNA E was queried if they were keeping the same isolation gown on all day and they reported they were. CNA E was queried if they used the same isolation gown to provide care for the residents on the COVID-19 unit that they did for the residents at the end of the hall who didn't have COVID-19 and they reported that they did. CNA E reported the facility only provided one gown a day and they had to wear it for all the residents on the hall. On 4/27/20 at approximately 11:56 a.m., CNA F was observed wearing a white lab coat in the hallway. CNA F was queried regarding what residents they were assigned to provide care for. CNAF indicated they were working with CNA E and caring for all the residents on the hallway. CNA F was queried if they were wearing any disposable gowns when caring for the residents with COVID-19 and they reported they didn't. CNA F reported they were provided a white lab coat as their gown and were expected to wear the same lab coat all shift. CNA F was queried if they wore the same lab coat while caring for residents without COVID-19 that they did for residents with COVID-19 and they indicated that they did. On 4/27/20 at approximately 12:00 p.m., R#728 (positive for COVID-19) was observed in the hallway without a mask concealing their mouth or nose. On 4/27/20 at approximately 12:09 p.m., PTA G was observed in R#723, R#724 and R#725's room (COVID-19 designated room) wearing a lab coat (with no isolation gown over top) and gloves. PTA G was observed leaving the room, walking down the COVID-19 designated hallway, leaving the COVID-19 unit and returning to therapy gym wearing the same lab coat they had on in the room. On 4/27/20 at approximately 12:15 PM, Unit Secretary 'D' was observed to be wearing a lab coat and mask and entered the room where R#707 resided and asked the resident about their coffee or tea request. It was later noted per record review that R#707 was in isolation related to [MEDICAL CONDITION]. On 4/27/20 at approximately 12:15 p.m., CNA E was observed coming out of R#715 and R#716's room (COVID-19 designated room) wearing the same yellow isolation gown and was observed walking down the COVID-19 hallway into the shower room with the same isolation gown on. On 4/27/20 at approximately 12:19 p.m., CNA F was observed to enter R#723, R#724 and R#725's room (COVID-19 designated room) with a white lab coat (no isolation gown) and shortly thereafter was observed coming out of the room, went into the hallway with gloves still on, reached into the clean linen cart (located in the middle of the COVID-19 designated hallway) and pulled out clean linen with their gloved hand and was observed to reenter the room. On 4/27/20 at approximately 12:24 p.m., CNA F was observed coming out of R#723, R#724 and R#725's room with same white lab coat on, going down the hallway and entered R#704 and 705's room (designated non-COVID-19 room). On 4/27/20 at 12:24 PM, Unit Secretary 'D' was observed to enter the room where R#715 and R#716 resided (designated COVID-19 room). Unit Secretary 'D' was not observed to wear gloves and moved the curtain in the resident's room. On 4/27/20 at 12:33 PM, Unit Secretary 'D' was observed in the hallway in a lab coat and mask. Unit Secretary 'D' was not observed to have on a face shield, eye protection, or gloves and was observed to enter the room where R#726 resided. It was noted that R#726 was identified by the facility as being positive for COVID-19. On 4/27/20 at 12:40PM, Unit Secretary 'D' was observed to enter the room where R#717 and R#718 resided and was not observed to don gloves. It was noted that both residents were identified by the facility as positive for COVID-19. On 4/27/20 at approximately 12:46 p.m., Staff Member/Unit Secretary D was queried regarding wearing their lab coat and not utilizing any isolation gowns when they entered rooms on the COVID-19 unit. Staff member D indicated they brought their lab coat from home, used it all shift and then took it off when they got to their car when they left for the day. Staff member D was queried if they had used any other isolation gowns when entering the COVID-19 rooms or when they entered the non-COVID-19 rooms and they reported that they did not. On 4/27/20 at approximately 1:05 p.m., Nurse N (who also was working the 1 South unit) was queried if they had changed their isolation gown that they had been wearing that day and they indicated they had not. Nurse N was queried if they had