STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115447	A. BUILDING _____ B. WING _____	07/02/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HERITAGE INN OF BARNESVILLE HEALTH AND REHAB	946 VETERANS PARKWAY BARNESVILLE, GA 30204

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** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon observation, interview, record review and review of facility policy, the facility failed to consistently implement an infection control program to contain and prevent the spread of coronavirus 2019 (COVID-19) in the facility's memory care unit for eight of eight sampled residents who tested positive for COVID-19 and who resided on the unit (Resident (R) #1, R#2, R#3, R#4, R#5, R#6, R#7, and R#8). -The staff did not don all required personal protective equipment (PPE), specifically gowns when entering residents' rooms, in accordance with physicians' orders, the facility's policies and procedures for droplet precautions and Center for Disease Control (CDC) recommendations. -Residents who were COVID positive wandered throughout the memory care unit without consistent use of masks and interacted with other residents, of unknown COVID status, in close proximity without adequate staff redirection. -The facility did not provide dedicated staff to provide care to only COVID positive residents. The staff in the memory care unit provided care to both COVID positive and COVID negative residents. COVID positive and COVID negative residents resided together on the memory care unit, which was also the facility's designated COVID isolation unit. These failures put residents, who were not positive for COVID on the memory care unit, at risk for contracting COVID-19 infection. Findings include: 1. Policies and Professional References Review of the facility's policy titled, COVID-19 Facility Exposure Management dated 3/16/2020 reflected: Prior to entering and exiting the unit and a patient room, healthcare personnel must perform hand hygiene by washing hands with soap and water or applying alcohol-based hand sanitizer . If resources allow, consider having staff who provide direct care weal (sic) all recommended (personal protective equipment) PPE (gowns, gloves, eye protection, facemask) for the care of all residents regardless of presence of symptoms .If residents leave their room they should wear a facemask, perform hand hygiene, limit their movement in the facility, and perform social distancing (stay at least 6 feet away from others). Review of the facility policy titled, Skilled Inpatient Services Transmission Precautions dated 2017 reflected no specific guidance for coronavirus associated with [DIAGNOSES REDACTED] (Severe Acute Respiratory Syndrome) ([DIAGNOSES REDACTED]-CoV); however, indicated, See acute respiratory syndrome. Severe acute respiratory syndrome ([DIAGNOSES REDACTED]) guidance recommended airborne, droplet, and contact precautions for the duration of the illness, which included: -Contact precautions: Gloves, gown only when anticipating direct contact with resident or contaminated environmental/equipment. Remove gown and observe hand hygiene before leaving the resident care area. -Droplet precautions: Contact precautions plus masks, gowns, and physical separation. -Airborne precautions: Droplet precautions plus fit-tested N-95 mask or respirator recommended. Review of the CDC Considerations for Memory Care Units in Long-term Care Facilities dated 5/12/2020 reflected: Healthcare personnel (HCP) working in memory care units in long-term care facilities including nursing home .should follow the IPC (Infection Prevention and Control) guidance for those specific settings .In addition to the current IPC guidance for long-term care facilities, nursing homes .providing memory care should consider the following: -Routines are very important for residents with dementia -Dedicate personnel to work only on memory care units when possible and try to keep staffing consistent. Limit personnel on the unit to only those essential for care. -Continue to provide structured activities .throughout the day to maintain social distancing. -Limit the number of residents or space residents at least 6 feet apart as much as feasible when in a common area, and gently redirect residents who are ambulatory and are in close proximity to other residents or personnel. -Consider potential risks and benefits of moving residents out of the memory care unit to a designated COVID-19 care unit -Moving residents with confirmed COVID-19 to a designated COVID-19 care unit can help to decrease the exposure risk of residents and HCP; however, moving residents with cognitive impairments to new locations .may cause disorientation, anger, and agitation as well as increase risks for other safety concerns such as falls or wandering -Additionally, at the time a resident with COVID-19 or asymptomatic [DIAGNOSES REDACTED]-COV-2 infection has been identified, other residents and personnel on the unit may already have been exposed or infected, and additional testing