| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245447 | A. BUILDING _____ B. WING _____ | 09/23/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| SACRED HEART CARE CENTER | 1200 12TH STREET SOUTHWEST AUSTIN, MN 55912 |

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<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Some | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview and document review, the facility failed to implement all necessary infection control practices to prevent and/or minimize a facility wide outbreak of COVID-19 for 21 of 46 residents (R1, R2, R3, R4, R5, R7, R8, R9, R10, R11, R12, R13, R14, R15, R16, R17, R18, R19, R20, R21, R22) resulting in an immediate jeopardy (IJ). This deficient practice had the potential to affect all residents residing in the facility and staff who were at risk for contracting COVID-19. The immediate jeopardy began on [DATE], when the facility's failure to implement appropriate infection control practices to mitigate or reduce the spread of COVID-19 in the facility, the IJ was identified on [DATE]. The administrator and director of nursing (DON) were notified of the immediate jeopardy at 5:10 p.m. on [DATE]. Additional IJ findings were identified on [DATE], when it was identified the facility failed to separate a symptomatic resident from a healthy resident roommate, and failed to initiate risk assessments to determine potential causal factors of transmission and identify high risk resident exposures. The administrator and director of nursing were notified of this additional information at 3:00 p.m. on [DATE]. The immediate jeopardy was removed on [DATE], when the facility had developed and implemented an acceptable plan. However, non compliance remained at the lower scope and severity level of G, isolated scope and severity level, which indicated harm that is not immediate jeopardy. Findings include CMS memo COVID-19 Long Term Care Facility Guidance, dated [DATE], directed nursing homes to immediately ensure they were complying with all CMS and CDC guidance related to infection control which included the use of standard, contact and droplet precautions. In addition, the memo directed long-term care facilities to separate patients and residents who have COVID-19 from patients and residents who did not, or whose status was unknown. Upon entrance to the facility, on [DATE] at 8:30 a.m. the receptionist, who was responsible for screening staff and contracted staff, was not wearing a mask or eye protection. The receptionist stated because she was not a direct care provider, and was not working on the nursing floor, she didn't have to wear a mask or eye protection. During the entrance conference on [DATE], at 8:46 a.m. the DON stated the facility had a COVID isolation unit that had six beds which had been filled after they'd conducted testing earlier in the month. The DON stated because there was not enough available staff to have another separate unit, the facility had designated their 200 wing to be the new quarantine area and was in the process of moving another four residents into that area. The DON and IP (infection preventionist) verified wing 200 currently had both COVID positive and negative residents. The DON further stated the 100 and 300 wings did not have symptomatic or COVID positive residents. The IP stated the facility had identified their first COVID positive resident on [DATE], and then other residents started demonstrating symptoms around the same time. The IP stated 13 residents and 7 staff tested positive after testing was conducted [DATE]. The IP also stated she was unaware which residents currently displayed signs and symptoms of illness, and stated the information would be in the resident infection tracking notes in the electronic health record. The IP stated she had not completed the infection control surveillance log and/or performed any related activities such as track/trending, risk assessments, or audits since around the end of [DATE]. During a facility tour with the DON on [DATE], at 10:10 a.m. the DON again stated not all residents on the 200 wing were positive for COVID, and confirmed the wing was not divided into sections for COVID-19 positive and negative. During the tour R1 and R2 were observed to reside in the same room. The DON stated R1 and R2 continued to share a room even though R1 had tested COVID-19 positive and had symptoms. The DON stated staff were using transmission based precautions (TBP) when they entered the room. The DON stated R8 was the first resident to test positive for COVID-19 and was immediately transferred to the COVID unit. The DON stated after the unit was at capacity, residents who tested positive remained in their rooms, and residents with shared rooms who became positive, or who had symptoms, remained in the same room as the roommate even