STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215043	A. BUILDING _____ B. WING _____	07/14/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KENSINGTON HEALTHCARE CENTER	3000 MCCOMAS AVENUE KENSINGTON, MD 20895

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 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor review of the clinical record and interview with facility staff, it was determined that the facility failed to review and revise a resident's plan of care. This finding was evident for 1 of 7 residents selected for review during a Focused Infection Control survey (Resident #1). The findings included: This finding was identified during the investigation of complaint #MD 418. On 07-02-2020, a review of the clinical record for Resident #1 revealed to the resident was admitted to facility on 03-26-2020. Nursing documentation, dated 04-08-2020, indicating the resident was observed with a stage 2 pressure ulcer on the sacrum, located towards the left buttock. Further review of the clinical record revealed that the primary physician was notified and an order for [REDACTED].#1 review revealed the resident's comprehensive plan stated the resident has, Potential for pressure ulcer related to medical condition, although there was documented evidence that Resident #1 had already sustained pressure wound on his/her sacral area. There was no evidence that the facility's interdisciplinary team reviewed and revised Resident #1's plan of care that addressed the change in resident skin condition. On 07-06-2020 at 11:42 AM, surveyor interview with the Director of Nursing did not reveal any new information.
F 0660 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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 clinical record review and staff interviews, it was determined that the facility staff failed to develop and implement an effective discharge planning process for 1 of 3 residents reviewed for discharge planning process during the COVID-19 focused infection control survey (Resident #8). The findings include: On 07-07-2020 a review of Resident #8's clinical record revealed the resident was admitted to room [ROOM NUMBER]-A on 04-06-2020. Resident #8 was screened negative for COVID-19 symptoms/fever prior to being admitted to the facility on [DATE]. On 04-09-2020, Resident #8 was moved to a semi-private room (room [ROOM NUMBER]-A). However, Resident #9, a general population resident, had resided in that room (room [ROOM NUMBER]-B) since 12-12-2018. Resident #9 tested positive for COVID-19 on 04-28-2020. Resident #8 refused to be tested for COVID-19 so Resident #8's COVID-19 status was unknown. Resident #8 and Resident #9 continued to share the room until Resident #8 05-08-2020, when Resident #8 was discharged from the facility. Further review of Resident #8's clinical record revealed the resident was admitted to the facility for short term rehabilitation. On 04-07-2020, social services staff initiated a discharge plan the resident. The plan was for the resident to receive home health services. However, a Social Services discharge note, dated 05-05-2020, had no evidence that Resident #8's family or the selected home health agency staff were notified of Resident #8's exposure to a COVID-19 positive resident at the facility. In addition, a nurse's discharge note dated 05-08-2020 did not have evidence that COVID-19 education and instructions for self-isolation was provided to the resident. On 07-08-2020 at 2:00 PM, an interview with the Social Services assistant revealed that family members are notified of residents' COVID-19 status prior to their discharge home. She further stated the home health agency staff are also notified of residents' COVID-19 status to find out whether home health agency staff will go out to see the residents or not. She stated Resident #8's discharge plan was completed by the previous social services director who no longer works at the facility. On 07-08-2020 at 12:47 PM, an interview with the Administrator revealed discharge instructions on COVID-19 status and the precautions to be taken are given to residents prior to their discharge to the community. The Administrator also stated the social services staff communicate with home health agency staff on residents' COVID-19 status when referrals are made. However, the administrator was unable to provide evidence that social services staff communicated Resident #8's COVID-19 status with Resident #8's family member and home health services staff. On 07-09-2020 at 10:57 AM, an interview with home health services staff revealed Resident #8's referral submitted by the facility's social services department did not contain information on Resident #8's COVID-19 status. The home health service's staff also stated that Resident #8's history and physical did not have any information on the resident's COVID-19 status.
