STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365425	A. BUILDING _____ B. WING _____	08/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NEWARK CARE AND REHABILITATION	**75 MCMILLEN DRIVE NEWARK, OH 43055**

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 -** Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the unprecedented global pandemic that resulted in the Presidential declaration of a State of National Emergency dated [DATE], Nursing Home Guidance from the Centers for Disease Control (CDC), review of the facility's policies and procedure, review of the facility's Coronavirus (COVID-19) outbreak timeline, review of daily resident census reports, record review, staff and family interview, the facility failed to perform adequate contact tracing to properly identify, quarantine, and appropriately test all residents with known exposure to a staff member who had tested positive for COVID-19. This resulted in Immediate Jeopardy on [DATE] when Licensed Practical Nurse (LPN) #3 notified the facility on [DATE] that she tested positive for COVID-19. LPN #3 last worked in the facility on their quarantine unit (Units 6 and 7) on [DATE]. Residents #10, #202, #206 and #207 all resided on the quarantine unit on [DATE] but had been moved to other units in the facility between [DATE] and [DATE]. They had been placed in semi-private rooms with four other residents (Resident #29, #49, #70, and #208) resulting in spread of COVID-19 and death of residents. This resulted in the likelihood to cause serious harm injury or death and affected eight residents (Residents #10, #29, #49, #70, #202, #206, #207, and #208) with the potential to affect all the residents in the facility. On [DATE] at 9:15 A.M., the Administrator was notified Immediate Jeopardy began on [DATE] when the facility had been made aware LPN #3 tested positive for COVID-19 after she last worked the facility's quarantine unit on [DATE]. The facility failed to perform adequate contact tracing to identify all residents who had been exposed to LPN #3 when she worked on [DATE]. This resulted in four residents (Resident #10, #202, #206, and #207), who had been moved off the quarantine unit since their exposure, not being immediately quarantined or tested . All four residents were allowed to remain in a semi-private room with another resident after their known exposure had occurred. Resident #206 moved again and was placed in a new room with another roommate on [DATE] (two days after the facility had been made aware of her exposure) when the facility was clearing out a unit to be used as their new quarantine unit. Resident #206 was never tested for COVID-19 after she had been exposed and was discharged home on [DATE] not knowing if she had COVID-19 or not. Residents #10, #202, and #207 were not immediately tested for COVID-19 when the other residents who resided on the quarantine unit got tested for COVID-19 on [DATE]. Their testing was not completed until [DATE] when the facility started testing the residents on the remaining units in the building. The facility's failure to immediately quarantine and test those residents likely contributed to the COVID-19 outbreak that spread throughout the facility infecting 71 residents with COVID-19 resulting in 20 deaths. The Immediate Jeopardy was removed on [DATE] when the facility implemented the following correction actions: On [DATE], the facility developed QIO Action Plan focused on testing of residents in a more timely and efficient manner to include test frequency, rapid testing, online requisition processing for faster turnaround times. It will provide updates to Ohio QIO coordinator. As of [DATE], Units 5, 6, and 7 remain the COVID-19 unit. It currently has 22 residents who remain in transmission-based precautions. The quarantine unit currently has nine (9) residents. As of [DATE], the facility has 75 COVID-19 tests available in house with an additional 200 tests on order, which will be used for symptomatic residents and to test residents if new cases develop in the future. On [DATE], the Director of Nursing (DON), who is also the facility infection preventionist, audited all resident rooms to validate isolation procedures were correctly implemented, including location of residents and implementation of isolation precautions. The audit revealed all isolation precautions were correctly implemented. On [DATE] the facility implemented a new COVID 19 Testing and Contract Tracing policy. The policy identified the facility will determine which residents received direct care from and which staff had unprotected exposure to staff member who worked with symptoms consistent with COVID-19 or in the 48 hours prior to symptom onset, or any staff or residents who had exposure to a resident with symptoms of COVID-19. Residents who had exposure to symptomatic resident or were cared for by symptomatic staff will be restricted to their room and be cared for using all recommended COVID-19 PPE until results of health care provider (HCP) COVID-19 testing are known. If the HCP or resident is diagnosed with [REDACTED]. Exposed staff will be assessed and evaluated for work exclusion. On [DATE], the DON began mandatory