if the roommate was not positive or had symptoms. During the tour, dietary assistant (DA)-A was observed in the kitchen area with a cloth mask on. DA-A stated said she was wearing a cloth mask per the facility policy. DA-B stated dietary staff could use either a cloth mask or a medical grade mask because they didn't have direct contact with residents. DA-B stated up until a couple of weeks ago dietary staff were not wearing any type of mask. R8's census line indicated R8 resided on wing 200. A progress note dated [DATE], indicated R8 was tested for COVID-19. Progress noted dated [DATE], indicated R8 tested positive for COVID-19. A subsequent progress note at 11:40 a.m. indicated R8 was tested again, and swab was sent to local clinic for processing. At 11:59 p.m., a physician notification note was sent to the physician to inform the physician of R8's positive test results, another swab was collected and sent to local clinic, and R8 was in an isolation room, and staff were wearing N95's masks when in her room. A progress note dated [DATE] included, Tolerated move to quarantine area well. The facility lacked evidence of completed risk analysis of potential exposures and/or transmission to other residents, investigation of the illness, and identification of potential causal factors of disease transmission. According to the facility's census report R11 and R12 resided in the same room on 200 wing. R11's Admission Record provided by the facility on [DATE], included [DIAGNOSES REDACTED]. R11's quarterly Minimum Data Set ((MDS) dated [DATE], indicated R11 had severe cognitive impairment. R11's progress note dated [DATE] at 3:42 a.m., indicated R11 had low blood oxygen saturation of 88% and required an increase of supplemental oxygen from 2 LPM (liters per minute) to 4 LPM. An Illness Tracking Note (ITN) from [DATE] at 2:46 p.m., indicated R11 had reported to nursing she didn't feel good. The ITN included, Type of illness: Possible Respiratory. States doesn't feel good and face flush. Despite the ITN dated [DATE], indicating a possible respiratory illness, the facility lacked evidence transmission based precautions (TBP) were implemented immediately and R11 was separated from her roommate. According to an ITN note dated [DATE], R11 tested positive for COVID with use of the [MEDICATION NAME] testing machine; R11 was then moved to the COVID isolation unit. R12's Admission Record provided by the facility on [DATE], included [DIAGNOSES REDACTED]. R12's progress notes for [DATE], indicated R12 had testing conducted with the facility's [MEDICATION NAME] machine with negative results, and was moved to the COVID isolation unit. A subsequent progress note dated [DATE], indicated R12 tested positive for COVID-19 with the [MEDICATION NAME] machine. According to the facility's census report R9 and R10 resided in the same room on 200 wing. R10's Admission Record provided by the facility on [DATE], included [DIAGNOSES REDACTED]. R10's annual Minimum Data Set ((MDS) dated [DATE], indicated R10 had moderate cognitive impairment. R10's progress note dated [DATE] included, Resident had a small emesis this A.M. Yellow in color. Resident has a temp (temperature) of 99.6. Will continue to monitor. R10's record lacked evidence TBP were immediately implemented and R10 was separated from her roommate. An ITN's dated [DATE], indicated R10 had loose stools. ITN note dated [DATE], indicated R10's blood oxygen saturations were ,[DATE]% on room air. On [DATE], the ITN indicated R10 had a fever of 100.0. On [DATE], at 2:51 a.m. indicated R10 had fever of 99.7 and had a dry harsh cough. R10's [DATE] progress note from 9:25 a.m., indicated R10 tested positive for COVID-19 from the [MEDICATION NAME] machine. Progress note on [DATE], at 11:44 a.m. indicated R10 was transferred to the COVID isolation unit. R10's progress notes dated [DATE], indicated R10 was transferred to the hospital for further evaluation related to worsening respiratory status and was subsequently admitted to the hospital. A physician notification note dated [DATE], indicated R10 had passed away in the hospital today at 5:10 p.m. R9's Admission Record provided by the facility on [DATE], included [DIAGNOSES REDACTED]. R9's quarterly MDS dated [DATE], indicated R9 had moderate cognitive impairment. R9's |

