STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065414	A. BUILDING _____ B. WING _____	06/01/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
POWERBACK REHABILITATION LAFAYETTE	329 EXEMPLA CIR LAFAYETTE, CO 80026

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 0660 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Plan the resident's discharge to meet the resident's goals and needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident, family and staff interviews and record review, the facility failed to develop and implement effective discharge planning for five (#1, #2, #3, #4, and #5) of 5 sample residents discharged while COVID-19 test results were pending or following the residents' exposure to [MEDICAL CONDITION]. Record review and interview revealed the facility failed to consider and address the post-discharge needs of these residents, their families and their communities. The facility conducted facility-wide COVID-19 testing from [DATE] to [DATE] after discovering one resident (#6) tested positive for COVID-19. The facility discharged Resident #1 home to his family on [DATE] while his test results were pending. At discharge, the facility failed to inform the family of Resident #1's pending COVID-19 test and failed to educate the family on COVID-19 precautions. The facility also discharged Residents #2, #3, #4 and #5 to home and the community after possible exposure to COVID-19; two of these residents (#2, #3), while COVID-19 test results were pending and two with exposure but not tested (#4, #5). These residents, too, failed to receive education on precautions to prevent the spread of COVID-19 at discharge. This potentially compromised their health as well as the health of their families and communities. The facility's failures in discharge planning created an immediate jeopardy situation, specifically, the likelihood of family and community spread of COVID-19 and its potentially serious adverse outcomes. Cross-reference 880; Infection Control. Findings include: I. IMMEDIATE JEOPARDY A. Findings of immediate jeopardy Resident #1, moderately cognitively impaired, admitted to the facility on [DATE] for a short-term stay; his planned discharge date was [DATE]. He arrived from a sister facility that was transitioning to an all COVID-19 facility. Resident #1 had tested negative twice when tested for COVID-19 prior to his transfer. Following the discovery that a resident (#6) had tested positive for COVID-19, the facility conducted facility-wide testing for COVID-19 on [DATE]. Resident #1 was administered a test on [DATE], and his test was sent to the lab on [DATE]. The test results were returned to the facility on [DATE], after Resident #1 had discharged home with his wife and daughter. The facility called the Resident #1's wife in the afternoon of [DATE] to inform her the resident's COVID-19 test had come back positive. The resident's wife was shocked to hear of the resident's positive test; she had no idea the resident had been tested for COVID-19. The facility's failure to consider and address Resident #1's post-discharge needs based on COVID-19 created the likelihood of Resident #1 spreading COVID-19 to his family and the community. On [DATE] at 1:35 p.m., the nursing home administrator (NHA) and the director of nurses (DON) were notified its failure to consider and address Resident #1's post-discharge needs created an immediate jeopardy situation. Specifically, the facility had failed to consider delaying the resident's discharge until after receiving the results of his COVID-19 test and failed to address the resident's and his family's need for education on how to ensure the resident's family and community would be safe from the possible transmission on COVID-19. B. Facility plan to remove immediate jeopardy On [DATE] at 10:46 a.m., the facility submitted a plan to abate the immediate jeopardy. The abatement plan read: Corrective Action: Effective [DATE] the center will document in the line listing of notification with the family/responsible party. Effective [DATE], discharge paperwork will include handouts with current CDC (center for disease control) guidance and considerations for PPE (personal protective equipment) upon discharge to home. All nursing staff will be re-educated by Center Nurse Executive or designee beginning on [DATE] and completed by [DATE] on proper documentation related to discharge paperwork and PPE guidance for families. To include handouts from the CDC and WHO (world health organization) on how to properly care for people with suspected COVID. On [DATE] Center Nurse Executive/Nurse Managers initiated/performed competency assessments and observations on confirming discharge paperwork to include PPE usage/guidance as appropriate or necessary for families on discharge. On [DATE], Center Executive Director called an immediate QAPI (quality assurance and performance improvement) meeting with (the) facility Medical Director and QAPI members to address concerns identified. Systematic Measures: Center Nurse Executive and/or designee will review discharges of suspected Covid-19 patients during the morning Clinical Meeting to ensure proper discharge paperwork and PPE education was provided to the family and documented. Clinical Quality Specialist or designee will review Covid-19 assessments daily to identify residents with Covid-19 triggers, possible pending tests and discharge date s. Quality Assurance and Monitoring: Quality Assurance Performance Improvement (QAPI) meeting held on [DATE] with Interdisciplinary Team members and the Medical Director specifically related to Covid-19 in the center. The Interdisciplinary Team will review and assess all discharged residents for discharge paperwork and PPE education for families during clinical meetings daily for four weeks, three times a week for four weeks, and then twice weekly for four weeks to monitor and validate compliance. Center Nurse Executive or designee will audit and ensure all residents tested for Covid-19 are notified of status and properly discharged with education five times a week for four weeks, then three times a week for four weeks, then twice a week for four weeks to ensure the facility is in compliance. C. Removal of immediate jeopardy The immediate jeopardy was lifted on [DATE] at 10:46 a.m. However, observations, interviews and record review revealed deficient practice remained at an E level, a pattern with the potential for more than minimal harm. II. Residents exposure to COVID-19 Record review revealed Resident #6 admitted to the facility on [DATE] from a sister facility that was transitioning to all COVID-19 positive residents. The resident was tested twice for COVID-19 before being transferred and tested negative for COVID-19 on both tests. However, prior to discharge to an assisted living facility, the resident was tested again for COVID-19. On [DATE], the resident's second COVID-19 test result came back positive, and on [DATE], the resident was transferred back to the all COVID-19 positive sister facility. The nursing home administrator (NHA) and director of nurses (DON) were interviewed on [DATE] at 10:55 a.m. The NHA said after Resident #6 tested positive for COVID-19 on [DATE], the corporate team wanted to make sure the facility was following all of the protocols, so they decided to test all of the staff and residents in the building to see if there had been any additional positive COVID-19 residents or staff. The DON and NHA said they had contacted families to inform them of the COVID-19 positive resident, but had not documented that communication in any resident records. III. Failure of the facility to consider and address the post-discharge needs of residents their families and communities following the residents' potential exposure to Resident #6 and COVID-19. A. Resident #1 Resident #1, [AGE] years old, admitted to the facility on [DATE]. According to the computerized physician orders [REDACTED]. The resident admitted for a short-term, rehabilitation stay. The [DATE] minimum data set (MDS) documented the resident was moderately cognitively impaired with a brief interview for mental status score of 11 out of 15. He required extensive assistance with bed mobility, transfers and toilet use. He required limited assistance with dressing and personal hygiene, and supervision with eating. 1. Record review revealed the facility failed to consider and address the post-discharge needs of Resident #1 and his family. a. Record review revealed the facility, the resident, and his representative were planning a [DATE] discharge date . -The medical practitioner note dated [DATE] documented the following: PT (physical therapy) reports nearing rehab potential - SW (social worker) targeting dc (discharge) ,[DATE] home with wife. -The Notice of Medicare Non-Coverage (NOMNC) dated [DATE] documented the following: I explained the last covered day will be [DATE]. Your liability (or an alternate payer) starts on [DATE]. The Discharge Transition Plan for Resident #1, dated [DATE], documented the resident was being discharged home with his wife on [DATE]. b. Further record review revealed no reference to