staff in-service education on COVID-19 procedures with emphasis on contact tracing, quarantine and testing requirements and frequency. All education will be completed by [DATE] for licensed nurses, nurse aides, dietary and housekeeping, therapists and additional staff. Staff not educated by [DATE] will not be permitted to work until the in-servicing is completed. As of [DATE], 120 staff had received in-service training. Twenty (20) staff had not received in-service training. The DON or assistant director of nursing (ADON) will call the 20 staff by the end of the day [DATE] and provide verbal in-service training. These 20 staff will also receive in person training when they return to work. On [DATE] the DON and Administrator were in-serviced by the Chief Clinical Officer on contact tracing guidance and testing of all residents when an outbreak occurs. On [DATE] the DON will begin to monitor all newly diagnosed residents and newly admitted residents or readmitted residents to ensure they are placed in appropriate transmission-based precautions according to their [DIAGNOSES REDACTED]. Audits will be completed weekly x 4 weeks or until otherwise directed by the QAPI committee. On [DATE] an ad hoc QAPI committee meeting was held with the medical director to review the preliminary survey findings and internal action plan. On [DATE] the DON or designee will conduct interview audits of a minimum of ,[DATE] staff members weekly x 4 weeks to evaluate retention of Inservice content. On [DATE] between 10:55 A.M. and 12:10 P.M. twelve (12) staff were interviewed and verified they had received in-service training in the areas of contact tracing, quarantine and testing requirements and frequency. All staff interviewed were knowledgeable on the in-service training. On [DATE] the facility had 208 COVID-19 test kits onsite at the facility for needed testing. Onsite observations on [DATE] revealed all staff were wearing appropriate PPE including N95 face masks and face shields. Although the Immediate Jeopardy was removed on [DATE], the facility remained out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility was still in the process of implementing their corrective actions and monitoring to ensure on-going compliance. Findings include: Review of the Department of Health and Human Services, Centers for Medicare and Medicaid (CMS) Memo QSO ,[DATE]-ALL dated [DATE] revealed CMS is committed to taking critical steps to ensure America ' s healthcare facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). As part of CMS guidance, the Focused Infection Control Survey was made available to every provider in the country to make them aware of infection control priorities during this time of crisis, and providers may perform a voluntary self-assessment of their ability to meet these priorities. The QSO Memo included additional instructions to nursing homes. We are disseminating the Infection Control survey developed by CMS and CDC so facilities can educate themselves on the latest practices and expectations. We expect facilities to use this new process, in conjunction with the latest guidance from CDC, to perform a voluntary self-assessment of their ability to prevent the transmission of COVID-19. We also encourage nursing homes to voluntarily share the results of this assessment with their state or local health department Healthcare-Associated Infections (HAI) Program. Furthermore, we remind facilities that they are required to have a system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility, and when and whom possible incidents of communicable diseases or infections should be reported (42 CFR

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

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 1) 483.80 (a) (2) (i) and (ii). 1. Review of the facility's timeline of their COVID-19 outbreak confirmed they were first notified by LPN #3 on [DATE] that she had been tested for COVID-19 the day before and her test results came back positive. LPN #3 was indicated to have been a nurse who worked Units 6 and 7 (quarantine unit) on an as needed basis (prn). The facility started their timeline on [DATE], as that was the date LPN #3 last worked. The facility started COVID-19 testing for the residents who currently resided on Units 6 and 7 on [DATE]. On [DATE], six of those residents had tested positive for COVID-19 after their exposure to LPN #3 occurred. The timeline indicated on [DATE] room changes were made on Unit 5. Unit 5 was cleared out to allow the facility to utilize it as their new COVID-19 unit. Those residents who resided on the quarantine unit that were tested on [DATE] and found to be negative for COVID-19 were moved to Unit 5. The facility designated Units 6 and 7 as their COVID-19 units when the first six residents tested positive for COVID-19. Those on Units 6 and 7 that tested negative for COVID-19 and still had quarantine days remaining were moved to Unit 5 when it was made the new quarantine unit. The timeline also reflected those residents, who had resided on Units 6 and 7 on [DATE] but had been moved to other units within the facility between [DATE] and [DATE]. There was a total of four residents (Residents #10, #202, #206 and #207) who were identified as having been moved off Units 6 and 7 between that time. A focused review of those four residents (Residents #10, #202, #206, and #207) was completed as there was no indication on the facility's timeline of those residents being placed back onto the quarantine unit after their known exposure had occurred. The facility also was not able to provide any COVID-19 test results to show those residents were included within the initial testing that had been done on those residents that resided on Unit 6 and 7. 