STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	05/28/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WESTPORT REHABILITATION AND NURSING CENTER	**7300 FOREST AVE RICHMOND, VA 23226**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews, interviews with local health-department staff, review of facility documents, and clinical record review, it was determined, that the facility staff failed to ensure the implementation of infection control practices and precautions, to prevent the spread of infection, and communicable disease during an identified outbreak of Coronavirus (COVID 19) for three of 37 residents residing on the 300 Unit, (Residents, #2, #4, and #5). The facility staff failed to implement standard and droplet precautions to prevent the spread of COVID 19* to residents that had tested negative for COVID-19, and who resided in the same room with a COVID 19 positive roommate on the 300 unit. The facility staff failed to pull privacy curtains the full length of the bed in three of three resident rooms in which COVID-19 positive and negative residents resided together in the same room, for Residents, #1, #2, #3, #4, #5 and #6. Cohorting COVID-19 positive and negative residents together and failing to pull privacy curtains the full length of the bed and to implement droplet precautions created the likelihood of residents being exposed to and contracting COVID-19. At the time of the survey, there had already been nine deaths of residents, who had contracted COVID 19. Review of the facility LTC (Long Term Care) Respiratory Surveillance List (for COVID-19 Outbreaks), submitted by the facility for review by fax on [DATE], revealed the facility census was 130 current residents, 81 residents had tested positive for the COVID-19 virus and nine had expired, (Residents #7, #8, #9, #10, #11, #12, #13, #14 and # 15). This failure resulted in Immediate Jeopardy. The State Agency informed the facility on [DATE] at 6:18 p.m. of the Immediate Jeopardy situation. On [DATE] at 11:59 a.m., the Immediate Jeopardy was abated and lowered to a level II isolated. The findings include: On [DATE] at 5:08 p.m., the survey team conducted an onsite, abbreviated, remote FICS (focused infection control survey) at the facility. As a part of the survey process, the survey team conducted observations and interviewed facility staff members and staff from the local health department. On [DATE] at 5:25 p.m., an observation was conducted of resident rooms on the 300 hall of the facility. Observation of the resident room shared by Residents #1 (COVID-19 positive) and #2 (COVID-19 negative) revealed, both residents lying in single beds. The curtain between the two beds was open (drawn back to the wall allowing visualization of both residents from the doorway). Observation of room shared by Residents #3 (COVID-19 positive) and #4 (COVID-19 negative) revealed the two residents lying in single beds. The curtain between the two beds was observed open. An isolation cart containing gloves, gowns and linen bags was observed outside of the doorway of Resident #3 and Resident #4's room. Observation of the room shared by Residents #5 (COVID-19 negative) and #6 (COVID-19 positive) revealed a semi-private room and a resident lying in the bed closest to the doorway, and the second resident sitting in a wheelchair in the center of the room between the two beds wearing a facemask. The curtain between the two beds was observed open behind the resident in the wheelchair. Further observation of the 300 hall revealed seven vacant rooms. On [DATE] at 4:57 p.m. through 6:11 p.m., an onsite visit and observation was completed. The long-term care supervisor was notified of the survey team's observations and a conference call was completed with two additional supervisors and the survey team. On [DATE] at 9:11 a.m., a telephone interview was conducted with CNA (certified nursing assistant) # 3 who worked on the 300 hallway. When asked if they were aware of any residents in the same room, where one resident was COVID-19 positive and the other resident COVID-19 negative CNA # 3 stated, Yes, we do have positive and negative together. When asked what procedure they follow to prevent the spread of [MEDICAL CONDITION] from the COVID-19 positive resident to the COVID-19 negative resident CNA # 3 stated, I take care of negative resident first, change all of my PPE (personal protective equipment) then do care for the positive resident. When asked about the