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

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F 0660 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) Resident #1's potential exposure to COVID-19, no reference to his COVID testing, and no documentation of resident and family education on transmission precautions. Record review on [DATE] at 12:00 p.m. revealed no documentation of Resident #1's potential exposure to COVID-19 or of facility-wide COVID-19 testing. The resident's Discharge Transition Plan did not document the resident potentially had been exposed to COVID-19, that he had received a test for COVID-19, or that the test results were pending. In addition, there was no documentation in the discharge packet regarding PPE usage while awaiting the test results of the resident's COVID-19 test. A [DATE] general nursing note documenting the resident's discharge read, Patient discharged home with home health services through (name). Patient declined to reviewe (sic) discharge packet and patient family states they will review it at home and call if they have any questions. All personal belongings taken by patient. Patient transported by wife and daughter assisted into vehicle without incident. c. Record review after facility notification of immediate jeopardy at [DATE] at 1:35 p.m. A subsequent review of Resident #1's record revealed a general note, written on [DATE] at 2:56 p.m., identified as a late entry for [DATE]. It read, Spoke with wife (name) to notify her of a patient who had tested positive for COVID-19 in our building. We have notified (name) County and Department of Health of these results. We are taking all the necessary precautions based on CDC guidelines. Staff is wearing all the required protective equipment - gown, gloves, masks, N95's. We are conducting facility wide testing to be done tomorrow. We are focused on the safety of your family member and staff. The NHA, on [DATE] at 12:13 p.m., provided a handwritten family notification note, also dated [DATE], but at 5:40 p.m., which included language similar to the general note above. The NHA said the date and time written on the top of the note ([DATE] at 5:40 p.m.) reflected when the nurse had called Resident #1's family, not the date and time the note was written. The NHA confirmed the family notification note was written after the facility was informed of immediate jeopardy. 3. Interviews revealed failure to consider and address the post-discharge needs of Resident #1 and his family. a. Resident #1's family member (FM #1) was interviewed on [DATE] at 9:57 a.m. She said she and her daughter came to pick up Resident #1 in the afternoon on [DATE]. She said she had been working with the facility case manager prior to the resident discharging and the discharge plan for several days. The family member said the facility had worked with her to coordinate home health services for the resident, and the home health agency planned to come and do the first assessment of the resident on [DATE]. She said the facility had called her prior to Resident #1's discharge to tell her the facility had a positive case of COVID-19 in the building but not to worry; the residents had been isolating. She said the facility never told her they were going to conduct facility-wide testing of all the residents, and she was shocked to learn Resident #1 had been administered a test for COVID-19. She further stated no one had told her during the call or at discharge about using PPE because of the resident's potential exposure to COVID-19. b. Resident #1's second family member (FM #2) was interviewed on [DATE] at 9:23 a.m. She said she had come to the facility on [DATE] to help get Resident #1 home following his discharge. She, too, said the discharge was planned and coordinated with the facility. She said the facility told her Resident #1 had two clean COVID-19 tests, and he had been kept away from everyone, so there was no chance he had been exposed to COVID-19. She said the facility did not inform her or any other family members that Resident #1 had a pending COVID-19 test. She said from the time Resident #1 was discharged on [DATE] until [DATE], she had direct contact with Resident #1; she said she had assisted him out of the wheelchair, in the bathroom, in and out of bed and while eating. She said staff in the facility never communicated to her to using PPE while providing care to Resident #1. She said she was in the room when the call came from the facility informing them Resident #1 had tested positive for COVID-19. She said FM #1 was sent immediately to another family member's home, as she was considered high risk for contracting COVID-19 due to her age. FM #2 said she immediately called Resident #1's primary care physician and he advised her to call 911. Resident #1 was transported to the emergency department where he again tested positive for COVID-19. The FM said Resident #1 was in the emergency room for a few days and then was placed on hospice. Resident #1 died about a week later while in hospice care in the hospital. His Certificate of Death, dated [DATE], listed his cause of death as a. [DIAGNOSES REDACTED] - onset to death: days and b. [MEDICAL CONDITION] pneumonia due to COVID-19 - onset to death: [DATE]. Both family members self-quarantined for 14 days due to their exposure to Resident #1. They said the hospice Chaplin worked with them so they could say goodbye to Resident #1 prior to his passing through the window in his room. 4. Interview with community providers revealed the facility failed to consider and address post-discharge needs related to Resident #1's interactions in the community. FM #1, in her interview on [DATE] at 9:57 a.m., said the home health agency had sent in a physical therapist (PT) to complete the initial assessment with Resident #1 on [DATE] when she received a call from the nursing facility DON letting her know that Resident #1 had tested positive for COVID-19. a. The therapy director for the home health agency was interviewed on [DATE] at 2:36 p.m. The therapy director said the home health agency had received Resident #1's referral information from the facility on [DATE], and at that time, the only indication Resident #1 had been possibly exposed and tested for COVID-19 was when he was discharged from the sister facility on [DATE]. The therapy director said the facility did not contact the home health agency after [DATE], so the agency did not know Resident #1 had possible exposure to COVID-19 or that he had a pending COVID-19 test. The therapy director said the home health agency would still have been able to provide services to Resident #1, but they would have utilized a team equipped with PPE for COVID-19. The therapy director said a pregnant physical therapist went to Resident #1's home to complete the initial assessment on [DATE] and was in the process of completing her assessment when the facility contacted the family of Resident #1 to inform them he had tested positive for COVID-19. The therapy director said she reached out to the facility to ensure