1(a). A review of Resident #206's electronic health record (EHR) revealed she was originally admitted to the facility on [DATE]. Her most recent admitted was [DATE]. Her [DIAGNOSES REDACTED]. A review of Resident #206's census report revealed she resided on Unit ,[DATE] on [DATE] when LPN #3 last worked and potentially exposed all the residents on that unit to COVID-19. She remained on that unit until [DATE] when she was moved to Unit 5 (a rehabilitation/ long term care unit at that time). There was no evidence of any room changes occurring on [DATE] when it had been known by the facility the resident had been possibly exposed to COVID-19 through LPN #3. She was moved again on [DATE] from Unit 5 when the facility was clearing that unit off to make room for their new quarantine unit. Review of the resident's record revealed Resident #206 was not retained on Unit 5 despite her having had a potential exposure from a staff member that tested positive for COVID-19 that should have required her to have a quarantine period of 14 days after the last date of her exposure. Resident #206's medical record provided no evidence of her being tested for COVID-19 after her known exposure on [DATE]. She did not get tested when the other residents who resided on Unit 6 and 7 with her were tested after their known exposure. A review of Resident #206's progress notes provided no documentation about her being tested for COVID-19 or an explanation as to why testing had not been completed. She was discharged home from the facility on [DATE] never being tested to know whether she contracted COVID-19 from her exposure. On [DATE] at 8:49 A.M., the surveyor received an email response from the Administrator with a follow up phone call confirming they did not have any evidence of a COVID-19 test being completed on Resident #206. He acknowledged she was one of the 23 residents that resided on Units 6 and 7 on [DATE] when LPN #3 worked shortly before she tested positive for COVID-19, potentially exposing all the residents on that unit. The Administrator stated the resident was abruptly discharged to home on [DATE] before they could test her. He was not able to explain why she could not have been tested on [DATE] when the other residents who resided on Units 6 and 7 were tested . On [DATE] at 12:46 P.M., a phone interview with LPN #12 revealed the facility tested the residents that still resided on Units 6 and 7 first, before testing other residents on other units. She denied Resident #206 was included in the testing of those residents on [DATE] despite her being one of the residents who resided on Units 6 and 7 on [DATE] when LPN #3 last worked and possibly exposed them to COVID-19. She stated if the residents had been moved off those units between [DATE] and [DATE], they would have been tested when their respective units were tested . When asked why those residents were not put back into quarantine after their known exposure, she replied they were following protocol and CDC guidelines. She indicated those residents that were taken off Units 6 and 7 between [DATE] and [DATE] completed their initial 14-day quarantine period and were not having symptoms at the time they were moved. She did not feel their exposure to LPN #3 on [DATE] and risk they may contract COVID-19 warranted the need for them to be placed back into quarantine for another 14 days. When asked why Resident #206 would have been taken off Unit 5 on [DATE] when the facility was making that their new quarantine unit and her having her recent exposure to a positive staff member with COVID-19 she again stated they were following CDC guidelines on what they recommend them to do. She was not able to give any specific information on what CDC guidelines they were following. On [DATE] at 10:30 A.M. a call was placed to Resident #206's son. He reported Resident #206 came home after being discharged from the facility on [DATE] and passed out a day or two after her discharge. He stated they sent her to the local hospital, and she tested positive for COVID-19. He confirmed she had passed away on [DATE] as a result of her COVID-19 infection. On [DATE] at 10:32 A.M., a return call was received by Resident #206's daughter. She stated she was not informed the facility had a COVID-19 outbreak nor was she aware the resident had been exposed to a staff member who had tested positive for COVID-19. She did not know whether the resident had been tested while in the facility. She assumed she had been as she had not been told otherwise. She confirmed the resident was discharged from the facility on [DATE] but denied it was at the request