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<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Some | (continued... from page 1)<br>progress note dated [DATE], at 5:36 a.m. indicated R2's oxygen saturations were ,[DATE]% on room air so the nurse started oxygen at 2.5 lpm (liters per minute). R9's physician [DATE], at 11:41 a.m. notification included, (R9) seems more and more confused from her baseline, getting times of day mixed up. Had a fever today of 99.8. wheezing noted in upper lobes of lung sounds. The note also indicated R9 had low blood sugar, declined to each lunch. A response from the physician at 5:47 p.m. included, I recommend checking a COVID-19 test ASAP. R9's record lacked evidence TBP were implemented or whether R9 was separated from her roommate immediately. The record identified TBP were implemented more than 24 hours later on [DATE]. R9's progress note dated [DATE], at 9:20 a.m. included Results for COVID came back Positive with [MEDICATION NAME] machine<br>testing. A subsequent note on [DATE], indicated R8 moved to the COVID isolation unit. According to the facility's census report R1 and R2 resided in the same room on 200 wing. R1's Admission Record provided by the facility on [DATE], included [DIAGNOSES REDACTED]. R1's quarterly Minimum Data Set ((MDS) dated [DATE], indicated R1 did not have cognitive impairment.<br>R1's Illness Tracking Note (ITN) dated [DATE], at 11:19 a.m. included R1 had dry non-productive cough, potential Covid exposure. R1's ITN dated [DATE] at 11:49 a.m,. included: Dry non-productive harsh cough, Covid [MEDICATION NAME] test was negative. A Subsequent note at 8:58 p.m. indicated R1 had a cough, and rubs were noted in both lungs. Despite R1's symptoms, R1's record lacked evidence of initiation of transmission based precautions (TBP) or whether R1 was separated from her roommate (R2) to prevent and/or mitigate the risk of disease transmission. R1's ITN dated [DATE] at 10:29 a.m., indicated R1 had a cough and lungs were clear. A subsequent note at 12:37 p.m. included, Resident swabbed for COVID and tested with the [MEDICATION NAME] Machine. Results = POSITIVE (+). R1's physician visit note dated [DATE], included: [DIAGNOSES REDACTED]-CoV-2 [MEDICATION NAME] test was positive on [DATE]. Due to the COVID-19 isolation unit being at full<br>capacity, she has remained on isolation in her semi-private room. Nursing staff indicates that she has had a fever and occasional cough. R1's ITN notes from ,[DATE] to [DATE], identified R1 continued to have symptoms associated with COVID-19 which included: elevated temperatures up to 101.6, non-productive cough, wheezing lung sounds, and congestion. A progress note dated [DATE], indicated R1 needed to be reminded to try to keep a mask on and a progress note dated [DATE], indicated R1 was reminded to cover her mouth when she coughs. Despite R1's COVID symptoms, R1's record did not identify when TBP were initiated and R1 was not separated from her roommate to prevent and/or mitigate the risk of disease transmission. R2's Admission Record provided by the facility on [DATE], included [DIAGNOSES REDACTED]. R2's significant change MDS dated [DATE], indicated R2 did not have cognitive impairment. R2's ITN note dated [DATE], indicated R2 had an elevated temperature of 100.2. The ITN for [DATE], indicated R2 had a temperature of 99.0. A subsequent note on [DATE], indicated R2 was tested via [MEDICATION NAME] machine with negative results. R2's record lacked evidence that TBP were initiated when she initially developed the fever [DATE]. ITN note dated [DATE], indicated droplet precautions were in place. R2's record indicated R2 was moved to a private room on the 200 wing on [DATE], after the facility was notified of the immediate jeopardy. R2's progress note dated [DATE], indicated the registered nurse assessed R2's mobility and included, Transferred her with AO1 (assist of one), belt, and 4 w/w (wheeled/walker) from her recliner and walked her to just outside her room and then back in again. R2's progress note dated [DATE], indicated R2 was tested for COVID-19. R2's progress note dated [DATE], indicated R2 tested positive for COVID-19. According to the facility's census report R13 and R14 resided in the same room on 300 wing. R13's Admission Record provided by the facility on [DATE], included [DIAGNOSES REDACTED]. R13's quarterly MDS dated [DATE], indicated R13's cognitive skills for daily decision making were severely impaired. R13's ITN dated [DATE], indicated R13 had a fever of 99XXX,[DATE].2 and had an emesis. A progress note dated [DATE], indicated R13 was tested with the [MEDICATION NAME] machine with negative results. R13's record lacked evidence TBP were immediately implemented or whether R13 was separated from her roommate. R13's progress note dated [DATE], indicated R13 had some coughing with large amounts of phlegm while eating On [DATE], the ITN indicated R13 had experienced temps of 102.3, 100.8, and 101.4, and had exhibited a cough and sinus congestion. Subsequent progress notes on [DATE], indicated R13 tested positive for COVID-19 with the [MEDICATION NAME] machine and was moved to the COVID isolation unit . R13's progress note<br>dated [DATE], indicated R13 died . R14's ITN note dated [DATE], indicated R14 had exhibited an increase in temperature of 99.5 degrees. R14's record lacked evidence TBP were