STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235604	A. BUILDING _____ B. WING _____	09/02/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WOODHAVEN RETIREMENT COMMUNITY	29667 WENTWORTH AVENUE LIVONIA, MI 48154

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 implement and operationalize a comprehensive infection control and prevention program including lack of thorough, methodical, and cohesive infection control tracking, surveillance and data analysis, lack of appropriate utilization and disinfection of reusable Personal Protection Equipment (PPE), and lack of a designated area within the facility for new and readmitted Residents. This deficient practice resulted in lack of appropriate PPE use during care of Resident #701, intermingling of Residents with known and unknown Covid-19 status throughout the facility including Resident #702 being placed in a general area of the facility, while displaying signs and symptoms of Covid-19, with subsequent Covid-19 infection of six facility staff and 10 of 11 (#'s 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, and 712) Residents reviewed, hospitalization , the likelihood for continued transmission of infection to all 15 facility Residents, and death related to Covid-19. The Administrator was notified of the Immediate Jeopardy on 9/1/20 at 4:41 PM. A plan to remove the immediacy was requested. The IJ begin on 7/31/20, and was removed on 9/2/20 based on the facility's implementation of the plan removal as verified onsite on 9/2/20. Although the IJ was removed, the facility's deficient practice remained widespread. No actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: An entrance conference was conducted with the facility Administrator and Director of Nursing (DON) on 9/1/20 at 10:00 AM. When queried regarding the facility census, the DON stated, I think there are 15 (Residents). When asked if any Resident in the facility had Covid-19, both the Administrator and DON indicated there were no positives cases in the building. The Administrator and DON were then queried regarding Residents in isolation related to suspected or unknown Covid-19 status. The DON revealed Residents admitted to the facility within the past 14 days were in isolation. With further inquiry regarding facility policy/procedure related to isolation for Residents admitted within the past 14 days, the DON stated, Full Covid PPE. The DON was then asked what full PPE included, the DON replied, Mask, face shield, gown, gloves. When asked what type of mask was required, the DON replied, An N95 preferred for 14 day (period after admission). When asked if the newly admitted and readmitted Residents in isolation were located within a designated Transition unit of the facility, the DON stated, No transition unit. With further inquiry regarding the location of Residents with unknown Covid status in the facility, the DON and Administrator revealed the facility has single rooms and Residents are placed in any available room when they are admitted . When queried how many Residents were currently in full PPE for 14 days related to Covid-19, the DON revealed they were unsure of the number, but they would check and provide a list. Facility infection control program and surveillance data including Covid-19 data was requested at this time. A tour of the facility began at 10:30 AM on 9/1/20. During the tour, Nursing Assistant B was observed standing in the hallway, just outside of Resident #701's room. The door to Resident #701's room was open, and a hanging PPE caddy was noted on the door. The sign on the PPE caddy indicated Full PPE was required for entry in the room. Nursing Assistant B was wearing a gown and procedural facemask over a KN95 mask (filtration respirator approved only for emergency use in United States). Resident #701 was noted to be in their bed from the hallway of the facility. An interview was conducted with Nursing Assistant B at this time. When queried, Nursing Assistant B revealed they were waiting for another staff member to bring them a wrist name band for the Resident before they exited the room. When asked the reason Resident #701 was in isolation precautions, Nursing Assistant B revealed the Resident was recently admitted to the facility. At this time, another facility staff handed Nursing Assistant B a wrist band and Nursing Assistant B entered Resident #701's room without wearing eye protection. Throughout the tour, no staff were observed wearing eye protection and all Resident rooms doors were noted