F 0835 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Administer the facility in a manner that enables it to use its resources effectively and efficiently.** Based on surveyor review of the clinical records, interviews with staff and a review of the facility's observation and monitoring plan implemented in response to the COVID-19 pandemic, the facility's administration failed to provide oversight for safe cohorting practices to prevent or limit the spread of COVID-19, despite having knowledge of guidance from the Maryland Department of Health (MDH). The lack of appropriate and timely action from the facility's administration placed seven (7) of 18 residents reviewed at risk of contracting COVID-19 (Residents #2, #4, #5 #6, #7, #8 and #9). The findings include: The Center for Medicare and Medicaid Services (CMS) defines cohorting as the practice of grouping residents infected or colonized with the same infectious agent together to confine their care to one area and prevent contact with susceptible residents. According to the Maryland Department of Health guidance Preparing for and Responding to COVID-19 in Long-term Care and Assisted Living Facilities published on March 23, 2020, if a new resident screens negative, they should be admitted to this observation unit/area for 14 days. They can mix with other residents in this unit/area but not with other residents in the facility. They should also be screened daily with temperature and symptom checks and placed on strict isolation if they screen positive. After 14 days on the observation unit, if the resident does not ever screen positive, they can be released to mix with the general population. From 07-07-2020 through 7-08-2020 reviews of clinical records for Residents #2, 4, 5, 6, 7, 8, and 9 revealed that the facility failed to implement an infection control program that ensured newly admitted residents were properly isolated to prevent mixing new admissions (Residents #2, #5 and #8) with residents from the general population (Residents #4, #6, #7 and #9). The clinical record review further revealed that the facility's administration did not move two (2) COVID-19 positive residents (Resident #7 and #9) to the unit dedicated for COVID-19 positive residents. Instead the facility's administration allowed Resident #7 to remain in the room with a resident with a confirmed negative result for COVID-19 (Resident #2). The facility's administration allowed Resident #9 to remain in the room with Resident #8, despite not having an update on Resident #8's COVID-19 status to verify if the resident was COVID-19 negative or positive. On 07-09-2020 at 2:00 PM, the Administrator and the Director of Nursing (DON) were asked if they were aware of the Maryland department of health's guidance on 03-23-2020 and how they used the guidance to help their facility to implement the facility's process for managing new admission and readmission during the COVID-19 pandemic. The administrator answered that he was aware of the guidance however, the fluidity of the information coming in

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0835 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) at the time did not make it feasible for him to follow the guidance accurately. The administrator stated that he was in charge during the heat of the pandemic and takes full responsibility of whatever happened at the time. Between 04-06-2020 and 07-01-2020, the facility's administration did not implement sufficient measures to prevent or limit the spread of COVID-19 between residents. Cross reference F880
F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the review of clinical records, observations, and interviews with the facility's staff, it was determined that the facility failed: 1) to implement an infection control program that ensured newly admitted residents were properly isolated to prevent mixing new admissions with residents from the general population and; 2) to cohort residents appropriately by not separating newly diagnosed Coronavirus Disease 2019 (COVID-19) positive residents from their roommates with either negative COVID-19 test result or an unknown COVID-19 status. The facility's noncompliance with infection control practices placed seven (7) of 18 residents reviewed at an increased risk for contracting COVID-19 (Residents #2, 4, 5, 6, 7, 8 and #9). As a result of these findings, an immediate jeopardy was declared on 07-09-2020 at 1:00 PM. The facility submitted a plan of removal at 5:22 PM. This plan was accepted by the State Agency at 10:32 PM. The immediate jeopardy was lifted by the State Agency on 07-14-2020 at 3:20 PM. After removal of the immediacy, the deficiency remained at a potential for more than minimal harm, with a scope and severity of E. The findings include: 1. According to the Maryland Department of Health guidance Preparing for and Responding to COVID-19 in Long-term Care and Assisted Living