of the family. She stated her brother called her on that date and told her they were discharging the resident. Her brother was working and was not able to go pick her up. They arranged for a granddaughter to go get her and bring her home. She stated the resident was so weak she had a fall earlier that morning while still in the nursing home and fell again when she got home. The family sent her to the hospital on [DATE] because she was so weak, she could not stand. The hospital immediately tested her for COVID-19, and she tested positive. She stated she felt they had poor communication at the facility, and she did not feel they kept them aware of the resident's change in condition. She reported the resident was placed on [MEDICAL CONDITION] at the hospital and was admitted to the critical care unit (CCU), but she never recovered. She confirmed her mother passed away on [DATE]. 1(b). A review of Resident #49's medical record revealed she was admitted to the facility on [DATE]. Her [DIAGNOSES REDACTED]. A review of Resident #49's census report revealed she resided on Unit 4 in room [ROOM NUMBER]-A from [DATE] through [DATE]. She shared a room with Resident #206 between [DATE] and [DATE]. Resident #206 was brought to her room after the resident had been exposed to LPN #3 on [DATE]. LPN #3 later tested positive for COVID-19 when she was tested at a hospital on [DATE]. A review of Resident #49's Coronavirus report for [DATE] revealed the facility was monitoring her temperature and oxygen saturation (level of oxygen in the blood measured by a pulse oximeter placed on the finger) four times a day. She was noted to start having a fever beginning [DATE]. Her temperature was recorded as having been between 99.2 degrees F. and 100.4 degrees F. She had one episode of her oxygen saturation level being low (less than 90%) on [DATE] when her reading was 89%. A review of Resident #49's COVID-19 Person Under Investigation (PUI) Case Report dated [DATE] revealed her symptoms of COVID-19 included a fever with a date of onset being [DATE]. Her exposure history was marked as having been unknown. The course of treatment at that time was to move her to a private room. An updated COVID-19 PUI Case Report dated [DATE] revealed the resident was moved to the COVID-19 unit. Full barrier precautions were in place. The resident was indicated to previously have been on droplet precautions. The physician declined any further interventions at that time. A review of Resident #49's COVID-19 test done on [DATE] revealed the results came back on [DATE] showing she tested positive for COVID-19 (11 days after Resident #206 had been moved into her room). A review of Resident #49's nurses' progress notes revealed a note dated [DATE] that indicated the resident was in the active dying phase. She expired in the facility with her family at her bedside on [DATE]. 2 (a). A review of Resident #202's medical record revealed she was originally admitted to the facility on [DATE]. Her most recent admission was on [DATE]. Her [DIAGNOSES REDACTED]. Review of Resident #202's census report revealed she resided on the facility's quarantine unit on [DATE] when LPN #3 (who was the first person in the facility known to test positive for COVID-19 on [DATE]) last worked on [DATE]. The census report showed she was moved from the quarantine unit to Unit 2 in room [ROOM NUMBER]- A on [DATE]. She was placed in the same room as Resident #208, who resided in room [ROOM NUMBER]- B. She remained in that room even after [DATE] when the facility had known on that date that she was potentially exposed to COVID-19 by LPN #3 on [DATE]. Resident #202 was tested for COVID-19 on [DATE] when the residents on Unit 2 were being tested . She was tested as part of the facility's facility wide testing after LPN #3 was known to have tested positive for COVID-19. Her specimen was collected on [DATE]. The lab received the specimen on [DATE] and the results were reported back to the facility as being positive on [DATE]. While her COVID-19 test was still pending, Resident #202 was moved onto the COVID-19 unit on [DATE] before it was known whether she was positive for COVID-19 and asymptomatic at that time. She was then moved the very next day on [DATE] off the COVID-19 unit onto the quarantine unit in room [ROOM NUMBER]- A. On [DATE], they moved her again and back on the COVID-19 unit when her COVID-19 test results were received, and she was positive for COVID-19. Review of a COVID-19 PUI Case Report dated [DATE] revealed Resident #202 was