to be open. Fourteen (of 15 Residents) had isolation precautions in place related to Covid-19. Each room with a hanging isolation PPE caddy which either indicated Continuous Full PPE or Full PPE until (date). None of the hanging isolation PPE caddies contained eye protection. On 9/1/20 at 10:47 AM, LPN C was observed standing at the medication cart in the hall of the facility wearing a KN95 mask with a procedural mask over it. An interview was conducted at this time. When queried regarding the rationale for Residents being on isolation precautions, LPN C revealed isolation precautions were related to Resident's being readmit or admits. When asked about the dates on the hanging PPE caddies, LPN C revealed the dates indicated when the precautions were able to be discontinued. LPN C was then asked why the caddy on some Resident rooms, including Resident #701 indicated continuous PPE, LPN C replied, Those we suspect for other infections like a UTI (Urinary Tract Infection). When queried what PPE is worn in rooms with Full PPE isolation precautions in place, LPN C replied, Gown, gloves, masks. LPN C was then asked if eye protection such as a face shield was required to be worn and replied, We have our own. At 11:00 AM on 9/1/20, Registered Nurse (RN) E was observed exiting Resident #701's room with a transparent, dark tinged colored, garbage bag in their hand. A face shield and two boxes of wound care supplies were visible in the bag. An interview was completed with RN E at this time. When asked, RN E revealed they had been in Resident #701's room providing care. When queried regarding the items in the bag, RN E divulged they placed their face shield in the garbage bag to take to the utility room to clean it. When asked about the other supplies in the bag, RN E hesitated and then stated, It's garbage. RN E did not provide an explanation regarding why they placed their reusable face shield in a bag with garbage nor why they did not dispose of the garbage in the Resident's room when asked. RN E was then observed taking their face shield to the Utility Room of the facility. RN E washed their hands, removed the face shield from the bag, and placed the boxes of wound care supplies in the garbage bin. At this time, RN E placed hand sanitizer on a paper towel and wiped the inside of the face shield but did not wipe the outside (most contaminated) surface of the shield. RN E then placed the shield on the counter with the outside surface of the shield directly on the counter and indicated they were done disinfecting their face shield. No disinfecting cleaners/products were noted in the Utility room. When asked if they frequently utilize hand sanitizer to disinfect their face shield and RN E stated, Yes. RN E exited the room at this time without performing hand hygiene. Review of Resident #701's medical record revealed the Resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Nursing Admission Screening/History Assessment, dated 8/28/20 at 9:54 PM, revealed Resident #701 had intact cognition, was alert to Person, Place, Time, and Situation and required partial to total assistance to perform Activities of Daily Living (ADLs). Review of Resident #701's medical record revealed the following progress note, dated 8/31/20 at 12:01 PM, Physician's Prog. Note . Covid-19 negative on 8/20/20 .Universal precautions in place for 14-days following admission . Note, per the Centers for Disease Control (CDC), Universal precautions were developed in response to the HIV/AIDS epidemic, applied only to blood and body fluids contaminated by blood, and do not include transmission-based isolation precautions. Universal precautions is now referenced to as Standard Precautions (2019). Review of Resident #701's care plans did not include a care plan related to isolation precautions and/or Covid-19. Resident #701's Treatment Administration Record (TAR) revealed a section entitled, Monitor for signs/symptoms of COVID-19 (respiratory, temperature, cough) every shift. Notify MD (Medical Doctor) if symptoms present . (Start Date: 7/28/20). On 9/1/20 at 12:00 PM, an interview was completed with the facility Administrator and Business Office Manager J. When queried regarding the disposition Residents diagnosed with [REDACTED]. When asked, both staff indicated Residents were either transferred to the hospital, to a different Long Term Care Facility, or sent home. An

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)