after this incident. as she did not want it to happen again. She said she spoke with the registered nurse case manager (RN) #3, and she assured the home health agency that in the future she would communicate if there a COVID-19 test was pending or if the resident had a possible exposure to COVID-19. b. The community liaison with the home health agency was interviewed on [DATE] at 4:07 p.m. The community liaison said she had spoken with RN #3 on [DATE] and was told the resident was COVID-19 negative. She said RN #3 did not call her any time after [DATE] to inform her about Resident #1's possible exposure to COVID-19 or his pending COVID-19 test. The community liaison, in her interview said she followed-up with RN #3 after the [DATE] potential exposure. The community liaison said RN #3 apologized for the lack of communication with the home health agency. c. RN #3 was interviewed on [DATE] at 10:00 a.m. RN #3 said she had communicated with the home health agency prior to Resident #1's discharge from the facility. She said she did not document when she had sent Resident #1's information to the home health agency, but assumed it was [DATE], because of the note she had written stating Resident #1 was using home health. RN #3 said she did not communicate with the home health agency after [DATE], and she confirmed she did not inform the home health agency of Resident #1 potential exposure or pending COVID-19 test. She also confirmed she had communicated with the home health community liaison about a week after Resident #1 had been discharged regarding the importance of informing the home health agency about any potential exposure they could have to COVID-19. 4. Staff interviews confirmed at Resident #1's discharge, the facility failed to communicate to Resident #1, his family and the community health care providers that Resident #1 potentially had been exposed to COVID-19, that he had received a test for COVID-19, and the test results were pending. The interviews also confirmed the facility had not discussed PPE use with the resident or his family. a. RN #3 was interviewed on [DATE] at 10:00 a.m. She said she had spoken with Resident #1's wife prior to his discharge to make sure he had home health set up when he discharged from the facility. RN #3 said she had never spoken with Resident #1's wife regarding the resident's potential exposure to COVID-19 or the fact that he had a pending COVID-19 test at the time of discharge. She reviewed the discharge packet provided to Resident #1 and stated there was no evidence in the packet of the resident's potential exposure to COVID-19 or that he had a pending COVID-19 test. She further said there was no information in the discharge packet about using PPE while providing care for the resident. The RN said the resident had signed the discharge packet, but she said he had cognitive deficits and she did not feel he would have understood what he was signing. b. The DON was interviewed on [DATE] at 1:20 p.m. She said she was not aware Resident #1 was scheduled for discharge on [DATE] with a pending COVID-19 test. The DON said the resident should not have been discharged with a pending COVID-19 test; instead, the facility should have waited until after all of the test results came back to discharge any resident. c. Resident #1's physician (MD) and nurse practitioner (NP) were interviewed on [DATE]. They said they had been part of meetings with Resident #1 during the discharge process and had concerns regarding Resident #1's cognition. They said they had not spoken with Resident #1's wife regarding his pending CVOID-19 test prior to his discharge. d. RN #1 was interviewed on [DATE] at 9:41 a.m. She said she was the staff member who called Resident #1's wife to inform her that another resident in the building tested positive for COVID-19. The RN said she did not document the conversation with Resident #1's wife until [DATE], when she was instructed to type the general note in the resident's electronic medical record and write the handwritten family notification note (see notes above). She said she had contacted three other families about a resident in the building testing positive for COVID-19 and did not document any of these contacts. Rather, she had completed the handwritten family notifications to the other residents' families on [DATE] at the

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F 0660 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) instruction of the facility's corporate team. e. RN #2, who discharged Resident #1, was interviewed on [DATE] at 10:04 a.m. She said she was the nurse who discharged Resident #1 in the afternoon of [DATE]. She said Resident #1 had some confusion, but she had him sign his discharge packet and left it in his room. She said the packet would have been placed with his personal items and sent with him when he left the facility. She said [DATE] was her first day back at work after several days off and said she did not know Resident #1 had been tested for COVID-19, so she never told the family or the resident that he had a pending COVID-19 test. She said she had spoken with Resident #1's wife and had gone over his current medications, but they did not discuss Resident #1 potential exposure to COVID-19 and never discussed using PPE when providing care to the resident. f. The NP was interviewed a second time on [DATE] at 10:04 a.m. The NP said Resident #1 had been scheduled to discharge on [DATE], and the only concerns she and the MD had were related to the resident's dementia and cognition. She said she did not have any discussion with Resident #1's wife (FM #1) regarding the pending COVID-19 test, but looking back, that discussion should have taken place prior to discharging the resident. The NP said the resident was not symptomatic but there should have been a dialogue about the implications of discharging a resident who potentially had been exposed to COVID-19, and had a pending COVID-19 test. The NP said it is always her goal and that of the MD, to ensure a safe discharge for any resident and there should have been more conversations regarding the potential exposure and pending COVID-19 tests for all of the residents that were discharged with pending COVID-19 tests. C. Resident #2 Resident #2, [AGE] years old, admitted to the facility on [DATE]. According to the computerized physician orders [REDACTED]. The [DATE] minimum data set (MDS) documented the resident had a BIMS score of 9 out of 15. She required supervision with bed mobility, transfers, walking in her room, eating and toilet use. She required limited assistance with dressing and personal hygiene. 1. Record review revealed no reference to Resident #2's potential exposure to COVID-19 in her medical record and no reference to her COVID testing, and no documentation of resident and family education on transmission precautions as she prepared for discharge to home. Resident #2's medical record was reviewed on [DATE] at 12:05 p.m. The medical record review revealed there was no documentation in the resident's medical record that she potentially had been exposed to COVID-19 or that she had been tested for COVID-19. A [DATE] general nursing note documented, Patient discharged to home with home health services through the (name). Reviewed medication list and discharge packet and patient states she has no questions or concerns. Patient transported via her daughter and assisted into vehicle without incident. The Discharge Transition Plan for Resident #2 dated [DATE], documented the resident was being discharged home alone on [DATE]. The transportation for the discharge indicated the resident's family was transporting her. The discharge transition plan did not document the resident had potentially been exposed to COVID-19, that she had received a test for COVID-19, or that the test results were pending. There was no documentation about using PPE while in the community or when others came to her home to provide care. 2. Resident and family interview confirmed the facility failure to communicate with the resident and her family about her potential exposure