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 2) asymptomatic, but the date of symptom onset was listed as [DATE]. The course of treatment indicated the resident had a positive COVID-19 test come back and was moving to the COVID-19 positive unit. She was placed in full barrier precautions. Resident #202's Coronavirus report for [DATE] revealed she started to have temperatures recorded that were above 99 degrees F. on [DATE]. On [DATE], her SPO2 began to drop below 90 as well. Her highest temperature between [DATE] and [DATE] was 99.8 degrees F. On [DATE], her SPO2 was recorded as being 79%. Review of her progress notes revealed she had a [MEDICAL CONDITION] the morning of [DATE] with no prior history. The physician was notified, and new orders were received for [MEDICATION NAME] [MEDICATION]) and stat labs. Her condition continued to decline and on [DATE] she had crackles and wheezes in her lungs and low oxygen saturation despite being on oxygen at 5 LPM. The physician was updated, and new orders were received for her to receive [MEDICATION NAME] prn. The family was updated on her condition. She continued to decline and started refusing everything orally. She expired in the facility on [DATE]. On [DATE] at 12:46 P.M., an interview with LPN #12, who was standing in for the DON during her absence, was conducted. She was asked why Resident #202 was not placed back into quarantine when she had a known exposure to LPN #3 on [DATE], who tested positive for COVID-19 on [DATE]. She confirmed the facility was aware of LPN #3 ' s positive COVID-19 status on [DATE]. She stated they were following CDC guidelines and protocols. She did not feel leaving Resident #202 in Resident #208's room after [DATE] (when Resident #202 was exposed to LPN #3) put Resident #208 at risk of getting COVID-19 herself. She was then asked why Resident #202 was not tested for COVID-19 on [DATE] when the other residents on Units 6 and 7 that were also exposed to LPN #3 were tested . She stated the resident graduated from quarantine and they did not consider her exposure on [DATE] to require a new quarantine period. She was not able to explain why the census in the resident's EHR showed she had been moved to the COVID-19 unit without her being symptomatic at that time and before her test results came back. She was then asked why Resident #202 was moved to the quarantine unit on [DATE] the day after. She thought maybe the resident had an appointment outside the building that would require her to be quarantined but the nurses' progress notes did not support that she had been out of the facility. 2 (b). A review of Resident #208's medical record revealed her most recent admission to the facility was on [DATE]. Her [DIAGNOSES REDACTED]. Review of Resident #208's census report confirmed she shared a room with Resident #202 between [DATE] and [DATE], after Resident #202 had been exposed to LPN #3 on [DATE]. She remained in room [ROOM NUMBER]- B even after [DATE] when the facility had known of Resident #202's potential exposure to COVID-19. Resident #202 subsequently tested positive for COVID-19 on [DATE] when she was tested as part of the facility's facility wide testing. Review of Resident #208's COVID-19 report for [DATE] revealed the facility was checking her temperature and SPO2 four times a day. She was noted to start having an elevated temperature above 99.4 degrees F. when her temperature was 101.5 degrees F. on [DATE] (six days after Resident #202 had moved into her room). On [DATE] her temperature was elevated three different times that day when checked. The temperatures recorded for that day was 101.7 degrees F., 102.9 degrees F., and 103.2 degrees F. On [DATE], her temperature was 99.5 degrees F. There were no abnormal SPO2 readings recorded. Review of Resident #208's COVID-19 test completed on [DATE] revealed she was positive for COVID-19 and her results were reported to the facility on [DATE]. Review of Resident #208's COVID-19 PUI Case Report dated [DATE] revealed the resident had a cough and fever with date of onset of [DATE]. Her exposure to COVID-19 was indicated to be unknown. The course of treatment indicated was an x-ray along with stat labs. She was indicated to be in isolation at that time, but her census report showed she shared a room with Resident #202 through [DATE]. The COVID-19 PUI Case Report for [DATE] again documented her symptoms as an elevated temperature above 99.4 and a cough. The course of treatment was to send her to the local hospital. Review of Resident #208's progress notes confirmed she became symptomatic of COVID-19 on [DATE]. The physician was notified, and the note indicated in addition to an x-ray and stat labs she was placed in isolation. Her chest x-ray came back negative. The resident's family was updated on her condition and the plan of action. She continued to have a fever through [DATE] being medicated with [MEDICATION NAME]. She was increasingly weak, was having more confusion and her SPO2 was noted to be 78%. The physician was notified, and she was transferred to the hospital on [DATE]. She was admitted to the hospital with [REDACTED]. The resident expired on [DATE] as noted by a Google search for her obituary. She was also included on the list the facility provided of those residents who had COVID-19 and died . On [DATE] at 12:46 P.M., an interview with LPN #12, who was standing in for the DON in her absence, was conducted. LPN #12 was asked why they continued to allow Resident #208 share a room with Resident #202, after it had been known on [DATE], that Resident #202 had been exposed to a staff member that tested positive for COVID-19. She stated they were following guidelines and protocols provided by CDC. She was asked to clarify why Resident #208's COVID-19 PUI Case Report dated [DATE] indicated she was placed on isolation when there was no evidence in her census report showing a room change had taken place. She was supposed to check into that but did not provide any additional information to support she had a room change on [DATE] and it was known Resident #208 still resided in room [ROOM NUMBER] until [DATE]. 