STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235036	A. BUILDING _____ B. WING _____	06/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDILODGE OF ROCHESTER HILLS, INC	1480 WALTON BLVD ROCHESTER HILLS, MI 48309

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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 was placed in Immediate Jeopardy due to the facility's systemic failure to institute and operationalize appropriate Infection Control practices in accordance with the Centers for Disease Control and Prevention's (CDC's) recommended measures of the cohorting and isolation of residents with similar signs and symptoms of infection to prevent exposure and transmission of the Covid-19 virus to other facility residents and staff, including 21 residents (Residents #1, #2, #3, #4, #5, #6, #7, #9, #11, #12, #13, #14, #15, #17, #18, #20, #21, #23, #24, #25, and #27),. This included implementation of appropriate interventions, such as Transmission Based Precautions, timely creation of a Covid unit and designated staff for the Covid and Transitional monitoring units to prevent the spread of respiratory illness from the Covid-19 virus. The failure to maintain infection control practices resulted in the likelihood for a serious adverse outcome including infectious illness and death if appropriate Infection Prevention and Control Standards of Practice were not enacted. Immediate Jeopardy: During a tour of the facility on [DATE] at 1:05 PM the Director of Nursing (DON) identified the 1st floor North East Hall (NE) as the area designated for residents being monitored for potential Covid-19 exposure and those residents with signs and symptoms of Covid-19 (there were 5 residents identified by the DON in Rooms 111, 115, 117 and 119); with the remainder of the 10 residents on the hall who were asymptomatic residents (that had not had potential exposure to Covid-19 (Rooms ,[DATE]). This unit was not enclosed and was open to the hallway leading to the elevators and front entry hall. The DON indicated the first 5 rooms at the beginning of the hallway (,[DATE] a Transitional Unit) were residents being monitored for signs and symptoms of Covid-19 after potential exposure. This area was open and a continuous part of the rest of the hallway to include rooms ,[DATE]. The residents' doors were open to the hallway. room [ROOM NUMBER] was at the very front of the hallway, diagonal from the main elevators to the 2nd floor and basement (where offices and the Employee Break Room were located). While walking down the hallway, it was noted that many of the residents' rooms shared a bathroom with the room next door. room [ROOM NUMBER] had 2 Residents with potential exposure to Covid-19 who were being monitored for signs and symptoms of illness This room shared a bathroom with room [ROOM NUMBER]. The resident in 121 did not have potential exposure to Covid-19 but was placed at risk of exposure should either resident in room [ROOM NUMBER] become symptomatic. Resident rooms that shared a bathroom on the 1st floor NE unit: ,[DATE], ,[DATE], ,[DATE], ,[DATE] and ,[DATE]. In addition, the resident bathrooms did not have a shower. There was 1 shower on the NE unit located between rooms [ROOM NUMBERS] in the Transitional monitoring area. All residents, regardless of exposure status, were transported to this potentially infectious area for a shower, per the DON. The Director of Nursing said the 1st floor North West (NW) Hall, directly across from the 1 NE Hall, was the designated Covid-19 Unit. The double doors to the hallway were observed closed. The area was immediately adjacent to room [ROOM NUMBER] (a Transitional monitored room). The Covid Unit was approximately ,[DATE] feet from the main elevators. The designated area for staff to don (put on) and doff (remove) Personal Protective Equipment (PPE) was inside the doorway to the Covid Unit. The DON said there were 3 residents who tested positive for the Covid-19 virus on the 1 NW Covid Unit, including Resident #1 (who tested positive at the facility) and 2 residents admitted with Covid-19. During the tour on [DATE] at 1:25 PM, staff were observed walking from one unit on the first floor to the other unit. The Director of Nursing was asked if there were dedicated staff for the Covid unit and Transitional monitoring units and said they were usually the same staff who normally worked each hall. The Covid-19 Unit (1 NW) had 1 nurse and 1 Certified Nursing Assistant (CNA) on the day shift. The 1 NE unit that included the Transitional Monitoring rooms was staffed by 1 nurse and 2 CNA's; There was no separation of staff on the Transitional unit. Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007), last update: [DATE] . Any infectious agents transmitted in healthcare settings may, under defined conditions, become targeted for control because they are epidemiologically important .In determining what constitutes an epidemiologically important organism, the following characteristics apply: A propensity for transmission within healthcare facilities based on published reports and the occurrence of temporal or geographic clusters of >2 patients . A single case of healthcare-associated invasive disease . is generally considered a trigger for investigation and enhanced control measures because of the risk of additional cases and severity of illness associated with these infections . Common and uncommon microorganisms with unusual patterns of resistance within a facility . A newly discovered or reemerging pathogen . Numerous factors influence differences in transmission risks among the various healthcare settings . LTCF's (Long Term Care Facilities) are different from other healthcare settings in that elderly patients at increased risk for infection are brought together . Documented LTCF outbreaks have been caused by various viruses . and bacteria . prompt detection and implementation of effective control measures are required . Fundamental Elements Needed to Prevent Transmission of Infectious Agents in Healthcare Settings . Adherence to recommended infection control practices decreases transmission of infectious agents . Surveillance is an essential tool for case-finding of single patients or clusters of patients who are infected or colonized with epidemiologically important organisms . Surveillance of both process measures and the infection rates to which they are linked are important for evaluating the effectiveness of infection prevention efforts and identifying indications for change . Cohorting is the practice of grouping together patients who are colonized or infected with the same organism to confine their care to one area and prevent contact with other patients. Cohorts are created based on clinical diagnosis, microbiologic confirmation when available, epidemiology and mode of transmission . Assigning or Cohorting healthcare personnel to care only for patients infected or colonized with a single target pathogen limits further transmission of the target pathogen to uninfected patients . A review of the facility Respiratory Infection Surveillance Line Listings for March - [DATE] revealed that 41 residents tested positive for Covid-19 and 20 residents had died . 34 residents were positive for signs and symptoms of Covid-19 including: fever, cough, congestion, sore throat, shortness of breath, decreased oxygen saturation levels, increased confusion, decreased appetite and lethargy. [DATE]: 16 residents tested positive for Covid-19 from a census of 82 = 19.5%. [DATE]: 20 residents tested positive for Covid-19 from a census of approximately 78 = 25.6%. [DATE]: 5 residents tested positive for Covid-19 from a census of approximately 55 = 9%. 33 of 53 resident rooms shared a bathroom. Between [DATE] and [DATE], 40 staff were identified with signs and symptoms of Covid-19. The facility did not have consistent dedicated and separate staff for Covid-19 positive residents, residents with potential exposure to Covid-19 and Covid-19 negative residents . On [DATE] the Centers for Medicare and Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC) issued the following recommendations: . new recommendations to State and local governments and long-term care facilities (known as nursing homes) to help mitigate the spread of the 2019 Novel Coronavirus (Covid-19) . To provide critical, needed leadership for the Nation's long-term care facilities to prevent further spread of Covid-19, CMS and CDC are now recommending the following immediate actions to keep patients and residents safe: . To avoid transmission within long-term care facilities, facilities should use separate staffing teams for Covid-19 positive residents . and work with State and local leaders to designate separate facilities or units within a facility to separate Covid-19 negative residents from Covid-19 positive residents and individuals with unknown Covid-19 status . The goal is to decrease the number of different staff interacting with each patient and resident

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) as well as the number of times those staff interact with the patient and resident. Also, staff as much as possible should not work across units or floors . Long-term care facilities should separate patients and residents who have Covid-19 from patients and residents who do not, or have an unknown status . Covid-19 positive units and facilities must be capable of maintaining strict infection control practices and testing protocols, as required by regulation . The facility did not designate a separate Covid-19 resident unit until [DATE]. This was 22 days after the CMS and CDC guidance was issued and almost 6 weeks after the facility began to identify multiple residents and staff with signs and symptoms of Covid-19. The first symptomatic staff member was identified on [DATE] and the first symptomatic resident was identified on [DATE]. The first Covid-19 positive resident was identified on [DATE] and first Covid- 19 positive staff member was identified on [DATE]. As of [DATE] the facility was still housing residents suspected of exposure to Covid-19 next to asymptomatic residents. Residents continued to share bathrooms. The Immediate Jeopardy began on [DATE]. The Immediate Jeopardy was identified on [DATE]. The Administrator