worn the same isolation gown into COVID-19 positive rooms and non-COVID-19 rooms and they indicated they had. Nurse N reported the facility only gave them one gown a day. On 4/27/20 at approximately 2:12 p.m., CNA E was observed leaving the COVID-19 unit wearing the same yellow isolation gown they had used all day to care for the COVID-19 residents. CNA E was observed walking into the 1 north unit (designated non-COVID-19) with the isolation gown still on. CNA E was then observed walking back from the 1 north unit back into the designated COVID-19 unit (1 south). On 4/27/20 at 3:58 PM, the facility's Administrator and Clinical Liaison 'M' were queried regarding PPE at the facility. When queried, the Administrator explained that the facility had everything. Per the Administrator they had 400 gowns, 100 N-95 masks, and 75 goggles. It was explained during the interview that the county had been sending equipment as well. When queried about the use of a lab coat, it was explained that the company supplied the lab coat, and the lab coat would be washed and hung on hangers outside the laundry. Staff would punch in (clock in) and get the lab coat, then would get their temperature obtained. When queried as to gown use, it was explained that a gown would be provided if lab coat was not a suitable size for a staff member. Per Clinical Liaison 'M', staff were to apply a gown over the lab coat if a resident was in isolation. On 4/28/20 at approximately 9:00AM, it was noted that the room doors where R#708, R#710, R#711, R#712, R#713, R#714, R#715, R#716, R#717, R#718, R#719, R#720, R#721, R#722, R#723, R#724, R#725, and R#726 resided (all of whom were identified by the facility as positive for COVID-19) did not have a sign present on the room door to indicate that transmission-based precautions were being utilized. On 4/28/20 at approximately 9:08 a.m., restorative aide (RA) K was observed coming out of R#707's room (positive for [MEDICAL CONDITION]-[MEDICAL CONDITION]) with a blue disposable isolation gown on. RA K was then observed walking into hallway without taking off their isolation gown. On 4/28/20 at 9:12 a.m., RA K was observed to enter R#712's room (COVID-19 designated room) to attempt to weigh R#712 wearing the same blue isolation gown they had on when they were in R#707's room. On 4/28/20 at approximately 9:20 a.m., RA L was observed entering R#706's room (designated non-COVID-19 room) to weigh them wearing the same blue isolation gown they had on when they were observed walking from the COVID-19 designated unit. On 4/28/20 at approximately 9:25 AM, PTA 'G' was observed to enter the room where R#712 resided. It was noted that R#712 had been identified by the facility as positive for COVID-19. PTA 'G' was observed to wear a lab coat, mask, and goggles. The staff member was not observed to wear a disposable gown. On 4/28/20 at approximately 9:25 a.m., CNA F was observed dragging an open garbage bag of disposable dishware (used by COVID-19 positive residents to eat their meals) down the COVID-19 hallway on the floor past the designated COVID-19 unit and into the soiled utility room. CNA F was observed to be wearing a blue plastic isolation gown and face shield. On 4/28/20 at approximately 9:28 a.m., CNA F was observed to enter R#704 and R#705's room (designated non-COVID-19) wearing the same blue plastic isolation gown they had been wearing when they were observed in the COVID-19 designated unit. Immediately after leaving the room and returning a meal tray to the meal try cart, CNA F was observed entering R#703's room (another designated non COVID-19 room) wearing the same blue plastic isolation gown. On 4/28/20 at approximately 9:36 a.m., RA K was observed entering R#701 and R#702's room (designated non-COVID-19) with the same blue plastic isolation gown they were wearing when they were in R#707 (resident treated for [REDACTED].