cubicle curtain CNA # 3 stated that the curtain was to be pulled between the residents. On [DATE] at 9:22 a.m., a telephone interview was conducted with CNA # 4 who worked on the 300 hallway. When asked if they were aware of any residents in the same room, where one resident was COVID-19 positive and the other resident COVID-19 negative CNA # 4 stated, Yes, we do have positive and negative in the same room. When asked what procedure they follow to prevent the spread of [MEDICAL CONDITION] from the COVID-19 positive resident to the COVID-19 negative resident CNA # 4 stated, Put all of PPE gear on first, then I take care of negative person first, then change PPE gear, wash hands Put on new PPE and poncho. When asked about the cubicle curtain CNA # 4 stated that the curtain was to be pulled between the residents. On [DATE] at 9:35 a.m., a telephone interview was conducted with OSM # 7, nurse supervisor of (Name of City) health department and OSM # 8, epidemiologist. OSM # 7 and OSM # 8 had been in contact with (name of facility) and OSM # 7 was last on site on [DATE]. OSM #7 and #8 were asked about any recommendations they had made to the facility. OSM # 7 and OSM # 8 stated that they made recommendations after recent testing at the facility and finding some residents testing positive for COVID-19 and other resident residing in the same rooms, who tested negative for COVID-19. OSM #8 and #7 stated they recommended to the facility that the facility shelter the resident's in-place because the roommate who was negative, was already exposed to the COVID-19 virus and moving the residents to separate them could spread [MEDICAL CONDITION]. On [DATE] at 11:00 a.m., a telephone interview was conducted with ASM (administrative staff member) # 1, facility administrator and ASM # 2, interim director of nursing and infection control coordinator. When asked how facility staff knows which residents are COVID-19 positive or negative ASM # 2 stated they notify the staff each morning, there is a list at the units and it is reflected on their 24-hour report. ASM #2 was asked what they were doing to reduce the spread of COVID-19 within the facility when there is COVID-19 positive and negative residing in the same room. ASM # 2 stated the CNAs (certified nursing assistants) provide care to the negative resident first, change their PPE (personal protective equipment), wash their hands, put on new PPE before providing care the COVID-19 positive resident, the resident's beds are six feet apart and the curtain is pulled between the beds. ASM # 1 and ASM # 2 further stated that they had an outbreak on the 300 hall. They stated that 21 of the 37 residents on the 300 hall tested positive for COVID-19, 13 were negative, two test results were pending and one resident refused to be tested . When asked if they had been in contact with OSM # 7 and OSM # 8 and if they had discussed any recommendations ASM # 2 stated yes, that they were in contact with OSM # 7 by telephone and that they recommended the facility shelter the resident's in place. When asked what explanation was provided for not moving a resident who tested positive for COVID-19 or a resident who tested negative for COVID-19 who were residing in the same room, ASM # 1 and ASM # 2 stated that they were told the more they try to move the residents around [MEDICAL CONDITION] will spread. When asked if there was discussion about pulling the privacy curtains to divide the residents in the room ASM # 1 and ASM # 2 stated that OSM # 7 and OSM # 8 did not say anything about it. When asked if they had received written documentation about the sheltering the residents in place ASM # 1 and ASM # 2 stated no. A remote review of the clinical records for Residents #1, #2, #3, #4, #5, and #6, revealed the following: Remote review of Resident #1's clinical record revealed, Resident # 1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident # 1's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of [DATE], coded Resident # 1 as scoring a four on the brief interview for mental status (BIMS) of a score of 0 - 15, four - being severely impaired of cognition for making daily decisions. Resident # 1 was coded as requiring extensive assistance of one staff member for activities of daily living. The comprehensive care plan for Resident #1 dated [DATE] documented in part, Focus. I am at risk for psychosocial well-being concern r/t (related to) medically imposed restrictions r/t COVID-19 precautions.