to COVID-19, her test for [MEDICAL CONDITION], or precautions to prevent its transmission. Resident #2 was interviewed on [DATE] at 11:11 a.m. She said she had tested negative for COVID-19 prior to coming to the facility. She said no one in the facility had told her there had been a COVID-19 positive resident in the facility. She said the only reason she knew she was going to be tested for COVID-19 was they were in my room, testing me. She said she never had any additional follow-up from the facility after the test. She stated, I assumed I was negative, otherwise they would not have let me go home. She said the facility never had a discussion with her about using PPE after she left the facility; she said she just thought it was for the staff in the building. Resident #2's family member was interviewed on [DATE] at 3:25 p.m. She said the facility contacted her to inform her there was a resident in the facility who had tested positive for COVID-19. She said the facility told her all of the residents had been in their rooms, so there was no concern about Resident #2 exposed to COVID-19. The family member said no one in the facility told her Resident #2 was going to be tested or had been tested for COVID-19 and she was never informed of the results of such a test. She said she did not think the facility would discharge any resident with a COVID-19 test pending. 3. Staff interview further confirmed the facility's lack of communication to Resident #2 and her family about COVID-19 exposure, testing and precautions. RN #3 was interviewed on [DATE] at 10:00 a.m. She reviewed the signed discharge plan for Resident #2. She said there was nothing documented in the paperwork to indicate the resident had possible exposure to COVID-19, that the resident had been tested for COVID-19, signs or symptoms of COVID-19 to monitor for, or when there would be follow-up from the facility regarding the COVID-19 test. In addition, there was no documentation of discussion about use of PPE after the resident left the facility. D. Resident #3 Resident #3, [AGE] years old, admitted to the facility on [DATE]. According to the computerized physician orders [REDACTED]. The [DATE] minimum data set (MDS) documented the resident was cognitively intact with a BIMS score of 15 out of 15. He required supervision for bed mobility, transfers, toilet use and personal hygiene. He was independent with eating. 1. Record review revealed no reference to Resident #3's potential exposure to COVID-19 in his medical record, and no reference to his COVID testing, and no documentation of resident and family education on transmission precautions as he prepared for discharge to home. Resident #3 medical record was reviewed on [DATE] at 12:10 p.m. The medical record review revealed there was no documentation in the resident's medical record that he potentially had been exposed to COVID-19 or that he had been tested for COVID-19. The [DATE] social services note documented, Patient will DC (discharge) today per request, DOR (director of rehabilitation) and PA (physician assistant) approve. Will DC to second home in (name of city). Referral faxed to (name of home health agency) PT/OT/CNA (physical therapy/occupational therapy/certified nurse aide), rep (representative) states (name of home health) will begin ,[DATE]. Patient and wife updated- state they have no further questions at this time. Wife to p/u (pick-up) at 1400 (2 p.m.). The Discharge Transition Plan for Resident #3, dated [DATE], documented the resident was being discharged home with spouse on [DATE]. The transportation for the discharge indicated the resident's wife was transporting him. The discharge transition plan did not document the resident potentially had been exposed to COVID-19, that he had received a test for COVID-19, or that the test results were pending. There was no documentation about using PPE while awaiting the results of his COVID-19 test. 2. Resident and family interview confirmed the facility failure to communicate with the resident and his spouse about his potential exposure to COVID-19, his test for [MEDICAL CONDITION], and precautions to prevent its transmission while his test results were pending. Resident #3 and his wife were interviewed on [DATE] at 11:00 a.m. He said his wife was contacted about a resident testing positive for COVID-19 in the building. His wife said they did not tell her they would be testing Resident #3, and assured her all of the resident's in the facility had been isolated in their rooms. Resident #3 said he was not told about being tested until some guy I did not know came into my room on 7th and told me I am being tested for COVID-19. He said at that point, he was concerned for his health as well as his wife's health, and thought it best that he leave the facility. He said there were never any discussions with any staff members regarding his possible exposure to COVID-19 or discussions about waiting for his test results before discharging. He said he contacted the DON several times over the following week to obtain the results of his COVID-19 test, and after several messages were left, he finally got his results. He said while his results were pending, he and his wife decided to self-isolate in order to keep the rest of his family and community safe. He said no one in the facility had provided him or his wife any education regarding using PPE while he was awaiting the results of his COVID-19 test. He said he had informed the home health agency about the possible COVID-19 exposure and pending test, and when they came to provide services, they wore full PPE. 3. Staff interview further confirmed the facility's lack of communication to Resident #3 and his spouse about the resident's COVID-19 exposure, testing and precautions. RN #3 was interviewed on [DATE] at 10:00 a.m. She reviewed the signed discharge plan for Resident #3. She said there was nothing documented in the paperwork to indicate the resident had possible exposure to COVID-19, that the resident had been tested for COVID-19, signs or symptoms of COVID-19 to monitor for, or when there would be follow-up from the facility regarding the COVID-19 test. She said there was no documentation regarding PPE use in the discharge plan. E. Resident #4 Resident #4, [AGE] years old, admitted to the facility on [DATE]. According to the computerized physician orders [REDACTED]. The [DATE] minimum data set (MDS) documented the resident was cognitively intact. He required supervision for bed mobility, transfers, walking in his room, toilet use and personal hygiene. He was independent with eating. According to the DON, interviewed on [DATE] at 1:20 p.m., Resident #4 had refused to be tested for COVID-19 during the facility-wide testing [DATE]. 1. Record review revealed no reference to Resident #4's potential exposure to COVID-19 in his medical record, no reference to his refusal to be tested for COVID-19, and no documentation of resident education on transmission precautions as he prepared for discharge to home and family. Resident #4 medical records were reviewed on [DATE] at 12:13 p.m. The medical record review revealed there was no documentation in the resident's medical record that he potentially had been exposed to COVID-19 or that he had refused to be tested for COVID-19. The [DATE] practitioner note documented, Review of patients VS (vital signs), medications, paracentesis scheduling, dc (discharge) plan, and nursing concerns. Patient up independently in room; looking towards dc,

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F 0660 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 3) understands need for ETOH (ethyl alcohol) cessation supports in the community. The Discharge Transition Plan for Resident #4, dated [DATE], documented the resident was being discharged home with family on [DATE]. The transportation for the discharge indicated the resident's wife was transporting him. The discharge transition plan did not document the resident had potentially been exposed to COVID-19, or signs and symptoms of COVID-19 to monitor himself for. There was no documentation in the discharge plan regarding PPE usage. 2. Staff interview confirmed the facility's lack of communication with Resident #4 and his family about the resident's COVID-19 exposure and precautions to prevent transmission of [MEDICAL CONDITION]. R