implemented, and failed to identify illness tracking was immediately initiated. R14's record indicated R14 was tested for COVID on [DATE], results were not documented in the record. A progress note dated [DATE], indicated R14 had undergone follow up testing for COVID by PCR. A subsequent progress note dated [DATE], indicated R14 had negative results. R14's record did not identify PCR test results. R14 was transferred to 100 wing and on [DATE] and then on [DATE] was transferred to the 200 wing. R14's progress note did not identify reason for room change, but indicated contact TBP's were implemented on [DATE]. According to the facility's census report R15 resided in a private room on 200 wing. R15's Admission record provided by the facility on [DATE], included [DIAGNOSES REDACTED]. R15's progress note dated [DATE], indicated R5 got short of breath with activity, had slight wheeze with trying to get out of bed, another progress note dated [DATE], indicated the [MEDICATION NAME] machine was used with negative results. Despite R15's symptoms, R15's record lacked evidence TBP's were immediately implemented. R15's progress notes on [DATE], indicated R15 required an increase in supplemental oxygen related to decreased saturations of 88%, in addition to temperature of 100.8. A note at 12:36 p.m. indicated R15 tested positive for COVID using the [MEDICATION NAME] machine. R15's progress note dated [DATE], indicated R15 was transferred to the hospital for hypoxic respiratory distress. A progress note dated [DATE], indicated R15 died at the hospital at 10:20 a.m. According to the facility's census report R19 resided on the 200 wing in a private room. R19's Admission Record provided by the facility on [DATE], included [DIAGNOSES REDACTED]. R19's ITN note dated [DATE], indicated R19 reported being weak, was short of breath and dizzy during a transfer, face was red and warm, temp of 101.0, and exhibited decreased oxygen saturations at 88% which required supplemental oxygen. A progress note dated [DATE], indicated R19 had a negative COVID test per use of the [MEDICATION NAME] machine. Despite R19's symptoms, the record lacked evidence TBP were implemented. R19's record identified, R19 continued to have symptoms of elevated temperature, diarrhea, and required oxygen. The record further indicated R19 was tested on ,[DATE] and [DATE] with negative results from the [MEDICATION NAME] machine. A progress note dated [DATE], indicated R19 was transferred to the hospital for further evaluation for [MEDICAL CONDITION] and change in condition. A progress note dated [DATE], indicated the facility had been notified R19 was transferred to the intensive care unit. A progress note dated [DATE], indicated R19 had been diagnosed with [REDACTED]. A subsequent progress note dated [DATE], indicated R19 was readmitted to the facility into a private room on the 200 wing. According to the facility's census report R3 and R4 resided in the same room on 200 wing. R3's Admission Record provided by the facility on [DATE], included [DIAGNOSES REDACTED]. R3's quarterly Minimum Data Set ((MDS) dated [DATE], indicated R3 had severe cognitive impairment. R3's ITN dated [DATE], indicated R3 had an elevated temperature of 99.4 degrees. A subsequent progress note indicated R3 tested positive for COVID-19 using the [MEDICATION NAME] machine. R3's record did not address implementation of TBP or whether R3 was separated from roommate. R4's Admission Record provided by the facility on [DATE], included [DIAGNOSES REDACTED]. R4's admission MDS dated [DATE], indicated R4 had severe cognitive impairment. R4's progress note dated [DATE], indicated R4's family was notified R3 had tested positive for COVID-19. R4's progress note dated [DATE], indicated R4 tested positive for COVID-19. R4's record did not address implementation of TBP until [DATE]. R4's progress note dated [DATE] included on isolation precautions. According to the facility's census report R18 resided on the 200 wing in a private room. R18's Admission Record provided by the facility on [DATE], included [DIAGNOSES REDACTED]. of nicotine dependence, and [MEDICAL<br>CONDITION] stage 3. R18's quarterly MDS dated [DATE], indicated R18 had severe cognitive impairment. R18's ITN note dated [DATE], indicated R18 had an elevated temp 99.3, and had vomited three times within 2 minutes. R18's record lacked evidence TBP were immediately initiated. On [DATE], R18's ITN's indicated temp of 99.3 and emesis. From ,[DATE] thru [DATE], R18's record did not include ITN. On [DATE], an ITN note indicated R18 had a cough. Progress notes dated ,[DATE] and [DATE], indicated R18 tested negative with the [MEDICATION NAME] machine. An ITN note dated [DATE], indicated R18, had a fever of 100.0. A progress note dated [DATE], indicated R18 tested positive with the [MEDICATION NAME] machine. Even