interview was conducted with the Social Services Director on 9/1/20 at 12:25 PM. When queried regarding the disposition of Covid-19 positive Residents who were transferred to another Long Term Care Facility. The Social Services Director revealed they coordinated discharge to a facility that had a dedicated area for Covid Residents. When asked if the Residents were transferred to a designated Covid-19 Regional Hub Facility, the Social Services Director replied, No. When asked why the Residents were not transferred to a Covid-19 Regional Hub Facility, the Social Services Director stated, I heard on the news they closed down. When asked if they had received official notification from the State of Michigan that the Hubs had closed, Social Services Director replied, No. When queried if they contacted the Regional Hub facilities, the Social Services Director replied, No. An interview was conducted with the DON on 9/1/20 at 12:41 PM. When asked the total number of facility Residents who had been diagnosed with [REDACTED]. Facility Covid-19 infection control data was requested again at this time. When queried what transpired in the facility that resulted in positive Covid-19 cases, the DON replied, We did education and training. We stopped admissions. When queried what systemic failure occurred which resulted in spread of Covid to multiple staff and Residents in the facility, the DON stated, We identified patient zero (Resident #702). The Resident was coughing in the hall when they were admitted . The DON further revealed the PA (Physician Assistant) was present in the facility when Resident #702 arrived to the facility from the hospital via EMS. The DON was then queried regarding infection control procedures and determination of how Covid-19 spread from Resident #702 to other facility Residents and staff. The DON stated, This thing (Covid-19) is Airborne (very small [MEDICAL CONDITION] particle, spread through the air and able to travel considerable distances and maintain suspended in the air for extended periods of time). When asked why Resident room doors were open if Covid -19 is spread via the Airborne route, the DON stated, The (doors) should not be open but we don't have negative pressure rooms so it (Covid-19) goes through the vents. The DON was then queried regarding the mitigation of the spread of Covid-19 by closing Resident room doors and did not provide a response. The DON then stated, They (Residents) have private rooms. We would have to move everyone's rooms to do that. When queried how the facility tracks and monitors signs and symptoms of Covid-19 in Residents, the DON replied, Discuss in morning meeting. When queried regarding facility policy/procedure regarding wearing face shields (eye protection) in Resident rooms with Full PPE, the DON revealed eye protection should be worn in Resident rooms. The DON was then asked about observation of Nursing Assistant B not wearing eye protection in Resident #701's room, the DON replied, It is what it is. The DON was then asked about facility policy/procedure regarding cleaning and disinfection of re-usable face shields. The DON stated, Clean with disinfectant spray or wipe, especially on the outside and then leave sit until dry. When queried if hand sanitizer was appropriate to use to clean a face shield, the DON stated, I haven't really thought about it. When queried if hand sanitizer is for use on plastic, the DON looked at the facility bottle of hand sanitizer located on the table and stated, It says for hands, but I use it to clean. When asked if hand sanitizer is meant to be used on plastic and for disinfection of re-usable medical equipment, the DON stated, No, I don't see anything for plastic (on label). The DON was then told about observations of RN E but did not provide a response and/or explanation. Review of requested documentation of Residents currently in isolation precautions related to Covid-19 revealed a handwritten list of Residents provided by the DON. The list was titled, 14 Day Monitoring Covid-19 and included the names of 13 Residents currently residing in the facility. An un-sampled Resident, observed to have isolation precautions in place with a Full PPE stop date on their door of 9/4/20, was not included on the list. Review of facility provided list of Residents who had been diagnosed with [REDACTED]. Detailed analysis revealed 10 Residents tested positive during the three-week time-frame from 7/31/20 until 8/21/20. Review of facility provided Resident room census/placement data revealed the Residents who had contracted Covid-19 were housed in