Facilities published on March 23, 2020, if a new resident screens negative, they should be admitted to this observation unit/area for 14 days. They can mix with other residents in this unit/area but not with other residents in the facility. They should also be screened daily with temperature and symptom checks and placed on strict isolation if they screen positive. After 14 days on the observation unit, if the resident does not ever screen positive, they can be released to mix with the general population. On 07-01-2020 at 9:30 AM, a review of the facility's COVID-19 Education, Observation and Monitoring Plan implemented on 01-28-2020, and revised on 03-14-20, 04-22-2020, and 06-04-2020, revealed the facility's policy and procedure required all new admissions and positive residents to be isolated in a private room when available and monitored for 14 days. After 14 days without any COVID-19 symptoms, the resident will then be transferred to other units with the general resident population. Further review of the facility's COVID-19 Education, Observation and Monitoring Plan revealed the facility established three zones (green, yellow, and red) to separate the general resident population, new admissions or readmissions, and COVID-19 positive residents. The rooms in the green zone were for general population residents who were negative. The rooms in the yellow zone, established on 04-23-2020, was the observation area for newly admitted and readmitted residents. Rooms in the red zone were for residents with COVID-19. The red zone rooms were established on 04-09-2020. a. On 07-01-2020 at 10:15 AM during a tour of the dedicated observation unit a surveyor observed Resident #4 and Resident #5 sharing a semi-private room (room100). Resident #4 was observed in bed A (100-A) and Resident #5 was observed in bed B (100-B). On 07-08-2020 a review of the clinical records for Resident #4 and for Resident #5 revealed that Resident #4 was admitted to the facility on [DATE] and assigned to room [ROOM NUMBER]-A. On 06-24-2020, 25 days later, Resident #5 was admitted to the facility and assigned to 100-B. On 07-01-2020 a review of the facility's daily census record for 06-24-2020 revealed that room [ROOM NUMBER], a room on the observation unit, was unoccupied. On 07-02-2020 at 10:20 AM, interview with the Admission Coordinator revealed that Resident #5 was admitted to room [ROOM NUMBER]-B, because two other new admissions were expected to arrive on 06-24-2020. However, the expected admissions did not come. The admission coordinator further stated, I didn't know that all new admissions to the observation unit should be placed in a single-person room (without a roommate). My understanding was that we could admit to the observation unit as long as there was an available bed. On 07-02-2020 at 10:25 AM an interview with the DON revealed that Resident #4 should have been moved from the observation unit (the yellow zone) to the general population (the green zone) since the resident had been in the room for more than 14 days without COVID-19 symptoms. b. On 07-01-2020 at 10:15 AM a surveyor observed Resident #4 and Resident #5 sharing a semi-private room (room [ROOM NUMBER]). Resident #4 was observed in 100-A and Resident #5 was observed in 100-B. On 07-01-2020 a review of Resident #5's clinical records on 07-01-2020 revealed a hospital screened the resident for COVID-19 symptoms on 06-24-2020, prior to discharging the resident. Based on the screening assessment, Resident #5 did not show signs or symptoms of COVID-19. Resident #5 was admitted to the facility on [DATE] and assigned to room [ROOM NUMBER]-B with Resident #4, who had been in 100-A for 25 days prior to Resident #5's admission. On 07-08-2020 a review of the Resident #4's clinical record revealed the hospital tested Resident #4 for COVID-19 on 05-21-2020. The resident's results were negative. Further review of the record revealed that Resident #4 was admitted to the facility's observation unit on 05-30-2020. On 07-08-2020 a review of the daily census record for 06-24-2020 revealed that room [ROOM NUMBER] in the green zone was unoccupied. On 07-08-2020 at 2:34 PM, an interview with the infection control nurse revealed that all direct care staff were in-serviced on 04-22-2020 regarding the facility's policies on COVID-19. In addition, all management staff were briefed on the policies during regular morning meetings. On 07-02-2020 at 10:25 AM in an interview, the DON was unable to explain why Resident #4 was not moved to an area with the general population after completing the required observation period. The DON stated, I think I dropped the ball because there was too much going on. No additional information was provided. On 07-08-2020 at 1:10 PM, an interview with the Unit Manager revealed she lost track of the number of days Resident #4 was on the observation unit. The unit manager stated that the Director of Nursing (DON) usually kept track of the number of days residents stayed in the observation unit. c. On 07-07-2020, a review of Resident #2's clinical record revealed that on 04-06-2020 the resident was admitted from a hospital to the facility and assigned to an observation unit in a semi-private room (room [ROOM NUMBER]-B). Resident #2 was screened negative for COVID-19 symptoms/fever prior to being admitted to the facility. Further record review revealed Resident #2's roommate (Resident #8 in 200-A) was also admitted from a hospital on 04-06-2020. A continued review of Resident #2's clinical record revealed that after two days of admission, on 04-08-2020, the resident was moved to room [ROOM NUMBER]-A with Resident #6, a general population resident who had resided in room [ROOM NUMBER] since 09-24-2019. Further review of Resident #2's clinical record revealed that on 04-15-2020, nine days after admission, the resident was moved a second time and placed in a semi-private room (room [ROOM NUMBER]-A) with Resident #7. Resident #7 is another general population resident who had occupied bed 217-B since 08-15-2017. On 07-07-2020 at 5:13 PM, an interview with DON revealed Resident #2 was moved with general population because Resident #2 had screened negative for signs and symptoms of COVID-19 prior to admission to the facility. The DON stated that Resident #2 was not believed to be at risk of exposing the general population to COVID-19. On 07-08-2020 at 12:47 PM, an interview with the Administrator revealed Resident #2 was moved multiple times because the facility's staff were trying to expand the red zone, rooms available for COVID-19 positive residents. On 07-08-2020 at 1:19 PM, an interview with the ICP confirmed Resident #2 was moved to different rooms before completing the required 14 days of observation period to create additional bed availability for COVID-19 positive residents. d. On 07-07-2020 a review of Resident #8's clinical record revealed the resident was screened negative for COVID-19 symptoms/fever on 04-06-2020 at a hospital prior to admission to the facility. The same day the resident was admitted to room [ROOM NUMBER]. Resident #2 shared a room with Resident #8 (200-A). On 07-07-2020 a review of Resident #2's clinical record revealed Resident #2 in 200-B was also admitted from a hospital on 04-06-2020. Resident #2 was screened negative for COVID-19 symptoms/fever prior to being admitted to the facility on [DATE]. On 07-07-2020, an additional clinical record review of Resident #8 revealed the resident was moved to a semi-private room (room [ROOM NUMBER]-A) on 04-09-2020, three (3) days after admission. Resident #9, a general population resident, had resided in that room (room [ROOM NUMBER]-B) since 12-12-2018. On 07-07-2020 at 5:20 PM, an interview with the DON (Director of Nursing) revealed Resident #8 was moved to room [ROOM NUMBER] with Resident #9 because Resident #8 had screened negative for signs and symptoms of COVID-19 prior to admission to the facility. The DON stated that Resident #8 was not believed to be at risk of exposing the general population to COVID-19. On 07-08-2020 at 12:47 PM, an interview with the Administrator revealed Resident #8 was moved to room [ROOM NUMBER] because the facility's staff were trying to expand the red zone, rooms available for COVID-19 positive residents. On 07-08-2020 at 1:19 PM, an interview with the ICP (infection control preventionist) confirmed Resident #8 was moved to room [ROOM NUMBER] before he/she completed the required 14 days of observation to create additional bed availability for COVID-19 positive residents. 2. The Centers for Medicare for Medicare and Medicaid Services (CMS) defines cohorting as the practice of grouping residents infected or colonized with the same infectious agent together to confine their care to one area and prevent contact with susceptible residents (State

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) Operations Manual, Appendix PP last revised 11/22/17). On 04-02-2020 CMS released COVID-19 Long-Term Care Facility Guidance. Section five states, Long-term care facilities should separate patients and residents who have COVID-19 from patients and residents who do not, or have an unknown status. On 04-24-2020, the Maryland Department of Health (MDH) issued Directive and Order Regarding Nursing Home Matters on, Staff Assignment: Nursing homes shall immediately implement, to the best of their ability, the following personnel practices: Designate a room, series of rooms, unit, or floor of the nursing home to care for residents with known or suspected COVID-19. On 07-08-2020 a review of the facility's COVID-19 Education, Observation and Monitoring Plan revealed the facility established three zones (green, yellow, and red) to separate the general resident population, new admissions or readmissions, and COVID-19 positive residents. The rooms in the green zone were for general