was notified on [DATE] of the Immediate Jeopardy that began on [DATE]. The IJ Abatement (Removal) Plan was approved on [DATE] with a Removal Date of [DATE]. Findings Include: On [DATE] at 3:20 PM, a phone interview was conducted with Infection Control Nurse (IC) A, the Director of Nursing and the Administrator related to the positive Covid-19 resident and staff cases and those with signs and symptoms of Covid-related illness. The Administrator said the facility had started a Covid Unit on the 1st floor NW hall on [DATE]. The Administrator was asked why the facility waited so long to enact a designated closed unit. 15 residents tested positive for Covid-19; with most of those residents tested and diagnosed after transferring to the hospital with signs and symptoms of Covid-19. The Administrator said this was in response to a facility-wide testing of all residents on [DATE] with approximately 20 residents testing positive at that time. During the interview, the Director of Nursing (DON) and IC Nurse were asked about Transmission Based Precautions (Isolation precautions) for symptomatic residents and those with positive Covid-19 test results. The IC Nurse said the residents were placed in Transmission Based precautions. When asked for further clarification, the IC Nurse indicated Droplet Precautions. The IC Nurse was asked what precautions were recommended by the CDC for Covid-19 and said, It's Droplet and Contact, but they wear an N-95 in the Covid-positive rooms. Reviewed with the IC Nurse, DON and Administrator, that this was not clearly indicated outside of the room for each resident in precautions for Covid-19. Also, during the interview, the DON and IC Nurse were asked how the resident precautions were communicated to the staff. Was a physician's orders [REDACTED].? The IC Nurse said she documented a weekly SOC progress note that included if the resident was placed in Transmission Based Precautions, such as Droplet and Contact precautions. The DON said a physician's orders [REDACTED]. During the interview on [DATE] at 3:30 PM, the IC Nurse, DON and Administrator all said the facility staff were wearing an N-95 mask and isolation gown while caring for all residents including Covid-19 positive residents, Persons Under Investigation (PUI) or asymptomatic residents. They said this practice was discontinued several weeks prior to the survey. The process was clarified during the interview and the IC Nurse said the staff were wearing the same N-95 mask and isolation gown in every resident's room but would put another gown over top (wear 2 gowns) in the Covid-19 positive rooms. The staff were wearing the same mask and gown throughout the building during the course of their shift. They were not removing them or changing them to care for asymptomatic vs. residents symptomatic for Covid-19. The DON and Administrator were asked if there was dedicated staff assigned to the Covid-19 positive residents and they said the staff caring for the residents were Generally the same staff who worked on that hall prior to the designation of a Covid positive unit. A list of designated staff for Covid-19 residents and those with potential exposure was requested at this time. CDC, Strategies for Optimizing the Supply of Isolation Gowns, page last reviewed [DATE], . Crisis Capacity Strategies . Extended use of isolation gowns. Consideration can be made to extend the use of isolation gowns (disposable or cloth) such that the same gown is worn by the same HCP (Health Care Provider) when interacting with more than one patient known to be infected with the same infectious disease when these patients are housed in the same location (i.e. Covid-19 patients residing in an isolation cohort). This can be considered only if there are no additional co-infectious [DIAGNOSES REDACTED]. Disposable gowns are not typically amenable to being doffed (removed) and re-used because the ties and fasteners typically break during doffing . Staff that had signs and symptoms of illness were reviewed during the interview on [DATE] at 3:45 PM. The Administrator said there had not been an issue with having enough staff to care for the residents, but also said many staff had become ill with signs and symptoms of Covid-19 and several tested positive for Covid-19. When asked how long the symptomatic staff were off work with illness, the Administrator said it varied. In an interview on [DATE] at 4:20 PM, Epidemiologist H from the local health department stated, You need to be diligent about screening Residents and staff and make sure you have other measures in place such as Cohorting. You do not wait for the test result, because the result will not change what you need to do. That is why you don't wait until someone is symptomatic. Epidemiologist H was asked what other measures were needed to control an outbreak in a facility and said, Essentially dedicated staff. You don't have someone working the Covid unit one day and a different unit the next day. On [DATE] at 8:05 AM, during an interview with the IC Nurse A, a review of the March, April and [DATE] respiratory line listings for residents and staff indicated 