F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based resident, family and staff interviews and record review, the facility failed to establish and maintain an infection prevention and control program designed to help prevent the development and transmission of communicable diseases and infections, affecting five of five residents (#1, #2, #3, #4 and #5), as well as their families and communities. Specifically, the facility failed to take steps to limit the development and transmission of COVID-19, a highly infectious virus, through resident and family education and communication with community health care providers. The facility discharged Residents #1, #2, and #3, all of whom had potential exposure to COVID-19, before receiving the residents' COVID-19 test results. The facility and the family of Resident #1 learned of his positive COVID-19 test results after he had discharged home with family and home health services. Record review and interview revealed there were no discussions about Resident #1's potential exposure to COVID-19 and its implications upon discharge, no discussion with the family informing them of Resident #1's pending COVID-19 test results and what precautions should be taken. Finally, there was no notification to the home health agency about Resident #1's potential exposure to and pending test for COVID-19. The facility also discharged Residents #2, #3, #4 and #5 to home and the community after possible exposure to COVID-19, two of these residents (#2, #3), while COVID-19 test results were pending and two with exposure but not tested (#4, #5). These residents, too, failed to receive education on precautions to prevent the spread of COVID-19 at discharge to their families and communities. The facility's failure, when discharging Residents #1, #2, #3, #4 and #5, to take steps to limit the development and transmission of COVID-19, a highly infectious virus, through resident and family education and communication with community health care providers, created the likelihood of family and community spread of COVID-19 and potentially serious adverse outcome. In addition, observations and interviews during resident cares and housekeeping revealed practices not designed to prevent the spread of infection. Cross-reference 660; discharge planning process. The facility failed to have an effective discharge planning process related to their possible exposure to COVID-19 and pending COVID-19 tests for five (#1, #2, #3, #4 and #5) residents. Findings include: I. IMMEDIATE JEOPARDY A. Findings of immediate jeopardy The facility discharged Residents #1, #2, and #3, all of whom had potential exposure to COVID-19, before receiving the residents' COVID-19 test results. The facility and the family of Resident #1 learned of his positive COVID-19 test results after he had discharged home with family and home health services. Record review and interview revealed there were no discussions about Resident #1's potential exposure to COVID-19 and its implications upon discharge, and no discussion with his family informing them of Resident #1's pending COVID-19 test results and what precautions should be taken. Finally, there was no notification to the home health agency about Resident #1's potential exposure to and pending test for COVID-19. The facility also discharged Residents #2, #3, #4 and #5 to home and the community after possible exposure to COVID-19, two of these residents (#2, #3) while COVID-19 test results were pending and two with exposure but not tested (#4, #5). These residents, too, failed to receive education on precautions to prevent the spread of COVID-19 upon discharge to their families and communities. On [DATE] at 1:35 p.m., the nursing home administrator (NHA) and the director of nurses (DON) were notified its failures created a situation of immediate jeopardy for serious adverse outcome. B. Facility plan to remove immediate jeopardy On [DATE] at 10:46 a.m., the facility submitted a plan to abate the immediate jeopardy. The abatement plan read: Corrective Action: Center Nurse Executive and/or designee notified the 5 residents/families of possible exposure to COVID-19 and facility wide test results on [DATE] and [DATE]. Center Executive Director or designee mailed a copy of discharge instructions and education related to COVID-19 to the 5 discharged residents/families on [DATE]. Center Executive Director initiated a test based strategy and/or symptom based strategy on [DATE] to be utilized prior to discharge home for COVID suspected and/or COVID positive patients. Effective [DATE], the discharge paperwork to include handouts with current guidance from CDC and WHO regarding use of PPE upon discharge to home. On [DATE] Center Nurse Executive or designee initiated/performed education on Discontinuing of Transmission Based precautions to nursing staff. On [DATE], Center Executive Director hosted an AD HOC Quality Assurance Performance Improvement meeting with facility Medical Director and QAPI members to address discharge protocols as related to infection control processes. Systematic Measures: Regional Vice President of Operations re-educated the Center Executive Director and Center Nurse Executive on the Infection Control/Covid-19 policy, CDC guidelines and procedure to include Discontinuing of Transmission Based Precautions as it relates to discharging patients home on [DATE]. Center Executive Director and/or designee re-educated all department Managers, on the Discontinuing of Transmissions Based precautions policy and procedure as it related to discharging patients home. Center Nurse Executive or designee initiated education on [DATE] to nursing staff on proper education at time of discharge to include notification if COVID test is pending. Quality Assurance and Monitoring: Quality Assurance Performance Improvement (QAPI) meeting held on [DATE] with Interdisciplinary Team members and the Medical Director on Infection Control policy, CDC guidelines as it relates to discontinuing of Transmission Based Precautions and patient/family education at the time of discharge. The Interdisciplinary Team will review and assess all discharged patients during clinical meetings daily for four weeks, three times a week for four weeks, and then twice weekly for four weeks to monitor and validate compliance with proper discharge education as it related to Discontinuing Transmission Based Precautions and patient/family education to include handout from CDC. Center Nurse Executive or designee will audit and ensure all residents who discharge did so without a pending Covid-19 and/or where properly educated at the time of discharge five times a week for four weeks, then three times a week for four weeks, then twice a week for four weeks to ensure facility is in compliance with CDC guidelines and facility Transmission Based Precautions. Nurse Manager will audit all pending tests in con-elation with pending discharges three times a week for four weeks, two times a week for four weeks, then once weekly for four weeks to prevent any discharge with a pending test. Resident's discharged with pending COVID-19 tests without consideration from the resident's clinical care team, without education on signs and symptoms of COVID-19 to monitor for, and PPE usage and when to discontinue transmission-based based precautions C. Removal of immediate jeopardy The immediate jeopardy was lifted on [DATE] at 10:46 a.m. However, observations, interviews and record review revealed deficient practice remained at an E level, a pattern with the potential for more than minimal harm. II. Discovery of COVID-19 in the facility and facility response Record review revealed on [DATE], Resident #6, admitted to the facility on [DATE] from a sister facility, tested positive for COVID-19. The resident was transferred on [DATE] to an all COVID-19 positive sister facility. The nursing