#712's rooms (positive for COVID-19). On 4/28/20 at 9:38 AM, PTA 'H' was observed to exit the room where R#721 and R#722 (designated positive COVID-19 room) resided. The staff member was observed in a lab coat. PTA 'H' was observed to enter the room where R#710 and R#711 (positive for COVID-19) resided and was observed to wear a lab coat without a disposable gown. The staff member was then observed to exit the unit in the lab coat. On 4/28/20 at approximately 9:39 a.m., RA K was observed entering R#703's room (designated non-COVID-19) with the same blue plastic isolation gown they were wearing when they were in R#707 and R#712's rooms. On 4/28/20 at approximately 9:40AM, PTA 'G' was again observed to wear a lab coat with no gown and enter the room where R#712 resided. On 4/28/20 at 9:45 AM, Unit Secretary 'D' was observed to enter the room where R#708 (COVID-19 positive) resided. Unit Secretary 'D' was not observed to have worn a gown. On 4/28/20 at 9:47 AM, PTA 'G' was again observed to enter the room where R#712 resided. PTA 'G' wore a lab coat with no gown. On 4/28/20 at 9:51 AM, a linen cart was observed on the 1 South hallway in the area of the unit where residents positive for COVID-19 resided. The front of the linen cart was not observed to be covered, and linens were visible on the shelves of the cart. On 4/28/20 at approximately 9:46 a.m., RA L and RA K were queried regarding wearing their PPE (personal protective equipment). RA L was queried if they had completed weights for residents residing in

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 2) the designated COVID-19 unit and they indicated that they had. RA L was then queried if they had changed their isolation gown before getting the weights from the Non-COVID-19 residents and they indicated they had not. RA L indicated that they were told they had to wear the same isolation gown all day. On 4/28/20 at approximately 9:49 a.m., during a conversation with CNA I, CNA I was queried regarding their use of PPE while caring for residents on the one south hallway. CNA I indicated that prior to 4/28/20 they were not provided a face shield when caring for residents that had COVID-19. CNA I indicated that residents would cough all over them and the staff were getting sick. CNA I also indicated that they had to use the same isolation gown for all the residents on the hallway including the residents without COVID-19. CNAI was queried if they had any set residents for the day and they reported it was just them and another aide, so they were working the whole hall. CNAI was queried if they had provided care for residents with COVID-19 and residents without COVID-19 with the same isolation gown and they indicated that they had. CNA I reported the facility only gave them one gown that day and they had to care for everyone with it. CNA I reported that before 4/28/20 they weren't provided any isolation gowns and they had to provide care for all residents on the hallway just wearing lab coats. CNA I was queried how they knew what residents had COVID-19 and which residents did not, and they indicated that the only way they knew the difference was that residents who got standard meal trays didn't have the infection and residents that received paper dishware did. Review of a staff assignment sheet for CNAs for 4/28/20 for the 7:00AM to 3:30PM shift revealed the following: CNA 'I' was assigned to care for a set of rooms where R#701, R#702, R#703, R#704, R#705, R#706, R#707, R#708, R#710, R#711, and R#712 resided. It was noted that this assignment included residents who were identified as positive for COVID-19 and included care for residents without a [DIAGNOSES REDACTED]. CNA 'F', the second CNA on the unit, had been assigned to care for R#713, R#714, R#715, R#716, R#717, R#718, R#719, R#720, R#721, R#722, R#722, R#723, R#724, R#725, R#726, R#727, R#727, R#728, R#729, and R#730. All the residents included in the assignment for CNA 'F' had been identified by the facility as positive for COVID-19. On 4/28/20 at 9:52AM, PTA 'G' was observed to exit R#712's room in a lab coat and gloves. On 4/28/20 at approximately 9:56 a.m., Housekeeper J (HK J) was queried regarding what isolation gown they used when cleaning the rooms of the one south hallway. HK J indicated he used one isolation gown for the whole hallway. HK J was queried if they used any different isolation gowns for cleaning the non-COVID-19 rooms vs the COVID-19 rooms and they reported they didn't and that once they were finished with the whole hallway they would change their gown and go onto another unit. Review of the clinical record for R#708 to R#730 revealed the following: R#708 was admitted to the facility 4/21/20 with [DIAGNOSES REDACTED]. The resident had an order dated 4/22/20 for .transmission-based precautions related to positive or suspected COVID-19 status. R#710 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Per a physician order [REDACTED]. R#711 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The resident had