rooms within the same area of the facility. Detailed review of provided Covid-19 and seperate room census list revealed the following: -Resident #701: Symptom Onset: 7/31/20 . Description of Symptoms: Cough, failure to thrive, altered mental status . hospitalization Date: 8/4/20 . (Disposition: Hospital) . The Resident was in room [ROOM NUMBER] from 7/31/20 until 8/4/20. -Resident #706: Symptom Onset: 8/5/20 . Description of Symptoms: Altered mental status, dyspnea (shortness of breath) . hospitalization Date: 8/5/20 . (Disposition: Hospital) . Resident #706 was in room [ROOM NUMBER] from 7/31/20 to 8/5/20. -Resident #707: Symptom Onset: 8/6/20 . Description of Symptoms: Cough, weakness, fatigue . hospitalization Date: 8/6/20 . (Disposition: Hospital) . Resident #707 was in room [ROOM NUMBER] from 7/26/20 to 8/8/20. -Resident #708: Symptom Onset: 8/9/20 . Description of Symptoms: Dry cough, weakness, fatigue . hospitalization Date: 8/6/20 . (Disposition: Hospital) . Resident #708 was in room [ROOM NUMBER] from 7/30/20 to 8/10/20. -Resident #703: Symptom Onset: 8/6/20 . Description of Symptoms: Dry cough, weakness, fatigue . hospitalization Date: 8/6/20 . (Disposition: Hospital) . Resident #703 was in room [ROOM NUMBER] from 7/28/20 to 8/7/20. -Resident #705: Symptom Onset: 8/12/20 . Description of Symptoms: Cough, confusion . hospitalization Date: 8/13/20 . (Disposition: Hospital) . Resident #705 was in room [ROOM NUMBER] from 8/4/20 to 8/12/20. -Resident #704: Symptom Onset: N/A (Not Applicable) . Description of Symptoms: none . hospitalization Date: (N/A) . (Disposition) N/A .Resident #704 was in room [ROOM NUMBER] from 7/3/20 to 8/12/20. -Resident #709: Symptom Onset: N/A (Not Applicable) . Description of Symptoms: none . hospitalization Date: (N/A) . (Disposition) N/A . Resident #709 was in room [ROOM NUMBER] from 8/3/20 to 8/14/20. -Resident #710: Symptom Onset 8/13/20 . Description of Symptoms: Weakness, lethargy . hospitalization Date: 8/15/20 . Resident #710 was in room [ROOM NUMBER] from 8/13/20 to 8/17/20. -Resident #711: Symptom Onset: N/A (Not Applicable) . Description of Symptoms: none . hospitalization Date: (N/A) . (Disposition) N/A . Resident #711 was in room [ROOM NUMBER] from 8/6/20 to 8/11/20 and then room [ROOM NUMBER] from 8/12/20 until transferred. Record review revealed Resident #703 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was moderately cognitively impaired and required limited to extensive assistance to perform Activities of Daily Living (ADLs). Review further revealed Resident #703 was tested for Covid-19 on 8/4/20 and a positive result (indicating the Resident had Covid-19) was reported to the facility on [DATE]. Review of Resident #703's care plans revealed a care plan entitled, (Resident #703) is positive for COVID-19 (Initiated: 8/7/20). The care plan included the interventions: -Report to my physician worsening signs and symptoms of infection or lack of improvement from treatment. Report any of the following immediately: Trouble breathing/oxygen saturation < (less than) 90%; Persistent pain or pressure in my chest; New confusion or inability to arouse; Bluish lips or face (Initiated: 8/7/20) -Take my vital signs Q (every) shift, including pulse oximetry. Report abnormal findings (Initiated: 8/7/20) Review of Resident #703's medical record revealed the following progress note documentation: -8/6/20 at 4:07 PM: Physician's Prog. Note Note . Covid-19 positive . urinary frequency. Covid-19 . test collected on 8/3 resulted positive on 8/6 at 3:29 PM. Pt (patient) is with dry cough and weakness . -8/6/20 at 5:00: Health Status Note: PA (Physician Assistant) notified writer (Nurse) that Res Covid test was positive and order received to transfer to (Hospital). Res currently with mild cough but no other complaints, CNA (Nursing Assistant) had just transferred Res into bathroom to void . Report called to (Hospital ER) . called for transport . -8/7/20 at 2:09 PM: Physician's Prog. Note . Covid-19 positive. Patient seen and examined. Pt (Patient) returned from (Hospital ER) around 2:30 this morning with no new orders. No significant workup while in the ED reported. Pt continues with occasional dry cough, weakness, and fatigue . 