home administrator (NHA) and director of nurses (DON) were interviewed on [DATE] at 10:55 a.m. The NHA said after Resident #6 tested positive for COVID-19 on [DATE], the corporate team wanted to make sure the facility was following all of the protocols, so, on [DATE], they tested all the staff and residents in the building to see if there were any additional positive COVID-19 residents or staff. The DON and NHA said they had contacted families to inform them of the COVID-19 positive resident, although this communication with families was not documented in any resident records. The DON said the facility treated all the residents as if they were COVID-19 positive. She said the nursing staff was utilizing transmission-based precautions when working with any resident. III. Failure of the facility to respond to discovery of COVID-19 in a manner designed to prevent to the spread of infection. Specifically, record review and interview revealed Resident #1, #2, #3, #4, and #5 were discharged [DATE], following the facility's discovery of Resident #6's positive COVID-19 test results and the facility's [DATE] facility-wide resident and staff testing for COVID-19. The facility failed to take steps to limit the development and transmission of COVID-19, a highly infectious virus, through resident and family education and communication with community health care providers. A. Resident #1 1. Resident status Resident #1, [AGE] years old, admitted to the facility on [DATE]. According to the computerized physician orders [REDACTED]. His [DATE] minimum data set (MDS) documented the resident was moderately cognitively impaired, required extensive assistance with bed mobility, transfers and toilet use. He required limited assistance with dressing and personal hygiene, and supervision with eating. The resident admitted for a short-term, rehabilitation stay. Record review on [DATE] at 12:00 p.m. revealed no reference to Resident #1's potential exposure to COVID-19, no reference to his COVID test, and no documentation of resident and family education on transmission-based precautions. Yet, a subsequent review of Resident #1's record revealed a general note, written on [DATE] at 2:56 p.m. (after immediate jeopardy was

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	065414	A. BUILDING _____ B. WING _____	06/01/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
POWERBACK REHABILITATION LAFAYETTE	329 EXEMPLA CIR LAFAYETTE, CO 80026

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 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 4) called). This note was identified as a late entry for [DATE]. It read, Spoke with wife (name) to notify her of a patient (Resident #6) who had tested positive for COVID-19 in our building. We have notified (name) County and Department of Health of these results. We are taking all the necessary precautions based on CDC guidelines. Staff is wearing all the required protective equipment - gown, gloves, masks, N95's. We are conducting facility wide testing to be done tomorrow. We are focused on the safety of your family member and staff. The NHA, on [DATE] at 12:13 p.m., provided a handwritten family notification note, also dated [DATE], but at 5:40 p.m., which included language similar to the general note above. The NHA said the date and time written on the top of the note ([DATE] at 5:40 p.m.) reflected when the nurse had called Resident #1's family, not the date and time the note was written. The NHA confirmed the family notification note was written after the facility was informed of immediate jeopardy. Review of the resident's Discharge Transition Plan, however, did not document that the resident potentially had been exposed to COVID-19, that he had received a test for COVID-19, or that the test results were pending. In addition, there was no documentation in the discharge packet regarding personal protective equipment (PPE) use while waiting for the results of the resident's COVID-19 test. 3. Interviews revealed the facility failed to take steps to limit transmission of COVID-19; specifically, the facility failed to educate the resident, his family and the community health care provider (HCP) about their possible exposure to COVID-19, what signs and symptoms to monitor for, and what PPE to use while caring for the resident. a. Resident #1's family member (FM #1) was interviewed on [DATE] at 9:57 a.m. She said she and her daughter came to pick up Resident #1 in the afternoon on [DATE] and the home health agency planned to come and do the first assessment of the resident on [DATE]. She said the facility never told her they were going to conduct facility-wide testing of all the residents, and she was shocked to learn Resident #1 had been administered a test for COVID-19. She further stated no one had told her during the call about using PPE while with the resident, and there was never any discussion about using transmission-based precautions or monitoring the resident for any signs or symptoms of COVID-19 when Resident #1 was discharged . She said the home health agency had sent in a physical therapist (PT) to complete the initial assessment with Resident #1 on [DATE] when she received a call from the nursing facility DON letting her know that Resident #1 had tested positive for COVID-19. b. Resident #1's second family member (FM #2) was interviewed on [DATE] at 9:23 a.m. She said she had come to the facility on [DATE] to help get Resident #1 home following his discharge. She said the facility told her Resident #1 had two clean COVID-19 tests, and he had been kept away from everyone, so there was no chance he had been exposed to COVID-19. She said the facility did not inform her or any other family members that Resident #1 had a pending COVID-19 test. She said the resident's home was a high-rise condominium. The resident resided on the 27th floor, so they had to take a communal elevator to get the resident home. She said she was concerned they had exposed hundreds of people living in the condominium by taking the elevator without proper PPE on Resident #1. She said from the time Resident #1 was discharged on [DATE] until [DATE], she had direct contact with Resident #1; she said she had assisted him out of the wheelchair, in the bathroom, in and out of bed and while eating. She said staff in the facility never communicated to her to using PPE while providing care to Resident #1. She said she was in the room when the call came from the facility informing them Resident #1 had tested positive for COVID-19. She said FM #1 was sent immediately to another family member's home, as she was considered high risk for contracting COVID-19 due to her age (over 75). FM #2 said she immediately called Resident #1's primary care physician and he advised her to call 911. Resident #1 was transported to the emergency department where he again tested positive for COVID-19. The FM said Resident #1 was in the emergency room for a few days and then was placed on hospice. Resident #1 died about a week later while in hospice care in the hospital. His Certificate of Death, dated [DATE], listed his cause of death as a. [DIAGNOSES REDACTED] - onset to death: days and b. [MEDICAL CONDITION] pneumonia due to COVID-19 - onset to death: [DATE]. Both family members self-quarantined for 14 days due to their exposure to Resident #1. c. Interview with community HCPs revealed the facility failed to timely notify them of Resident #1's exposure to and pending test for COVID-19. The therapy director for the home health agency was interviewed on [DATE] at 2:36 p.m. -The therapy director said the home health agency had received Resident #1's referral information from the facility on [DATE], and at that time, the only indication Resident #1 had been possibly exposed and tested for COVID-19 was when he was discharged from an all COVID-19 positive sister facility on [DATE]. -The therapy director said the facility did not contact the home health agency after [DATE], so the agency did not know Resident #1 had possible exposure to COVID-19 or that he had a pending COVID-19 test. The therapy director said the home