transmission-based precautions ordered 4/23/20. R#712 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Per a physician order [REDACTED]. R#713 was admitted to the facility on [DATE] and was readmitted on [DATE] with [DIAGNOSES REDACTED]. Per a physician order [REDACTED]. R#714 was admitted to the facility on [DATE] and was readmitted on [DATE] with [DIAGNOSES REDACTED]. Per a physician order [REDACTED]. R#715 was admitted to the facility on [DATE] and was readmitted on [DATE] with [DIAGNOSES REDACTED]. Per a physician order [REDACTED]. R#716 was admitted to the facility on [DATE] and was readmitted on [DATE] with [DIAGNOSES REDACTED]. Per a Physician Assistant/Nurse Practitioner note dated 4/16/20 it was documented to continue isolation precautions for the resident. R#717 was last admitted to the facility on [DATE] and had [DIAGNOSES REDACTED].#717's MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/16/20 revealed R#717 needed extensive assistance from facility staff with their activities of daily living. An active physician's orders [REDACTED]. R#718 was last admitted to the facility on [DATE] and had [DIAGNOSES REDACTED].#718's MDS with an ARD of 4/17/20 revealed R#718 needed extensive assistance from facility staff with their activities of daily living. An active physician's orders [REDACTED]. R#719 was last admitted to the facility on [DATE] and had [DIAGNOSES REDACTED].#719's MDS with an ARD of 1/31/20 revealed R#719 needed extensive assistance from facility staff with their activities of daily living. An active physician's orders [REDACTED]. R#720 was last admitted to the facility on [DATE] and had [DIAGNOSES REDACTED].#720's MDS with an ARD of 2/6/20 revealed R#720 needed assistance from facility staff with their activities of daily living. An active physician's orders [REDACTED]. R#721 was last admitted to the facility on [DATE] and had [DIAGNOSES REDACTED].#721's MDS with an ARD of 2/1/20 revealed R#721 needed assistance from facility staff with their activities of daily living. A nursing note dated 4/16/20 revealed the following: Patient arrived at 4:42pm via stretcher by two ambulance personnel. Patient is a (age redacted) female patient that is A&Ox1-2 and had a primary [DIAGNOSES REDACTED]. R#722 was last admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. R#723 was last admitted to the facility on [DATE] and had [DIAGNOSES REDACTED].#723's MDS with an ARD of 4/16/20 revealed R#723 needed assistance from facility staff with their activities of daily living. An active physician's orders [REDACTED]. R#724 was last admitted to the facility on [DATE] and had [DIAGNOSES REDACTED].#724's MDS with an ARD of 4/5/20 revealed R#724 needed assistance from facility staff with their activities of daily living. An active physician's orders [REDACTED]. R#725 was last admitted to the facility on [DATE] and had [DIAGNOSES REDACTED].#725's MDS with an ARD of 4/19/20 revealed R#725 needed assistance from facility staff with their activities of daily living. An active physician's orders [REDACTED]. R#726 was last admitted to the facility on [DATE] and had [DIAGNOSES REDACTED].#726's MDS with an ARD of 4/19/20 revealed R#726 needed assistance from facility staff with their activities of daily living. An active physician's orders [REDACTED]. R#727 was last admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. R#728 was last admitted to the facility on [DATE] and had [DIAGNOSES REDACTED].#728's MDS with an ARD of 1/30/20 revealed R#728 needed assistance from facility staff with their activities of daily living. An active physician's orders [REDACTED]. R#729 was last admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. R#730 was last admitted to the facility on [DATE] and had [DIAGNOSES REDACTED].#730's MDS with an ARD of 3/29/20 revealed R#730 needed assistance from facility staff with their activities of daily living. An active physician's orders [REDACTED]. On 4/28/20 at 12:00 PM the facility's Assistant Director of Nursing (ADON), who was covering the infection control program, was queried regarding the 1 South (1S) unit. Per the ADON, the front of the 1S unit was where the facility would accept new admissions who would be quarantined for 14 days. Per the ADON the area was used to monitor new residents who did not have COVID (COVID-19), and the back hall was used for admissions of COVID-19 positive residents. The ADON was queried regarding PPE use, and explained that