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

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

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) I am at risk for s/sx (signs and symptoms). Positive for COVID-19 (,[DATE]) ([DATE]). Revision on: [DATE]. Under Interventions it documented in part, Observe for s/s of COVID-19/document and promptly report s/sx: fever, coughing, sneezing, soar (Sic.) throat, respiratory issues. Date Initiated: [DATE]. The nurse's note for Resident # 1 dated [DATE] documented in part, 22:32 (10:32 p.m.) COVID-19 results pending. Remains asymptomatic (4). The nurse's note for Resident # 1 dated [DATE] documented in part, 04:41 (4:41 a.m.) Continues on droplet precautions (5) for COVID-19. At 11:48 a.m., the nurse's note documented in part, COVID test for resident was positive, MD/NP (medical director/Nurse Practitioner) made aware .RP (responsible party) called made aware of COVID test results . Remote review of Resident #2's clinical record revealed, Resident # 2 was admitted to the facility on [DATE] and a readmission on [DATE] with [DIAGNOSES REDACTED]. Resident # 2's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of [DATE], coded Resident # 2 as scoring a 10 on the brief interview for mental status (BIMS) of a score of 0 - 15, 10 - being moderately impaired of cognition for making daily decisions. Resident # 2 was coded as requiring extensive assistance of one staff member for activities of daily living. The comprehensive care plan for Resident #2 dated [DATE] documented in part, Focus. I am at risk for psychosocial well-being concern r/t (related to) medically imposed restrictions r/t COVID-19 precautions. I am at risk for s/sx (signs and symptoms). Negative for COVID-19 (,[DATE]) ([DATE]). Revision on: [DATE]. Under Interventions it documented in part, Observe for s/s of COVID-19/document and promptly report s/sx: fever, coughing, sneezing, soar Sic. throat, respiratory issues. Date Initiated: [DATE]. The Physician/Practitioner Progress Note note for Resident # 2 dated [DATE] documented in part, 13:07 (1:07 p.m.) COVID-19 test pending. Resident is asymptomatic today. The Physician/Practitioner Progress Note note for Resident # 2 dated [DATE] documented in part, 12:35 p.m., Assessment/Plan: COVID-19 test negative. At 2:46 p.m., the Physician/Practitioner Progress Note documented in part, Telephoned the resident's RP, (Name of RP) to discuss the resident's recent negative COVID-19 test results from ,[DATE] ([DATE]). Remote review of Resident #3's clinical record revealed, Resident # 3 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident # 3's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of [DATE], coded Resident # 3 as scoring a two on the brief interview for mental status (BIMS) of a score of 0 - 15, two - being severely impaired of cognition for making daily decisions. Resident # 3 was coded as requiring extensive assistance of one staff member for activities of daily living. The comprehensive care plan for Resident #3 dated [DATE] documented in part, Focus. I am at risk for psychosocial well-being concern r/t (related to) medically imposed restrictions r/t COVID-19 precautions. I am at risk for s/sx (signs and symptoms). Positive for COVID-19 (,[DATE]) ([DATE]). Revision on: [DATE]. Under Interventions it documented in part, Observe for s/s of COVID-19/document and promptly report s/sx: fever, coughing, sneezing, soar Sic. throat, respiratory issues. Date Initiated: [DATE]. The nurse's note for Resident # 3 dated [DATE] documented in part, 22:35 (10:35 p.m.) COVID-19 results pending. The nurse's note for Resident # 3 dated [DATE] documented in part, 15:04 (3:05 p.m.), COVID results positive, resident has not had any sx (symptoms), N/V/D (nausea/vomit/diarrhea), sob (shortness of breath), or cough, MD/NP (medical director/Nurse Practitioner) and RP (responsible party) aware. Remote review of Resident #4's clinical record revealed, Resident # 4 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident # 4's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of [DATE], coded Resident # 4 as scoring a three on the brief interview for mental status (BIMS) of a score of 0 - 15, three - being severely impaired of cognition for making daily decisions. Resident # 4 was coded as requiring extensive assistance of one staff member for activities of daily living. The comprehensive care plan for Resident #4 dated [DATE] documented in part, Focus. I am at risk for psychosocial well-being concern r/t (related to) medically imposed restrictions r/t COVID-19 precautions. I am at risk for s/sx (signs and symptoms). Negative for COVID-19 (,[DATE]) ([DATE]). Revision on: [DATE]. Under Interventions it documented in part, Observe for s/s of COVID-19/document and promptly report s/sx: fever, coughing, sneezing, soar Sic. throat, respiratory issues. Date Initiated: [DATE]. The Physician/Practitioner Progress Note for Resident # 4 dated [DATE] documented in part, 14:40 (2:40 p.m.) Assessment/Plan: COVID-19 test pending. The nurse's note for Resident # 4 dated [DATE] documented in part, 00:08 (12:08 a.m.), Remains on droplet