14 staff with signs and symptoms of Covid-19 illness returned to work in less than 10 days from onset of symptoms and 9 staff returned in ,[DATE] days. The IC Nurse was asked if the facility was following the CDC recommendations for staff with signs and symptoms of Covid-19 and she said, some of the staff said they felt better, so they were allowed to return to work earlier. CDC, Coronavirus Disease 2019 (Covid-19), Criteria for Return to Work for Healthcare Personnel with Suspected or Confirmed COVID-19 (Interim Guidance), Last updated [DATE] and page last reviewed [DATE], Decisions about return to work for HCP (Healthcare Providers) with confirmed or suspected COVID-19 should be made in the context of local circumstances. Options include a symptom-based (i.e. Time-since-illness-onset and time-since-recovery strategy) or time-based strategy or test-based strategy . Symptom-based strategy. Exclude from work until: At least 3 days (72 hours) have passed since recovery defined as resolution of fever without the use of fever-reducing medications and improvement in respiratory symptoms . and At least 10 days have passed since symptoms first appeared . Test-based strategy. Exclude from work until: Resolution of fever without the use of fever-reducing medications and Improvement in respiratory symptoms . and Negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for Detection [DIAGNOSES REDACTED]-CoV-2 RNA from at least two consecutive respiratory specimens collected (> or =) to 24 hours apart . On [DATE] at 9:07 AM the March- [DATE] respiratory line listing for residents and staff was reviewed with IC Nurse A. There were 11 staff members who were symptomatic for Covid-19 from [DATE]- [DATE]. From [DATE] to [DATE], 16 residents at the facility, were symptomatic for Covid-19 prior to testing positive at the hospital for Covid-19. The IC Nurse was asked what measures were put in place to attempt to stop the spread of illness and she said the residents were placed in Transmission Based precautions in their rooms. The IC Nurse said there were symptomatic residents on both the 1st and 2nd floors and the facility attempted to group some of the symptomatic residents together on the 2nd floor, but asymptomatic residents continued to reside in the same hall and share bathrooms with symptomatic residents. The IC Nurse said after the facility tested all residents on [DATE] and there were approximately 20 more residents positive for Covid-19, a Covid Unit was created on the 1st floor NW hall. The IC Nurse said she documented an SOC Note weekly for those resident with signs and symptoms of an illness. When asked if the facility had specific, dedicated staff on the Covid Unit and if there was a list of those staff, the IC Nurse was not sure. A list of dedicated staff for the Covid Unit was requested on [DATE] and not received until [DATE] as part of the Immediate Jeopardy Abatement plan. CDC, Long-Term Care (LTC) Respiratory Surveillance Line List, [DATE], 'The Respiratory Surveillance Line List provides a template for data collection and active monitoring of both residents and staff during a suspected respiratory illness cluster or outbreak . Using this tool will provide facilities with a line listing of all individuals monitored for or meeting the case definition for the outbreak illness . Each row represents an individual resident or staff member who may have been affected . The information . capture data on the case demographics, location in the facility, clinical signs/symptoms, diagnostic testing results and outcomes . ' Information gathered on the worksheet should be used to build a case definition, determine the duration of outbreak illness, support monitoring for and rapid identification of new cases and assist with implementation of infection control measures . CDC, Transmission-Based Precautions, [DATE], . Recommendation, V.A.1, In addition to Standard Precautions, use Transmission-Based Precautions for patients with documented or suspected infection or colonization with highly transmissible or epidemiologically-important pathogens for which additional precautions are needed to prevent transmission CDC, Coronavirus Disease 2019 (Covid-19), Page last reviewed: [DATE], update [DATE], Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings, . Isolate symptomatic patients as soon as possible . cohort patients with COVID-19, limit the numbers of staff providing their care . A record review of the face sheet, vital signs, progress notes, physician orders, assessments, Minimum Data Set (MDS) assessments and Care Plans was completed for the following facility residents who were symptomatic or tested positive for Covid-19: Resident #1:

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 2) Resident #1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. On [DATE] Resident #1 was positive for Covid-19. The MDS assessment, dated [DATE], indicated the resident had full cognitive abilities as evidenced by a Brief Interview for Mental Status score (BIMS) of 15 out of 15 and needed assistance with all care. A review of the progress notes for Resident #1 revealed the following: -[DATE] SOC Infection, 9:55 AM, . Transmission precautions (related to) positive COVID-19 . Transmission-Based precautions were started after the resident had a confirmed positive test for Covid-19. -[DATE]:52 AM, SOC Infection, Precaution type: Transmission-based precautions . The resident was placed on Transmission-based precautions 3 days after suspicion of infection with Covid-19. -[DATE] at 8:23 AM, . resident's test results came back positive for COVID-19 . move to room [ROOM NUMBER]A . -[DATE] 11:06 AM. . (Nurse Practitioner- NP) ordered COVID-19 swab . There was no documentation that the resident was placed into specific Transmission Based precautions. Per prior interview with the IC Nurse, staff were wearing a mask and gown throughout the building, while going room to room to care for residents. -[DATE] 3:30 PM, . resident altered mental status . -[DATE] at 6:27 PM, Phone call received from resident's (family) . concerned that resident was dehydrated and possibly septic . (0xygen saturation (pulse oximeter), Mayo Clinic, [DATE], . Normal pulse oximeter readings usually range from ,[DATE]% .) 92% (room air- ra) . -[DATE] SOC Infection note, . Transmission based precautions throughout the facility r/t Covid-19 in the building . -[DATE] . transferred from (room) 108 . (No explanation documented). -[DATE] .Unable to give shower as resident is isolated at this time (related to) neighbor isolation . -[DATE] . resident has had poor fluid intake . (Doctor J) notified and orders taken for (IV fluids). -[DATE] . less than 50% taken for breakfast and approx. 50% taken for lunch (IV fluids) running in left arm . -[DATE] . Resident is not at her baseline and is not conversing or interacting with staff . (Doctor J) ordered (IV fluids) . -[DATE] 8:30 PM, . Resident was readmitted from hospital ([DATE]) on [MEDICATION NAME] (antibiotic) for UTI . Standard precautions . -[DATE] 9:55 AM, . After meeting with the resident, the (family) requested that the nurse send the resident to the hospital . -[DATE] 1:42 PM, . Resident continues to not be at baseline and has increased confusion . A review of the physician orders [REDACTED]. A previous order for Isolation precautions was not located in the medical record. A review of the Care Plans, indicated a Care Plan titled, Infection, dated [DATE], Transmission-Based precautions. with no details of what this included. Resident #3: Resident #3 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The MDS assessment, dated [DATE], revealed the resident had full cognitive abilities as evidenced by a BIMS score of ,[DATE] and needed assistance with all care. Per the March - [DATE] Respiratory surveillance report, Resident #3 was the first identified Covid-19 positive resident in the facility. He was transferred to the hospital on [DATE] for a change of condition including fever and shortness of breath. A review of the progress notes for Resident #3 revealed the following: -Per the admission provider note dated [DATE], the resident had abnormal lung sounds rhonchi bilateral. -February 28, 2020, The residents oxygen saturation (02sat) was 89% on room air and oxygen at 3 liters/minute was administered [MEDICAL CONDITION]. . expectorating copious amounts of yellow tinged secretions. -[DATE], 02sat 87% room air (ra), encouraged deep breathe and cough, sat increased to 93% ra. -[DATE], Resident had two episodes of emesis. Resident was suctioned multiple times, sp02 (02sat) 85% on 5L/02. Temp 100.8 HR (heart rate) 120 . Resident went 911 (to the hospital) . at 915. A review of the Medication Administration Records (MAR's) and Weights and Vitals indicated blood pressure, pulse and respirations were documented every shift, but temperatures were taken less than daily. There was no documented temperatures on [DATE], [DATE], [DATE], [DATE], ,[DATE] to [DATE], [DATE], ,[DATE] to [DATE] and [DATE]. There were 3 only skilled nursing notes dated [DATE]-[DATE] and documentation in the nurse's notes was less than daily. On [DATE], during the survey, Nurse K made a late entry note for 2 months prior. It was dated [DATE], Resident had [MEDICAL CONDITION]. Resident also developed respiratory distress and was sent out to the hospital. A review of the resident's Care Plans indicated a Care Plan titled, Monitor for signs and symptoms of infection . date initiated [DATE], with interventions, Monitor temperature every shift, dated [DATE] and Monitor vital signs daily, dated [DATE]. Resident #9: Resident #9 was initially admitted to the facility on [DATE] and readmitted [DATE] with [DIAGNOSES REDACTED]. The MDS assessment, dated [DATE], indicated the resident had moderate cognitive impairment as evidenced by a BIMS score of ,[DATE] and needed extensive assistance with all care. The progress notes revealed the resident began to have a fever and cough on [DATE]. The resident had several falls during her illness: [DATE] and [DATE]. A respiratory panel completed [DATE] was negative. The resident was tested for Covid-19 on [DATE] and the test was negative, although the resident was symptomatic. The resident was treated with antibiotics (,[DATE]-[DATE] and ,[DATE]-[DATE]) for pneumonia after a chest x-ray showing opacities on [DATE] and infiltrates [DATE]. The resident was transferred to the hospital on [DATE], returned to the facility on [DATE] and transferred to the hospital again on [DATE] where she died . Progress Notes: -[DATE] at 5:53 PM, Resident BG (blood sugar) 419 (very high) . (physician) gave order to send to the hospital . -[DATE] at 2:36 PM, . Temp 100.5 . Resident not eating or drinking this shift . -[DATE] provider note by Physician M, . We will monitor this patient closely since she is at high risk for decline and hospitalization . -[DATE] provider note be Physician M, .low grade fever Fall ([DATE])[DATE] Monitor temp every shift . -[DATE] Provider note- I am evaluating this patient today to assess her low-grade fever and cough. On [DATE] she had a temp of 100.1 as well as a productive cough . -[DATE] New onset of fever with a cough. Resident is currently on droplet precautions . A review of the IC Nurses SOC Infection Notes for Resident #9, indicated there were 4 notes for the year 2020: [DATE], [DATE], [DATE] and [DATE]. The IC Nurse had said she documented weekly on residents with signs and symptoms of illness, but Resident #9 began with a fever and cough on [DATE]. The IC note prior to [DATE] was dated [DATE]. The [DATE] note said, . presumptive Covid-19 .Transmission based precautions throughout the facility . During this timeframe, the facility staff were wearing PPE throughout the building (1 gown and mask for the entire shift- in all resident rooms). The Electronic Medical Record (EMR) indicated from [DATE] to [DATE], Resident #9 had been moved to several different rooms between the 2nd and 1st floors (3 room moves) prior to transfer to the closed Covid unit on [DATE]. The transfers between rooms and floors could have potentially exposed many residents to Covid-19. A review of Resident #9's Care Plan titled, The resident is on transmission based precautions r/t (related to) presumptive Covid-19 in the facility, date initiated and revised [DATE], with interventions, Staff to wear appropriate PPE including gowns, gloves, N-95 masks and goggles during care, date initiated and revised [DATE]. There was no further clarification. The Care Plan did not mention Droplet precautions, as indicated in the [DATE] progress note. Resident #11: Resident #11 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The MDS assessment, dated [DATE], indicated the resident had mild cognitive loss as evidenced by a BIMS score of ,[DATE] and needed some assistance with care. A review of the progress notes for Resident #11 provided the following: -The resident developed a fever on [DATE]. The physician ordered lab tests to be completed STAT (meaning immediately with results in ,[DATE] hours). The lab tests were not obtained until 2 days later on [DATE]. The residents condition declined, and he was sent to the hospital on [DATE], where he was diagnosed with [REDACTED]. -[DATE], . resident went to hospital . temp=102.0 Tylenol given . 99.8 . persistent cough . to ER . -[DATE] at 2020, 8:56 PM, .started a 20-gauge peripheral IV in resident's right wrist . IV infusing well . toileted x1 with extensive assist . extensive assist x1 for ambulation and clothing . The resident had become weaker and needed more assistance with care. -[DATE] at 7:02 PM, . resident lethargic, and not eating and drinking . orders given for BMP/CBC stat with IV fluids . x1 day or 24 hours at 75ml/hr. The STAT labs were drawn on [DATE] and reported to the facility on [DATE]. They indicated the resident was dehydrated (BUN 40 and Creatinine 2.2- both high). The IV fluids were not started until approximately 24 hours later. -[DATE] at 6:56 AM, Pt declines STAT labs . becomes agitated quickly . -[DATE] at 6:54 PM, Temp 100.4, (Physician M) notified and gave order for STAT BMP (Basic Metabolic Profile) CBC (Complete Blood Count) RSV (Respiratory [MEDICAL CONDITION] test) . A review of the physician's orders [REDACTED]. A review of Resident #11's Care Plan titled Monitor for signs and symptoms respiratory infections . date initiated [DATE], with interventions, Monitor temps ever shift (8 hour shifts) and Monitor vital signs daily, both dated [DATE]. There was no update to indicate the most recent orders for monitoring. A review of the Weights & Vitals, for the resident revealed multiple days that vital signs were not taken as ordered. Vital signs were not taken 4 times/day as ordered on [DATE], 0xygen saturation was not assessed every shift or daily. Vital Signs: Temperatures not taken as ordered on [DATE], [DATE], [DATE], [DATE]/ [DATE]. Oxygen saturation, Blood pressure, pulse, respiratory rate were not taken every shift on [DATE], [DATE], [DATE], ,[DATE]-[DATE]. Resident #13: Resident #13 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the progress notes for Resident #13 indicated the resident resident's roommate tested positive for Covid-19 and the resident developed a fever; Droplet precautions were referenced on [DATE], had a decreased appetite documented on [DATE], developed a low oxygen saturation rate on [DATE]= 90% and began recei