8/7/20 at 6:10 PM: Discharge Summary . Resident discharged at 6:00 PM via w/c (wheelchair) van. Resident discharged to (Long Term Care Facility) . -8/10/20 at 9:55 AM: Discharge Summary Note . Patient was discharged to (Long Term Care Facility) on 8/7/20 at approximately 6 PM. Patient transferred due to quarantine and further management of Covid-19 infection . Resident #703's Treatment Administration Record (TAR) revealed a section entitled, Monitor for signs/symptoms of COVID-19 (respiratory, temperature, cough) every shift. Notify MD (Medical Doctor) if symptoms present . (Start Date: 7/28/20). The TAR documentation indicated the Resident never had a cough or temperature but did have Yes documented once for Respiratory on 8/7/20 during day shift. Review of facility provided Covid-19 tracking documentation for July/August 2020 revealed the following a written form which included Resident name, room number, admitted , symptom onset date, symptom description, and medical record review. The document included Resident #702 and Resident #710 but did not indicate when either Resident tested positive for Covid -19 and/or interventions implemented to mitigate the spread of [MEDICAL CONDITION]/outcome. The facility Covid-19 tracking documentation did not include any information for Resident #'s 703, 704, 705, 706, 707, 708, 709, and/or 711. On 9/1/20 at 2:17 PM, an interview was conducted with the DON. When queried regarding infection control within the facility, the DON revealed the Assistant Director of Nursing (ADON) is the Infection Control Nurse. The DON then stated, I am doing everything (infection control) with Covid. The DON was asked about the recent outbreak of Covid-19 in the facility and stated, We had 10 Residents and six staff since (Resident #702). When queried if the positive Residents were located in the same area of the facility, the DON indicated they were. When asked where tracking documentation related to positive facility staff was maintained, the DON indicated staff lab results are on the lab system. With further inquiry related to infection control monitoring and tracking of staff, the DON revealed they did not maintain staff information on the facility Covid-19 tracking form but would provide the information. When queried regarding not all relevant Resident information related to infection control and Covid-19 being included on the facility provided Covid-19 tracking documentation. The DON indicated they are not tech savvy and stated the Administrator and Business Officer Manager J enter data for reporting in State and Federal systems. When queried regarding the Covid positive Residents not included on the facility Covid-19 tracking documentation and how the facility facility monitors and tracks infections without documented data, the DON stated, In meetings daily. The DON was then asked how they know and track when Residents are tested for Covid-19 and the results of the testing, the DON replied, It is in the lab system. When asked why the data was not included in the facility infection control data, the DON indicated they are able to view the information in the lab system results. The DON was then queried how they were able to identify a cluster of infections without all the data and did not provide a response. When queried how they track symptoms, including ongoing and resolved symptoms, for infection control the DON indicated symptoms are documented on the TAR. The DON was then asked about facility policy/procedure related to testing of Residents and staff and replied, If (Resident) tested greater than 72 hours before coming here, will order a test when admitted . The DON continued, We do weekly testing if there is a positive result (in building). If no positive tests for 14 days, will do the test on admission. When queried regarding no orders for transmission based isolation precautions noted in Resident medical records, the DON stated, It's protocol and indicated it was in the facility policy. When queried regarding verification that Residents were in isolation that are no longer in the facility and documentation in the medical record, the DON revealed documentation should be included in the notes (documentation). Record review of Resident #706's medical record revealed the Resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the MDS assessment dated [DATE] revealed the Resident was moderately cognitively impaired and required limited to extensive assistance to perform ADLs with the exception of eating. Review of Resident #706's medical record revealed the following documentation: -8/5/20 at 8:09 AM: Health Status Note . c/o (complain of) SOB (Shortness of Breath) on oxygen at 2 liters via nasal cannula. Lab result positive for COVID- 19 . -8/5/20 at 3:19 PM: Physician's Prog. Note . Patient transferred to (Hospital) on 8/5/20 due to positive Covid-19 . result, dyspnea, and altered mental status . There was not documentation of isolation precautions in Resident #706's progress note documentation. Resident #706's Treatment Administration Record (TAR) revealed a section entitled, Monitor for signs/symptoms of COVID-19 (respiratory, temperature, cough) every shift. Notify MD (Medical Doctor) if symptoms present . (Start Date: 7/31/20) revealed the Resident had a cough on 8/1/20 and 8/3/20. Per Resident #706's laboratory results, they were tested for Covid-19 on 8/3/20 and the positive result was received by the facility on 8/4/20. Review of Resident #706's care plans and health care provider orders revealed no orders for isolation precautions and did not include a care plan related to isolation precautions and/or Covid-19. Record review of Resident

#707's medical record revealed the Resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the MDS assessment dated [DATE] revealed the Resident was severely cognitively impaired and required assistance to perform ADLs. Review of Resident #707's documentation in the medical record revealed the following: -8/2/20 at 2:29 PM: Health Status Note . Resident sitting near nurse station for safety monitoring . -8/3/20 at 2:46 PM: Health Status Note . Resident sitting near nurse station for safety monitoring . -8/5/20 at 3:02 PM: Health Status Note . Resident sitting near nurse station for safety monitoring . -8/6/20 at 3:01 PM: Health Status Note . Resident sitting near nurse station for safety monitoring . -8/6/20 at 4:14 PM: Physician's Prog. Note . Covid-19 positive . wet cough this morning . -8/6/20 at 4:45 PM: Health Status Note . Resident is being transferred to (Hospital) d/t (due to) weakness cough and + Covid . -8/7/20 at 2:31 PM: Physician's Prog. Note . Covid-19 positive, cough . Pt returned from (Hospital) around 2:30 this morning with no new orders. No remarkable workup while in the ED reported, including CXR (Chest X-Ray) . did have temp of 99.8, while in ED .continues with wet cough, weakness, and fatigue . -8/7/20 at 11:41 PM: Health Status Note . Resident received back from (Hospital) at about 03:00 hour . appears stable . -8/8/20 at 2:32 PM: Resident D/C (Discharge) home with (Family) . Review of Resident #707's care plans revealed a care plan entitled, (Resident #707) is positive for COVID-19 (Initiated: 8/7/20; Revised: 8/8/20). The care plan included the interventions: -Administer my medications as ordered. Monitor for side effects -Report to my physician worsening signs and symptoms of infection or lack of improvement from treatment. Report any of the following immediately: Trouble breathing/oxygen saturation < (less than) 90%; Persistent pain or pressure in my chest; New confusion or inability to arouse; Bluish lips or face -Take my vital signs Q (every) shift, including pulse oximetry. Report abnormal findings Resident #707's TAR revealed a section entitled, Monitor for signs/symptoms of COVID-19 (respiratory, temperature, cough) every shift. Notify MD (Medical Doctor) if symptoms present . (Start Date: 8/28/20). Documentation included Yes for Respiratory on 8/3/20 and 8/7/20. Review of Resident #709's medical record revealed the Resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the MDS assessment dated [DATE] revealed the Resident was rarely/never understood and required extensive to total assistance to perform ADLs. Review of Resident #709's medical record documentation revealed the Resident was transferred to another Long Term Care facility on 8/14/20 due to testing positive for Covid-19. Additional review revealed Resident #709 was tested for Covid on 8/11/20 and the positive results were received by the facility on 8/13/20. Review of Resident #709's care plans did not include a care plan related to isolation precautions and/or Covid-19 prior to their date of discharge from the facility on 8/14/20. Review of Resident #711's medical record revealed the Resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the MDS assessment dated [DATE] revealed the Resident was cognitively intact and required supervision to extensive assistance to perform ADLs. Further review of Resident #711's medical record revealed the Resident was transferred to another Long Term Care facility on 8/20/20 due to testing positive for Covid-19 on 8/19/20. Review of Resident #711's care plans did not include a care plan related to isolation precautions for Covid-19. An interview and review of the facility infection