after R18 tested positive for COVID-19, R18's record identified TBP were not implemented until [DATE]. According to the facility's census report R16 resided on the 200 wing in a private room. R16's Admission Record provided by the facility on [DATE], included [DIAGNOSES REDACTED]. R16's quarterly MDS dated [DATE], indicated R16 had moderate cognitive impairment. R16's ITN dated [DATE], indicated R16 had a change in respiratory status and crackles could be heard in lungs. R16's record lacked evidence of immediate implementation of TBP. An ITN dated [DATE], indicated R16 had crackles in his lungs. An ITN dated [DATE], indicated R16 had a fever of 99.2 and did not eat or drink at supper. An ITN dated [DATE], indicated R16 had a fever of 99.3. A corresponding progress note dated [DATE], indicated R16 was tested with the [MEDICATION NAME] machine with positive COVID-19 results. Even after R16's tested positive, the record lacked evidence TBP were implemented. According to the facility's census report R17 resided on the 200 wing in a private room. R17's |

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| F 0880<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Some | (continued... from page 2)<br>Admission Record provided by the facility on [DATE], included [DIAGNOSES REDACTED]. R17's quarterly MDS dated [DATE], indicated R17's cognitive skills for daily decision making was severely impaired. R17's progress note dated [DATE], indicated R17 was diagnosed with [REDACTED]. lacked documentation of implementation of TBP. R17's ITN dated [DATE], indicated R17 had a non-productive cough, and on [DATE], a progress note indicated R17 had tested positive for COVID-19 with the [MEDICATION NAME] machine. R17's record lacked evidence TBP's were immediately implemented when R17 demonstrated symptoms, R1's record indicated TBP were not initiated until [DATE]. During an interview on [DATE], at 10:05 a.m. the infection preventionist (IP) was asked to provide a summary of any new onset of symptoms and/or new COVID positive residents or staff. IP stated on [DATE], R5 who resided on the 100 wing with a roommate, had developed a cough worse than usual, was put on droplet precautions, and was tested with the [MEDICATION NAME] machine with negative results. IP stated she also tested her roommate; results were negative. IP verified that while symptomatic, R5 was not separated from R6 because there was not another room available to move her to. IP indicated an unawareness R5 had an elevated temp of 100.0 on ,[DATE], coughing a lot with diminished lung sounds on ,[DATE], IP indicated precautions should have been implemented. IP stated, an exposure risk assessment was not completed for residents or staff. IP stated on [DATE], R7 developed symptoms of audible wheezing and decrease in oxygen saturations. She verified R7 tested positive for COVID with the [MEDICATION NAME] machine. IP stated R7 resided on wing 200 and placed on droplet precautions. IP indicated on [DATE], R20 who also resided on the 100 wing in a private room had developed shortness of breath, elevated fever, with no coughing; R20 was tested with the [MEDICATION NAME] machine with negative results, and placed on droplet precautions. The IP verified exposure risk assessments were not completed for residents or staff. During an interview on [DATE] at 1:30 p.m., the DON and administrator indicated the facility was in the process of moving residents including R5. When asked why R5 had not been separated from her roommate, the administrator stated R5's cough was thought to have been related to worsening asthma, and was not thought to be symptomatic for COVID. In addition, the administrator stated her roommate was already exposed and the facility did not want to move R5 or her roommate because they didn't want to spread the disease. DON and administrator was not aware R5 had displayed additional symptoms of illness on [DATE]. According to the facility's census report R5 resided on the 100 wing in a shared room. R5's Admission Record provided by the facility on [DATE], included [DIAGNOSES REDACTED]. R5's quarterly MDS dated [DATE], indicated R5 had moderate cognitive impairment. R5's ITN dated [DATE], indicated R5 had loose stools, and on [DATE], had a temp of 100.0 as well as dizziness and confusion. The record indicated R5 was tested with the [MEDICATION NAME] machine and was negative. ITNs were not completed from ,[DATE] thru [DATE] however, a progress note dated [DATE], indicated R5 complained of sternum pain and pain all over. On [DATE] progress notes and ITN's indicated R5 exhibited an occasional dry cough, complained of rattle in chest with diminished lung sounds. R5's record lacked evidence TBP were initiated immediately after symptoms presented. The record indicated R5 was placed on TBP on [DATE], however remained in the