3 (a). A review of Resident #207's medical record revealed he was admitted to the facility on [DATE]. His [DIAGNOSES REDACTED]. Review of Resident #207's census report revealed he resided on the facility's quarantine unit on [DATE] when he was exposed to a staff member that later tested positive for COVID-19. He was moved to Unit 1 and placed in room [ROOM NUMBER]- A on [DATE]. He shared a room with Resident #70 who was in room [ROOM NUMBER]- B. There was no evidence of Resident #207 being placed on the facility's quarantine unit after the facility had been made aware of Resident #207's exposure to a staff member who tested positive for COVID-19. The daily census report for Unit 1 on [DATE] confirmed they remained in the same room with one another after [DATE] until Resident #207 was placed on the facility's quarantine unit. Review of Resident #207's COVID-19 tests revealed he was not tested for COVID-19 until [DATE] when the residents on Unit 1 were tested as part of the facility's facility wide testing of residents. The specimen was collected on [DATE] but the lab did not receive the specimen to process it until [DATE] (4 days after it had been obtained). The results were reported back to the facility on [DATE] as being negative. He was tested and positive results were reported to the facility on [DATE]. Resident #207 was placed on droplet precautions on [DATE] as a result of his positive COVID-19 test. Review of Resident #207's COVID-19 PUI Case Report dated [DATE] revealed he was noted to have a fever greater than 99.4 degrees F. The date of onset for his symptoms was [DATE]. His exposure was marked as having been unknown. His course of treatment indicated he was to be put on droplet isolation precautions and in a private room. His COVID-19 report for [DATE] that documented his temperature and SPO2 levels revealed they were being checked four times a day. He started having a temperature above 99 degrees F. on [DATE] when it was noted to be 99.3. It was elevated again on [DATE] three different times when it was recorded as being 99 degrees F., 99.3 degrees F., and 99.4 degrees F. His temperature was elevated again on [DATE] with temperature of 99.1 degrees F. and 99.3 degrees F. His SPO2 was low on [DATE] when it was recorded as being 88% when checked at 5:00 P.M. with his oxygen at 5 liters per minute (LPM). No additional checks were done. A review of Resident #207's progress notes revealed he was transferred to the hospital on [DATE] and admitted . He did not return to the facility and the facility had him on their list of residents that died as a result of COVID-19. On [DATE] at 12:46 P.M., an interview with LPN #12, who was standing in for the DON during her absence, was conducted. She was asked why Resident #207 was not placed in quarantine when it had been known by the facility that he had potentially been exposed to COVID-19 through LPN #3. She stated they were following the guidelines and protocols of the CDC. She stated he graduated from quarantine after he completed his initial 14-day quarantine period. She did not see the reason for him to be put back into quarantine for 14 more days after his known exposure to LPN #3. She was asked why he was not tested when all the other exposed residents that resided on the quarantine unit were tested on [DATE]. She stated they tested those residents who were exposed and still on the quarantine unit first as they felt they were a priority. She did not see the importance in testing him at the same time as the other residents despite him being exposed at the same time. She stated they tested all residents on the other units throughout the facility when they got to them. She was then asked why it took four days after the specimen had been collected for the lab to receive it. She stated it was a holiday weekend and was collected on Thursday but not picked up until the following Monday. She was not sure if the delay in delivery had any impact in his results as those came back negative and the COVID-19 test done the following day was positive for COVID-19. She stated the specimen was just sent in a Fed-Ex bag that was provided by the lab. She denied they had any instructions to store or deliver the specimen packaged in ice. She did not know it was recommended to deliver it in dry ice or other means to keep it in a temperature of minus 94 degrees F. or below if the delivery was going to be delayed for more than 72 hours. She was not concerned the resident was exposed on [DATE] and his first COVID-19 test results were not received until [DATE]. She did not feel leaving Resident #207 in Resident #70's room, after he had been known to be exposed to a staff member that tested positive for COVID-19, put Resident #70 at an increased risk of getting COVID-19. 3 (b). A review of Resident #70's medical record revealed he was admitted to the facility on [DATE]. His [DIAGNOSES REDACTED].