may be needed. -Facilities may determine that it is safer to maintain care of residents with COVID-19 on the memory unit with dedicated personnel. Review of CDC guidance Preparing for COVID-19 in Nursing Homes updated 6/25/2020 indicated: -As a measure to limit HCP exposure and conserve PPE, facilities could consider designating entire units within the facility, with dedicated HCP, to care for patients with suspected or confirmed [DIAGNOSES REDACTED]-CoV-2 infection. Dedicated means that HCP are assigned to care only for these patients during their shift. -Determine how staffing needs will be met as the number of patients with suspected or confirmed [DIAGNOSES REDACTED]-CoV-2 infection increases and if HCP become ill and are excluded from work. HCP who enter the room of a patient with suspected or confirmed [DIAGNOSES REDACTED]-CoV-2 infection should adhere to Standard Precautions and use a NIOSH-approved N95 or equivalent or higher-level respirator (or facemask if a respirator is not available), gown, gloves, and eye protection. 2. Observations of the facility-designated COVID isolation unit on 7/1/2020 - 7/2/2020 revealed the facility had designated the memory care unit to be the COVID isolation unit. The facility had designed an isolation pod with entry and exit before the entrance to the memory care unit that had a PPE changing and sanitizing area. The isolation area included multiple signs on the doors and walls with PPE and sanitization instructions for personnel entering the area as well as policy and procedure instructions. Four rooms located immediately behind this area were designated for non-memory care residents who required isolation, and the remainder of the memory care unit was located beyond these rooms behind a secured door that restricted access into and from the memory care area for those residents who required memory care services. The door of each resident's room in the isolation area had a sign posted directing staff to use contact and droplet precautions and there were bags hanging on the doors containing PPE supplies. During interview with the Administrator and Director of Nursing (DON) on 7/2/2020 at 12:03 p.m. they said the memory care unit had been designated the COVID unit because COVID had initially and primarily affected the memory care unit residents. The DON stated that there were currently 19 residents on the COVID unit at the time, with four (4) residents in the memory care unit who were COVID negative. Observations of the memory care unit staff on 7/1/2020 beginning at 10:20 a.m. revealed all unit staff, including the Licensed Practical Nurse (LPN) AA, Certified Nurse Assistant (CNA) AA, and CNA BB wore N95 masks, face shields and gloves. However, the staff were not observed donning gowns as follows: Observation of CNA AA on 7/1/2020 at 10:20 a.m. revealed that CNA AA went into room [ROOM NUMBER] (COVID positive residents resided in the room) wearing a face mask and shield but no gown. CNA AA put on gloves without completing hand hygiene before entering the room and attended to the resident's call light. CNA AA removed gloves prior to leaving the room. During an interview on 7/1/2020 at 10:25 a.m. CNA AA stated that it was not necessary to wear a gown if just attending to requests for water or other non-(resident) contact care. During an interview with CNA AA and CNA BB on 7/1/2020 at 10:30 a.m. the CNAs stated that they did not know exactly who was COVID negative or positive on the memory care unit. They said they treated all residents as if they were positive. They stated the residents removed their masks and mingled in the halls and dining area despite redirection. The CNAs stated they only donned gowns if they were providing direct contact resident care. Observations on 7/1/2020 at 10:40 a.m. and 7/2/2020 at 10:30 a.m. and 3:35 p.m. revealed Resident #4 ambulated in the memory care unit without a mask and attempted to go into other residents' rooms but was redirected. Resident #4 approached other residents within a six (6) foot distance, who also were not wearing masks,

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115447	A. BUILDING _____ B. WING _____	07/02/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HERITAGE INN OF BARNESVILLE HEALTH AND REHAB	946 VETERANS PARKWAY BARNESVILLE, GA 30204