health agency would still have been able to provide services to Resident #1, but they would have utilized a team equipped with PPE for COVID-19. -The therapy director said a pregnant physical therapist went to Resident #1's home to complete the initial assessment on [DATE] and was in the process of completing her assessment when the facility contacted the family of Resident #1 to inform them he had tested positive for COVID-19. The community liaison with the home health agency was interviewed on [DATE] at 4:07 p.m. The community liaison said she had spoken with registered nurse case manager (RN) #3 on [DATE] and was told the resident was COVID-19 negative. She said RN #3 did not call her any time after [DATE] to inform her about Resident #1's possible exposure to COVID-19 or his pending COVID-19 test. c. RN #3 was interviewed on [DATE] at 10:00 a.m. She said she had communicated with the home health agency prior to Resident #1's discharge from the facility. She said she did not document when she had sent Resident #1's information to the home health agency, but assumed it was [DATE], because of the note she had written stating Resident #1 was using home health. She said she did not communicate with the home health agency after [DATE], and she confirmed she did not inform the home health agency of Resident #1 potential exposure or pending COVID-19 test. She said she had spoken with Resident #1's wife prior to his discharge to make sure he had home health set up when he discharged from the facility. RN #3 said she had never spoken with Resident #1's wife regarding the resident's potential exposure to COVID-19 or the fact that he had a pending COVID-19 test at the time of discharge. She reviewed the discharge packet provided to Resident #1 and stated there was no evidence in the packet of the resident's potential exposure to COVID-19 or that he had a pending COVID-19 test. She further said there was no information in the discharge packet about using PPE while providing care for the resident. The RN said the resident had signed the discharge packet. She said there was never a discussion during the discharge process regarding ending transmission-based precautions with Resident #1 or what signs and symptoms of COVID-19 the family should monitor the resident for. b. The DON was interviewed on [DATE] at 1:20 p.m. She said she was not aware Resident #1 was being discharged on [DATE] with a pending COVID-19 test. The DON said the resident should not have been discharged with a pending COVID-19 test; instead, the facility should have waited until after all of the test results came back to discharge any residents. The DON further said there should have been a discussion with the family about the use of PPE while working with Resident #1 at home. c. Resident #1's physician (MD) and nurse practitioner (NP) were interviewed on [DATE]. They said they had been part of meetings with Resident #1 during the discharge process and said they had not spoken with Resident #1's wife regarding his pending CVOID-19 test prior to his discharge. They further stated they never had any discussion with the family regarding using PPE with Resident #1 while at home. d. RN #2, who discharged Resident #1 on [DATE], was interviewed on [DATE] at 10:04 a.m. She said [DATE] was her first day back at work after several days off and said she did not know Resident #1 had been tested for COVID-19, so she never told the family or the resident that he had a pending COVID-19 test. She said she had spoken with Resident #1's wife and had gone over his current medications, but they did not discuss Resident #1 potential exposure to COVID-19 and never discussed using PPE when providing care to the resident. e. The NP was interviewed a second time on [DATE] at 10:04 a.m. She said she did not have any discussion with Resident #1's wife (FM #1) regarding the pending COVID-19 test, but looking back, that discussion should have taken place prior to discharging the resident. The NP said the resident was not symptomatic but there should have been a dialogue about the implications of discharging a resident who potentially had been exposed to COVID-19, and had a pending COVID-19 test. The NP said it is always her goal and that of the MD, to ensure a safe discharge for any resident and there should have been more conversations regarding the potential exposure and pending COVID-19 tests for all of the residents that were discharged with pending COVID-19 tests. B. Additional residents (#2 and #3) discharged with potential exposure to COVID-19 and pending COVID-19 tests, whose families failed to receive education about transmission-based precautions at discharge, as well as one community HCP who failed to receive notification from the facility of the resident's potential exposure to COVID-19. 1. Resident #2 Resident #2, [AGE] years old, admitted to the facility on [DATE]. According to the computerized physician orders [REDACTED]. The [DATE] minimum data set (MDS) documented the resident had a BIMS score of 9 out of 15. She required supervision with bed mobility, transfers, walking in her room, eating and toilet use. She required limited assistance with dressing and personal hygiene. Record review on [DATE] at 12:05 p.m. revealed no reference to Resident #2's potential exposure to COVID-19 in her medical record and no reference to her COVID testing. The Discharge Transition Plan for Resident #2, dated [DATE], documented the resident was being discharged home alone on [DATE]. The transportation for the discharge indicated the resident's family was transporting her. The discharge transition plan did

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 5) not document the resident had potentially been exposed to COVID-19, that she had received a test for COVID-19, or that the test results were pending. There was no documentation about using PPE while in the community or when others came to her home to provide care. Resident #2 was interviewed on [DATE] at 11:11 a.m. She said no one in the facility had told her there had been a COVID-19 positive resident in the facility. She said the only reason she knew she was going to be tested for COVID-19 was they were in my room, testing me. She said she never had any additional follow-up from the facility after the test. She said the facility never had a discussion with her about using PPE after she left the facility or for how long it should be used; she said she just thought PPE was for the staff in the building. She said there were never any discussions with staff about continuing to monitor herself for any signs or symptoms of COVID-19. Resident #2's family member was interviewed on [DATE] at 3:25 p.m. She said the facility contacted her to inform her there was a resident in the facility who had tested positive for COVID-19. She said the facility told her all of the residents had been in their rooms, so there was no concern about Resident #2 exposed to COVID-19. The family member said no one in the facility told her Resident #2 was going to be tested or had been tested for COVID-19 and she was never informed of the results of such a test. She further stated she had never been part of any discussion regarding using PPE while she was with Resident #2, or that Resident #2 should be using transmission-based precautions, stating she did not even know what that meant. RN #3 was interviewed on [DATE] at 10:00 a.m. She reviewed the signed discharge plan for Resident #2. She said there was nothing documented in the paperwork to indicate the resident had possible exposure to COVID-19, that the resident had been tested for COVID-19, signs or symptoms of COVID-19 to monitor for, or when there would be follow-up from the facility regarding the COVID-19 test. In addition, there was no documentation of discussion about using PPE or discontinuing its use after the resident left the facility. 