population residents who were negative. The rooms in the yellow zone, established on 04-23-2020, was the observation area for newly admitted and readmitted residents. Rooms in the red zone were for residents with COVID-19. The red zone rooms were established on 04-09-2020. a. On 07-01-2020 at10:30 AM, Resident #2 and Resident #7 were observed in room [ROOM NUMBER]. Resident #2 was in 217-A and Resident #7 in 217-B. On 07-07-2020, a review of Resident #7's clinical record revealed the resident tested positive for COVID-19 on 04-29-2020. On 07-07-2020 a review of Resident #2's clinical record revealed the resident tested negative for COVID-19 on 05-03-2020. On 07-08-2020 a review of the facility's since records revealed there were two unoccupied rooms in the red zone on 04-29-2020. On 07-07-2020 at 5:13 PM in an interview, the DON reported that Resident #7 was not separated from Resident #2 after Resident #7 had tested positive, because Resident #2 and Resident #7 were already exposed to each other for more than a week and since both residents were asymptomatic, the residents were not separated or moved to designated units. On 07-01-2020 at 12:10 PM, an interview with the ICP revealed the facility did not have a cohorting policy in place until after 04-22-2020, when the National Guard reviewed the facility's cohorting practices and advised the facility to develop a subsequent policy. According to the ICP, prior to the arrival of the National Guard all direction on COVID-19 related issues were relayed from facility corporate headquarters. All of the department heads met each morning and discussed how to implement the recommendations from the corporate office. On 07-08-2020 at 12:47 PM, an interview with the Administrator revealed he was unable to explain why Resident #2 continued to share a room with Resident #7 after facility staff knew Resident #7 was positive for COVID-19 and Resident #2 had tested negative for COVID-19. On 07-08-2020 at 1:19 PM, in an interview the ICP (infection control person) stated that after Resident #7 tested positive for COVID-19 and Resident #2 tested negative for COVID-19, Resident #7 should have been moved to the positive unit and Resident #2 should have been isolated for at least 14 days. He was unable to explain why the two residents continued to share a room. b. On 07-07-2020 a review of Resident #8's clinical record revealed Resident #8 was screened negative for COVID-19 symptoms and fever on 04-06-2020 at the hospital prior to admission to the facility. That same day the resident was admitted to room [ROOM NUMBER]-A. On 07-07-2020, an additional clinical record review revealed on 04-09-2020, three days after being admitted to the facility, Resident #8 was moved to a semi-private room (room [ROOM NUMBER]-A). Resident #9, a general population resident, had resided in that room (208-B) since 12-12-2018. Resident #9 tested positive for COVID-19 on 04-28-2020. Resident #8 refused to be tested for COVID-19. However, Resident #8 and Resident #9 continued to share room [ROOM NUMBER] until Resident #8 was discharged home on 05-08-2020. On 07-08-2020 a review of the facility's since records revealed there were two unoccupied rooms in the red zone on 04-29-2020. On 07-07-2020 at 5:20 PM, in an interview, the DON reported that Resident #8 was not separated from Resident #9 after Resident #9 tested positive for COVID-19, because Resident #8 and Resident #9 were already exposed to each other for more than a week and since both residents were asymptomatic, the residents were not separated or moved to designated units. On 07-01-2020 at 12:10 PM, an interview with the IP (infection preventionist) revealed the facility did not have a cohorting policy in place until after 04-22-2020, when the National Guard reviewed the facility's cohorting practices and advised the facility to develop a subsequent policy. According to the IP, prior to the arrival of the National Guard all direction on COVID-19 related issues were relayed from facility corporate headquarters. All of the department heads met each morning and discussed how to implement the recommendations from the corporate office. On 07-08-2020 at 12:47 PM, an interview with the Administrator revealed he was unable to explain why Resident #8 continued to share a room with Resident #9 after facility staff knew Resident #9 was positive for COVID-19 and Resident #8 had unknown COVID-19 status. On 07-08-2020 at 1:19 PM, an interview with IP revealed Resident #9 was tested COVID-19 positive and Resident #8 refused to be tested so Resident #9 should have been moved to the positive unit, the Red Zone. IP was unable to explain why the residents continued to share the room. As a result of these findings, an immediate jeopardy was declared on 07-09-2020 at 1:00 PM. The facility submitted a plan of removal at 5:22 PM. The State Agency accepted the State Agency plan of removal at 10:32 PM. The