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** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) and spoke to them asking if she could go into their rooms. During an interview with the DON on 7/1/2020 at 10:56 a.m. the DON stated that she was also acting as Infection Control Nurse since the previous Infection Control Nurse was no longer with the company. She stated that the facility was following all CDC guidance for infection control. During an interview on 7/1/2020 at 11:00 a.m. with LPN AA she stated that she did not know which residents were COVID positive or negative. LPN AA stated the staff treated all residents as if they were COVID positive. An observation on 7/1/2020 at 11:10 a.m. revealed that LPN AA went into room [ROOM NUMBER] (COVID positive residents resided in the room) on the memory care hall with gloves and mask/face shield but no gown. LPN #1 spoke to the resident and canceled the resident's call light by pulling the cord, removed her gloves and used hand sanitizer. Observation of CNA CC at 7/2/2020 at 10:20 a.m. revealed that CNA CC went into room [ROOM NUMBER] (COVID positive residents resided in the room) with a face mask and shield but without a gown. CNA CC used hand sanitizer and put on gloves before entering the room and attended to the resident's call light and removed her gloves and used hand sanitizer before leaving the resident's room. During an interview on 7/2/2020 at 10:20 a.m. CNA CC stated that she only wore a gown if she was going to provide personal care like bathing or toileting. CNA CC also stated she did not know exactly which residents were positive or negative for COVID and she treated all residents as if they were positive. CNA CC stated the residents had to be constantly reminded to wear masks and the residents liked to walk around the halls. During an observation on 7/2/2020 at 10:40 a.m. Resident #8, Resident #4, and Resident #3 were all observed sitting in the dining area of the memory care unit at separate tables that were at least six (6) feet apart. None of the residents were wearing masks. The residents were identified by LPN AA, who stated that she could not make the residents keep their masks on. Record review reflected that Resident #8 was COVID positive and Resident #4 and Resident #3 were each COVID negative per most recent testing results (see examples below). During an interview on 7/2/2020 at 10:40 a.m. LPN AA stated the residents removed their masks and wandered on the unit and mingled with each other despite redirection. During an interview with the Administrator and DON on 7/2/2020 at 12:00 p.m. the DON stated the memory care residents were all treated as if they were COVID positive for infection control. The DON stated that the CDC had provided specific guidance for dementia care residents that allowed the facility to consider the potential risks and benefits of moving residents and provided a copy of the CDC publication Coronavirus Disease 2019 (COVID-19) Considerations for Memory Care Units in Long-term Care Facilities dated 5/12/2020. The DON and the Administrator stated they were taking full precautions to avoid resident infections while trying to accommodate the special needs of the memory care resident population. The DON and Administrator stated that moving the residents would be detrimental to the residents' well-being due to the disruption in their routines. They stated that no new admissions were being allowed, and that no residents in the unit (COVID positive or negative) had been moved out of the unit after the initial outbreak of COVID-19. They stated the COVID positive and negative residents were on the unit together but room assignments were changed as appropriate for COVID status. They further stated they isolated residents not requiring memory care services in the rooms outside of the memory care area; however, they stated that they did not have dedicated staff for COVID positive versus COVID negative residents in the entire isolation area because they were treating all residents in the isolation area as if they were positive. The DON stated that the residents in room [ROOM NUMBER] and room [ROOM NUMBER] were all COVID negative and that the residents residing in the other rooms were positive. The Administrator and DON stated that they had adequate PPE supplies for the isolation unit. The DON stated that the staff were not to wear gowns when going into residents' rooms unless they were providing personal care. The DON and Administrator also noted that the prior infection control nurse at the facility had been terminated the previous week for poor performance. Observations on 7/2/2020 at 10:35 a.m. and 3:35 p.m. revealed Resident #3 walking in the halls without a mask and talking to other residents, staff (LPN #1 and the DON, respectively), and the surveyor. The staff were not observed redirecting her or reminding her to put on a mask during those observations. During an interview on 7/2/2020 at 4:45 p.m. the Administrator and DON stated they had instituted a Quality Assurance Performance Improvement (QAPI) program on 6/19/2020 that addressed alleged infection control lapses by staff. Review of the QAPI project and training records reflected that the facility had been monitoring the staff for hand hygiene and providing ongoing supportive training. 3. Review of R#1's face sheet dated 7/2/2020 reflected that R#1 was initially admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. R#1's Quarterly Minimum Data Set ((MDS) dated [DATE] reflected a [DIAGNOSES REDACTED].