same room with her roommate even when ITN documentation through [DATE], indicated R5 continued to have symptoms of intermittent fevers and cough. According to the facility's census report R7 resided on the 200 wing in a private room. R7's Admission Record provided by the facility on [DATE], included [DIAGNOSES REDACTED]. R7's admission MDS dated [DATE], indicated R7 did not have cognitive impairment. R7's progress notes dated [DATE], indicated R7 had decreased oxygen saturations at 86% on room air. Progress notes also indicated R7 was tested with the [MEDICATION NAME] machine with positive results and transition based precautions were initiated. According to the facility's census report R20 resided on the 100 wing in a private room R20's Admission Record provided by the facility on [DATE], included [DIAGNOSES REDACTED]. R20's quarterly MDS dated [DATE], indicated R20 had moderate cognitive impairment. R20's ITNs dated [DATE], indicated R20 developed symptoms of elevated temp of 99.3, shortness of breath, chills, and was pale. R20's record indicated R20 tested negative for COVID using the [MEDICATION NAME] machine and was placed on TBP. A progress note dated [DATE], indicated R20 was retested with the [MEDICATION NAME] machine with positive results. R21's Admission Record provided by the facility on [DATE], included [DIAGNOSES REDACTED]. R21's quarterly MDS dated [DATE], indicated R21's cognitive skills for daily decision making were severely impaired. R21's progress notes dated [DATE], indicated R21's COVID PCR test that was collected on [DATE], was positive and TBP were implemented. R21's census line indicated R21 was moved to a different room on wing 200 as a result. R22's Admission Record provided by the facility on [DATE], included [MEDICAL CONDITION] stage 3, [MEDICAL CONDITION], fatigue, [MEDICAL CONDITION], and allegories. R22's significant MDS dated [DATE], indicated R22 did not have cognitive impairment. R22's progress notes dated [DATE], indicated R22 developed symptoms of loss of taste and temperature of 99.7. The notes indicated R22 tested positive for COVID with the [MEDICATION NAME] machine and was put on TBP and had a room change. R22's census line indicated R22 resided on the 100 wing and on [DATE], was moved to wing 200. The facility's policy Care For (Suspected) or Confirmed COVID-19 dated [DATE], was not consistent with CDC guidelines for removing isolation precautions. The policy included, It is the policy of Sacred Heart Care Center to promptly identify potential COVID infected residents, get orders for testing, get resident on isolation promptly and continue to provide care during duration of illness. It is also the policy to cohort residents with suspected or confirmed COVID test results to a designated area away from non-COVID infected residents. DEFINITIONS: Suspected: Will be defined as having symptoms closely related to an infectious disease and waiting for a sample to be obtained for testing or having had a test done and are still waiting for results. PROCEDURE: Once COVID-19 test results come back 1) If negative results, isolation precautions will be discontinued. 2) If positive, isolation precautions will continue. 4) Resident with positive COVID-19 test results will be moved to designated isolation area. The facility's policy Infectious Disease Outbreak dated [DATE], included, It is Sacred Heart's policy to protect residents form infectious diseases. It is our policy to stop or slow the spread of transmission of infectious disease from resident to resident during an outbreak by acting quickly during the first signs of illness. PROCEDURE: 1) When a resident presents with signs and symptoms of infectious disease (i.e. fever, cough sneezing, runny nose, diarrhea, vomiting, etc.) the resident will be asked to remain in their room until symptoms subside or they are deemed no longer to be contagious. During an interview on [DATE], 12:15 p.m., the DON stated since [DATE], three more residents had tested positive for COVID-19 including: R5, R21 and R22. The DON stated the facility had made wing 200 their dedicated COVID unit and residents were moved so they could be appropriately cohorted. She stated the COVID positive residents were either in private rooms or shared rooms, and residents who were presumptive positive related to displayed symptoms were in private rooms for ongoing monitoring. The also DON stated clinical managers had initiated risk assessments in order to ascertain potential causal factors of transmission that could be removed. The immediate jeopardy that began on [DATE], was removed on [DATE], when it could be verified the facility had reviewed their policies, had appropriately implemented cohorting and transmission based precautions strategies, had initiated risk assessments for residents, and had provided staff education. |