2. Resident #3 Resident #3, [AGE] years old, admitted to the facility on [DATE]. According to the computerized physician orders [REDACTED]. The [DATE] minimum data set (MDS) documented the resident was cognitively intact with a BIMS score of 15 out of 15. He required supervision for bed mobility, transfers, toilet use and personal hygiene. He was independent with eating. Record review revealed no reference to Resident #3's potential exposure to COVID-19 in his medical record, and no reference to his COVID testing, and no documentation of resident and family education on transmission-based precautions as he prepared for discharge to home. The Discharge Transition Plan for Resident #3, dated [DATE], documented the resident was being discharged home with spouse on [DATE] and home health services. The transportation for the discharge indicated the resident's wife was transporting him. The discharge transition plan did not document the resident potentially had been exposed to COVID-19, that he had received a test for COVID-19, or that the test results were pending. There was no documentation about using PPE while awaiting the results of his COVID-19 test. Resident #3 and his wife were interviewed on [DATE] at 11:00 a.m. He said his wife was contacted about a resident testing positive for COVID-19 in the building. His wife said they did not tell her they would be testing Resident #3, and assured her all of the resident's in the facility had been isolated in their rooms. -Resident #3 said he was not told about being tested until some guy I did not know came into my room on 7th and told me I am being tested for COVID-19. He said at that point, he was concerned for his health as well as his wife's health, and thought it best that he leave the facility. -He said there were never any discussions with any staff members regarding his possible exposure to COVID-19 or discussions about waiting for his test results before discharging. He said he contacted the DON several times over the following week to obtain the results of his COVID-19 test, and after several messages were left he finally got his results. He said while his results were pending, he and his wife decided to self-isolate in order to keep the rest of his family and community safe. -He said no one in the facility had provided him or his wife any education regarding using PPE while he was awaiting the results of his COVID-19 test. He said there had never been any discussion in the facility about transmission-based precautions. -He said he had informed the home health agency about the possible COVID-19 exposure and pending test, and when they came to provide services, they wore full PPE. RN #3 was interviewed on [DATE] at 10:00 a.m. She reviewed the signed discharge plan for Resident #3. She said there was nothing documented in the paperwork to indicate the resident had possible exposure to COVID-19, that the resident had been tested for COVID-19, signs or symptoms of COVID-19 to monitor for, or when there would be follow-up from the facility regarding the COVID-19 test. She said there was no documentation regarding PPE use in the discharge plan and said she did not have any discussion with the resident about transmission-based precautions or if he still needed to use them at home. C. Additional residents (#4 and #5) discharged with potential exposure to COVID-19 whose families failed to receive education about transmission-based precautions at discharge. 1. Resident #4 Resident #4, [AGE] years old, admitted to the facility on [DATE]. According to the computerized physician orders [REDACTED]. The [DATE] minimum data set (MDS) documented the resident was cognitively intact. He required supervision for bed mobility, transfers, walking in his room, toilet use and personal hygiene. He was independent with eating. According to the DON, interviewed on [DATE] at 1:20 p.m., Resident #4 had refused to be tested for COVID-19 during the facility-wide testing [DATE]. Record review on [DATE] at 12:13 p.m. revealed no reference to Resident #4's potential exposure to COVID-19 in his medical record, no reference to his refusal to be tested for COVID-19, and no documentation of resident education on transmission-based precautions as he prepared for discharge to home and family. The Discharge Transition Plan for Resident #4, dated [DATE], documented the resident was being discharged home with family on [DATE]. The transportation for the discharge indicated the resident's wife was transporting him. The discharge transition plan did not document the resident had potentially been exposed to COVID-19, or signs and symptoms of COVID-19 to monitor himself for. There was no documentation in the discharge plan regarding PPE usage. There was no documentation regarding the resident discontinuing transmission-based based precautions. RN #3 was interviewed on [DATE] at 10:00 a.m. She reviewed the signed discharge plan for Resident #4. She said there was nothing documented in the paperwork to indicate the resident had possible exposure to COVID-19 or signs or symptoms of COVID-19 to monitor for. The RN said there was no documentation of PPE usage in the discharge plan for the resident. The RN further stated there never was a discussion with the resident about discontinuing transmission-based precautions. The DON was interviewed on [DATE] at 1:20 p.m. She said there was no documentation in the resident's medical record that indicated he had refused the COVID-19 test or documentation of education regarding possible exposure to COVID-19. The DON said there was never any discussion with the resident regarding using PPE at home, or regarding the discontinuation of transmission-based precautions. 2. Resident #5 Resident #5, [AGE] years old, admitted to the facility on [DATE]. According to the computerized physician orders [REDACTED]. The [DATE] minimum data set (MDS) documented the resident was cognitively intact. He required supervision for bed mobility, transfers, walking in his room, toilet use and personal hygiene. He was independent with eating. According to the DON, interviewed on [DATE] at 1:20 p.m., the resident was out of the facility at [MEDICAL TREATMENT] at the time of the facility-wide COVID-19 testing. Record review on [DATE] at 12:20 p.m. confirmed Resident #5 had been out of the building at the time of the facility-wide COVID-19 testing. It further revealed no reference to Resident #5's potential exposure to COVID-19 and no documentation of resident education on transmission-based precautions as he prepared for discharge to home. There was no documentation about any education to the resident on discontinuing transmission-based precautions at home. The Discharge Transition Plan for Resident #4 dated [DATE], documented the resident was being discharged home alone on [DATE]. The transportation for the discharge indicated the resident's family was transporting him. The discharge transition plan did not document the resident potentially had been exposed to COVID-19, or signs and symptoms of COVID-19 to monitor himself for. There was no documentation in the discharge plan regarding PPE usage. RN #3 was interviewed on [DATE] at 10:00 a.m. She reviewed the signed discharge plan for Resident #5. She said there was nothing documented in the paperwork to indicate the resident had possible exposure to COVID-19 or signs or symptoms of COVID-19 to monitor himself for. She said there was no documentation regarding PPE usage in the discharge plan. The RN said there was never any discussion with the resident about when to discontinue transmission-based precautions. The DON was interviewed on [DATE] at 1:20 p.m. She said she was not part of the testing process, rather, it was completed by the facility corporation, so she did not know if the resident, who had been at [MEDICAL TREATMENT] during testing, was offered testing any other time. The DON said there was never any discussion about PPE usage or if the residents should use transmission-based precautions when they were discharged home. IV. Observations and interviews during resident cares and housekeeping revealed practices not designed to prevent the spread of infection. A. Mask use and social distancing [DATE] 1. Mask use -At 9:40 a.m., an agency certified nurse aide #4 (ACNA #4) entered room [ROOM NUMBER] to assist the resident. She did not offer