#1 was unable to complete the assessment, a staff assessment of R#1's mental status as severely impaired, no behaviors, and the requirement for extensive/total assistance with Activities of Daily Living (ADLs). R#1 was sent to the hospital for a fall with major injury ([MEDICAL CONDITION]) on 5/26/2020 and returned to the facility on [DATE]. Per the untitled and undated facility spreadsheet, R#1 was diagnosed with [REDACTED]. R#1 was tested again for COVID-19 on 6/4/2020 and was reported negative on 6/6/2020, tested again on 6/16/2020 and 6/25/2020 and reported positive for both tests. R#1's care plan dated 7/2/2020 reflected that R#1 was care planned for COVID-19 infection with onset date of 6/10/2020 with interventions of daily screening, maintenance of isolation precautions, staff encourage use of face mask when out of room (6/25/2020 update) and treat symptoms per physician (MD) orders. Review of Summary Report orders dated 7/2/2020 reflected a Medical Doctor (MD) custom order for droplet and contact precautions starting on 6/2/2020. 4. Review of R#2's Face Sheet dated 7/2/2020 reflected that R#2 was initially admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. R#2's Significant Change MDS dated [DATE] reflected a [DIAGNOSES REDACTED].#2 was unable to complete the assessment, a staff assessment of R#2's mental status as severely impaired, no behaviors, and the requirement for extensive assistance with Activities of Daily Living (ADLs). Per the untitled and undated facility spreadsheet, R#2 was diagnosed with [REDACTED]. R#2 was tested again for COVID-19 on 6/5/2020, 6/16/2020 and 6/25/2020 and reported positive for all tests. Review of a Nurse's Note dated 6/5/2020 reflected that R#2 was referred to and accepted by hospice on 6/5/2020. Review of Nurses' Notes on 6/15/2020, 6/16/2020, 6/17/2020, 6/19/2020, 6/20/2020, 6/21/2020, 6/23/2020, 6/24/2020, 6/25/2020, 6/26/2020, 6/27/2020, 6/28/2020, 6/29/2020, 6/30/2020, 7/1/2020, and 7/2/2020 reflected that R#2 was ambulating in the hallway. Nurses' notes dated 6/27/2020, 6/29/2020, and 7/2/2020 reflected that R#2 was wandering into other residents' rooms. Nurse's notes dated 6/25/2020 reflected that R#2 was eating items from other residents' trays. Nurse's Notes dated 6/25/2020 reflected that another resident pushed R#2 in the dining room (R#5) with no injury, indicating that the residents were in close physical contact. R#2's care plan dated 7/2/2020 reflected that R#2 was care planned for COVID-19 infection with onset date of 6/3/2020 with interventions of daily screening, maintenance of isolation precautions, and treat symptoms per MD orders. A care plan update of 6/25/2020 included resident aimlessly wandered memory unit hallway, staff to redirect resident to stay in room, and staff encourage use of face mask when out of room. Review of Summary Report orders showed a MD custom order for droplet and contact precautions starting 6/2/2020. 5. Review of R#3's Face Sheet dated 7/2/2020 reflected that R#3 was initially admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. R#3's Significant Change MDS dated [DATE] reflected a [DIAGNOSES REDACTED].#3 was unable to complete the assessment, behaviors, and the requirement for extensive assistance with ADLs. Per the untitled and undated facility spreadsheet, R#3 was the first resident diagnosed with [REDACTED]. The resident was placed on isolation precautions on 5/18/2020 due to initial symptoms. Nurses' notes dated 6/2/2020 reflected that the test results were positive. R#3 was tested again for COVID-19 on 6/4/2020 with a negative test result. R#3 was tested [DATE] with a positive result and again on 6/25/2020 with a negative result. R#3 was tested again on 6/30/2020 with no results reported. Review of R#3's Nurse's notes including 6/9/2020, 6/10/2020, 6/11/2020, 6/12/2020, 6/16/2020, 6/15/2020, 6/16/2020, 6/17/2020, 6/18/2020, 6/19/2020, 6/20/2020, 6/21/2020, 6/22/2020, 6/23/2020, 6/24/2020, 6/25/2020, 6/26/2020, 6/27/2020, 6/28/2020, 6/29/2020, 6/30/2020, 7/1/2020, and 7/2/2020 reflected that R#3 walked in the secured unit hallways; additionally, nurse's notes dated 6/11/2020, 6/12/2020, 6/17/2020, 6/18/2020, 6/19/2020, and 6/24/2020 reflected that R#3 was wandering into other residents' rooms. R#3's care plan dated 7/2/2020 reflected that R#3 was care planned for COVID-19 infection with onset date of 5/22/2020 with interventions of daily screening, maintenance of isolation precautions, and treat symptoms per MD orders. A care plan update of 6/25/2020 indicated the resident aimlessly wandered the memory unit hallway, staff to redirect resident to stay in room and staff encourage use of face mask when out of room. Review of Summary Report orders dated 7/2/2020 reflected a MD custom order for droplet and contact precautions starting on 5/22/2020. 6. Review of R#4's Face Sheet dated 7/2/2020 reflected that R#4 was initially admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. R#4's Quarterly MDS dated [DATE] reflected a BIMS score of 0 indicating that R#4 was unable to complete the assessment, no behaviors, and the requirement for extensive assistance with ADLs. Per the untitled and undated facility spreadsheet, R#4 was diagnosed with [REDACTED]. R#4 was tested again for COVID-19 on 6/16/2020 with positive results and again on 6/25/2020 with negative results. R#4 was tested again on 6/30/2020 with results pending. R#4's care plan dated 7/2/2020 reflected that R#4 was care planned for COVID-19 infection with onset date of 6/3/2020 with interventions of daily screening, maintenance of isolation precautions, and treat symptoms per physician (MD) orders. A care plan update of 6/25/2020 included the resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115447	A. BUILDING _____ B. WING _____	**07/02/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HERITAGE INN OF BARNESVILLE HEALTH AND REHAB	**946 VETERANS PARKWAY BARNESVILLE, GA 30204**