immediate jeopardy was lifted by the State Agency on 07-14-2020 at 3:20 PM. The provisions of the plan to remove the immediacy included but not limited to the following: A. The facility has established room numbers 100 to 108, which are located on the first floor as the designated location for the observation unit (yellow Zone) for new admissions and readmissions. New admissions and readmissions who are negative or unknown will be admitted to these rooms and remain for a minimum of 14 days and will not commingle with the general population. room [ROOM NUMBER]-A and 201-B have been designated as the COVID-19 positive unit (Red Zone). Residents admitted that are COVID-19 positive will be admitted to the COVID-19 positive unit. B. Resident #8 is no longer in the facility. Resident #9 remains in the facility and shows no sign or symptoms of COVID-19 so has been moved to the general population. Resident #4 has been moved from the observation unit to the non-COVID unit (Green Zone). Resident #5 has completed 14 days of observation with no sign or symptoms of COVID-19 and has been moved to the general population. Resident #2, #6 and #7 are still in the facility with no sign or symptoms of COVID-19. They are all currently residing in the non-COVID-19 unit with the general population. C. The Director of Nursing completed a 100% audit of signs and symptoms of COVID-19 of all residents on 7-8-2020 to ensure they are in the appropriate quarantine area. Audits will be on-going and will be completed by shift supervisor on the weekends and holidays. Currently, the facility does not have any COVID-19 positive residents. All residents in the observation unit (yellow unit) are in private rooms and are within their 14 days of quarantine post admission. D. The facility instituted a tracker that is reviewed daily by the clinical team during stand up meetings and daily clinical meetings to track the number of days in the observation unit for all new admissions. Residents who have remained symptom free for 14 days post-admission are moved to a COVID-19 free area of the facility (green zone). Facility cohorting areas for observation and COVID-19 positive areas are clearly identified. Red unit is located on the second floor, room [ROOM NUMBER]-A and room [ROOM NUMBER]-B are assigned rooms. E. Staff education was provided by either shift supervisor, staff development, infection control person or Director of Nursing. Education was provided either in-person or via phone calls. Nursing, administrative, housekeeping, activities, maintenance, dietary, rehab and weekend staff have been educated by staff development on facility's COVID-19 infection control program to ensure new admissions remain on observation unit for 14 days before mixing with general population, staff transfer newly diagnosed COVID-19 positive residents to isolation area and cohorting COVID-19 residents on same unit. F. Admissions Coordinator was educated on placement of new and readmitted residents per latest MDH guidance dated June 16, 2020. In addition, the admission coordinator will present admissions and readmissions to the Director of Nursing and/or the Nursing Home Administrator who will determine appropriateness of the admission and the proper room assignment for the resident. This process will also be followed on the weekends staff. Infection preventionist will be back up in case the Administrator and DON are not available. G. Facility has instituted the use of a COVID-19 tracker on 07-09-2020 to manage observation days for all new admissions, and COVID-19 positive residents quarantine days to determine when isolation should be discontinued. The COVID-19 tracker is reviewed daily during department head meetings and clinical reviews. The COVID-19 tracker will be reviewed by shift supervisors, manager on duty personnel on weekends and holidays. H. The facility administrator and/or the Director of Nursing will communicate to the team about New guidance from MDH, CDC, and/or CMS during department head meetings daily. I. The administrator will review the resident tracker with the Director of Nursing and Admissions Director to ensure new and readmitted residents are quarantined for the required 14 days in the observation unit, (red unit monitoring). COVID-19 Tracker Audit findings will be reviewed in facility QAPI meeting monthly until pandemic resolves. J. The Director of Nursing will review clinical changes of residents daily during clinical meetings, to ensure that all COVID-19 positive residents were placed in the appropriate quarantine area. COVID-19 Tracker Audit findings will be reviewed in the facility monthly QAPI meetings until pandemic resolves. Director of Nursing and/or designee will monitor all residents for signs and symptoms of COVID-19. The immediate jeopardy was removed on 07-14-2020 at 3:20 PM after confirmation of the facility's plan of removal by the surveyor who was on site at the facility.