control program was completed with the ADON (designated Infection Control Nurse) and LPN F. When queried, the ADON indicated LPN F assisted them with infection control. With further inquiry regarding the program, the ADON provided the facility infection control policy and revealed all infection control data is reported to the DON. When asked, the ADON indicated standard precautions were the most important part of their infection control program. When queried what infection control surveillance activities are performed, the ADON and LPN F both indicated 24 hour reports,[MEDICAL CONDITION] screens, and (antibiotic) orders are reviewed. When asked if any other infection control surveillance and tracking is completed, LPN F replied, Evaluate any trends that come up. When asked to view the facility line listing and surveillance data as well as any tools utilized, the ADON revealed they did not bring the documentation and would need to get it. Both the ADON and LPN F exited the room at this time and returned at 12:33 PM. Upon their return, a review of infection control data was completed. No data for August 2020 was included. When asked, the ADON stated, I have not had a chance to finish it. When asked if they complete infection control tracking after the month is over, the ADON reiterated that infections are reviewed during the daily meeting. Review of provided line listing documentation and mapping of Residents revealed the tracking documentation only included Residents who had received an antibiotic. Additionally, a separate infection control mapping tool was completed for nosocromial (facility acquired) and community acquired infections, receiving antibiotic therapy. The ADON and LPN F were asked about tracking and surveillance of Residents with signs and symptoms of infection who were not receiving an antibiotic, the ADON replied, We track the antibiotics. When queried regarding surveillance and monitoring of potential infections prior to an antibiotic being ordered and [MEDICAL CONDITION] infections that do not require an antibiotic, the ADON was unable to provide an explanation. Resident #705 was noted on the infection control line listing as being treated for [REDACTED]. When asked if Resident #705 also had Covid-19, the ADON stated, Not sure. When asked, the ADON and LPN F revealed they do not maintain Covid infection data. The ADON and LPN F were then asked about their role in Covid-19 tracking and surveillance for signs and symptoms and the ADON stated, (DON) is in charge of Covid information. When asked if they review the Covid-19 test results for Residents and staff, both the ADON and LPN F revealed the DON reviews all the Covid testing results. With further inquiry regarding the data included on the facility infection control mapping tool, the ADON stated, It is an outline for people on antibiotics. When asked how they were able to timely identifying infections including trends and patterns to mitigate transmission without including data related to all infections, including Covid-19 and other infections not treated by antibiotics, LPN F stated, Basically, (DON) is doing Covid, but we do collaborate. When asked if they were tracking all signs and symptoms of infections as part of the infection control program, the ADON stated, I am doing this for antibiotics only. The ADON was then asked if a Resident would be monitored and tracked by infection control if they had a cough and were generally not feeling well, but were not on an antibiotic. The ADON revealed they would collaborate with the Residents healthcare provider and the DON but would not include them in their infection control data. The ADON was then asked how they are able to quickly identify and mitigate transmission of communicable infections when they do not review and track all infections within the facility. The ADON reiterated they collaborate with the Healthcare provider and the DON. When asked if they had training in Infection Control, the ADON revealed the only education they received was a webinar. When asked, the ADON revealed they had not completed any training through the CDC or an Infection Control Organization. With further inquiry regarding the webinar they completed, the ADON revealed the webinars were about an hour long and did not include a comprehension test. On 9/2/20 at 10:30 AM, Housekeeping Staff D was observed cleaning a Resident room, which was a full PPE isolation room on 9/1/20. Housekeeping Staff D had a procedural mask over a KN95 mask but no other PPE was wor