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 -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) aimlessly wandered the memory unit hallway, staff to redirect resident to stay in room and staff encourage use of face mask when out of room. 7. Review of R#5's Face Sheet dated 7/2/2020 reflected that R#5 was initially admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. R#5's Quarterly MDS dated [DATE] reflected a [DIAGNOSES REDACTED].#5 was unable to complete the assessment, had no behaviors, and the requirement for extensive assistance with ADLs. Per the untitled and undated facility spreadsheet, R#5 was placed on isolation precautions on 5/29/2020 and diagnosed with [REDACTED]. R#5 was tested again for COVID-19 on 6/16/2020 with positive results and again on 6/25/2020 with negative results. R#5's care plan dated 7/2/2020 reflected that R#5 was care planned for COVID-19 infection with onset date of 6/3/2020 with interventions of daily screening, maintenance of isolation precautions, and to treat symptoms per MD orders. A care plan update of 6/25/2020 included resident aimlessly wandered memory unit hallway, staff to redirect resident to stay in room and staff encourage use of face mask when out of room. 8. Review of R#8's Face Sheet dated 7/2/2020 reflected that R#8 was initially admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. R#8's Significant Change MDS dated [DATE] reflected a [DIAGNOSES REDACTED]. Per the untitled and undated facility spreadsheet, R#8 was diagnosed with [REDACTED]. R#8 was tested again for COVID-19 on 6/16/2020 and again on 6/25/2020 with positive results. Review of Nurses' Notes reflected that R#8 was sent to the emergency roiagnom on [DATE] for agitation and violent behavior in the dining room. Nurses' notes including 6/15/2020, 6/17/2020, 6/20/2020, 6/22/2020, 6/24/2020, 6/25/2020, 6/27/ /29/2020, and 6/30/2020 reflected that R#8 ambulated with her walker in the hallways and dining room and visited room [ROOM NUMBER] on 6/22/2020 to watch television with another resident. R#8's care plan dated 7/2/2020 reflected that R#8 was care planned for COVID-19 infection with onset date of 6/3/2020 with interventions of daily screening, maintenance of isolation precautions, and treat symptoms per MD orders. A care plan update of 6/25/2020 included resident aimlessly wandered memory unit hallway, staff to redirect resident to stay in room and staff encourage use of face mask when out of room. 9. Review of R#6's Face Sheet dated 7/2/2020 reflected that R#6 was initially admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. and anxiety. R#6's Quarterly MDS dated [DATE] reflected a [DIAGNOSES REDACTED]. Per the untitled and undated facility spreadsheet, R#6 was diagnosed with [REDACTED]. R#6 was tested again for COVID-19 on 6/16/2020 with positive results and again on 6/25/2020 with negative results. R#6 was tested again on 6/30/2020 with results pending. R#6's care plan dated 7/2/2020 reflected that R#6 was care planned for COVID-19 infection with onset date of 6/3/2020 with interventions of daily screening, maintenance of isolation precautions, and treat symptoms per MD orders. Care plan update of 6/25/2020 included resident aimlessly wandered memory unit hallway, staff to redirect resident to stay in room and staff encourage use of face mask when out of room. 10. Review of R#7's Face Sheet dated 7/2/2020 reflected that R#7 was initially admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. and anxiety. R#7's Annual MDS dated [DATE] reflected no BIMS score, staff assessment of severely impaired mental status, no behaviors, and the requirement for extensive assistance with ADLs. Per the untitled facility spreadsheet provided on 7/2/2020, R#7 was diagnosed with [REDACTED]. R#7 was tested again for COVID-19 on 6/16/2020 with positive results and again on 6/25/2020 with negative results. R#7 was tested again on 6/30/2020 with results pending. R#7's care plan dated 7/2/2020 reflected that R #7 was care planned for COVID-19 infection with onset date of 6/3/2020 with interventions of daily screening, maintenance of isolation precautions, and treat symptoms per MD orders. A care plan update of 6/25/2020 included resident aimlessly wandered memory unit hallway, staff to redirect resident to stay in room and staff encourage use of face mask when out of room.