precautions related to COVID-19. The Physician/Practitioner Progress Note for Resident # 4 dated [DATE] documented in part, 12:41 (12:41 p.m.), COVID-19 test negative. At 14:55 (2:55 p.m.), the Physician/Practitioner Progress Note documented, Resident's RP (responsible party) (Name of RP-relationship), notified this afternoon of the resident's negative COVID-19 test results. Remote review of Resident #5's clinical record revealed, Resident # 5 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident # 5's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of [DATE], coded Resident # 5 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Resident # 5 was coded as requiring limited assistance of one staff member for activities of daily living. The comprehensive care plan for Resident #5 dated [DATE] documented in part, Focus. I am at risk for psychosocial well-being concern r/t (related to) medically imposed restrictions r/t COVID-19 precautions. I am at risk for s/sx (signs and symptoms). Negative for COVID-19 (,[DATE]) ([DATE]). Revision on: [DATE]. Under Interventions it documented in part, Observe for s/s of COVID-19/document and promptly report s/sx: fever, coughing, sneezing, soar Sic. throat, respiratory issues. Date Initiated: [DATE]. The Physician/Practitioner Progress Note for Resident # 5 dated [DATE] documented in part, 14:30 (2:30 p.m.) Screen for COVID-19. The nurse's note for Resident # 5 dated [DATE] documented in part, 14:29 (2:49 p.m.) RP (responsible party): left message in reference to COVID-19 testing, Awaiting return call. The nurse's note for Resident # 5 dated [DATE] documented in part, 17:17 (5:17 p.m.), COVID results were negative, call placed to RP, message left on answering machine. Remote review of Resident #6's clinical record revealed, Resident # 6 was admitted to the facility on [DATE] and a readmission on [DATE] with [DIAGNOSES REDACTED]. Resident # 6's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of [DATE], coded Resident # 6 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Resident # 6 was coded as requiring extensive assistance of one staff member for activities of daily living. The comprehensive care plan for Resident #6 dated [DATE] documented in part, Focus. I am at risk for psychosocial well-being concern r/t (related to) medically imposed restrictions r/t COVID-19 precautions. I am at risk for s/sx (signs and symptoms). Positive for COVID-19 (,[DATE]) ([DATE]). Revision on: [DATE]. Under Interventions it documented in part, Observe for s/s of COVID-19/document and promptly report s/sx: fever, coughing, sneezing, soar Sic. throat, respiratory issues. Date Initiated: [DATE]. The nurse's note for Resident # 6 dated [DATE] documented in part, 14:46 (2:46 p.m.) RP (responsible party) notified in reference to COVID-19 testing with consent, MD (medical director) notified. The nurse's note for Resident # 6 dated [DATE] documented in part, 17:19 (5:19 p.m.), COVID results were positive, resident was made aware, call placed to (Name of Relative), message left on answering machine. On [DATE] at approximately 11:52 a.m., ASM (administrative staff member) #1, the administrator, was contacted by telephone and asked for the standard used for sheltering residents in place (COVID 19 positive and negative in the same room). On [DATE] at 1:05 p.m., ASM # 1 provided this surveyor with the following email, The conversation was had with the DOH (Department of Health) about sheltering in place on Wing 3 was on Friday [DATE] until all of the Residents were tested and results in. The decision was based on the concerns that there was a widespread outbreak and even those that would be negative would already have been exposed and all would be treated as presumed positive. (Name of OSM # 7) provided this: Have a plan for how residents in the facility who develop COVID-19 will be handled (e.g., transfer to single room, implement use of Transmission-Based Precautions, prioritize for testing, transfer to COVID-19 unit if positive). Residents in the facility who develop symptoms consistent with COVID-19 could be moved to a single room pending results of [DIAGNOSES REDACTED]-CoV-2 testing. They should not be placed in a room with a new admission nor should they be moved to the COVID-19 care unit unless they are confirmed to have COVID-19 by testing. While awaiting results of testing, HCP should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown when caring for these residents. Cloth face coverings are not considered PPE and should only be worn by HCP for source control, not when PPE is indicated. Have a plan for how roommates, other residents, and HCP who may have been exposed to an individual with COVID-19 will be handled (e.g., monitor closely, avoid placing unexposed residents into a shared space with them). On [DATE] at 1:11 p.m., a telephone conference was conducted with OSM (other staff member) # 9, medical director, deputy director of (Name of City and County) Health District, Long Term Care (LTC) Supervisor and this surveyor. OSM # 9 was asked if they (local health department) talked with or visited the facility. OSM # 9 stated that there were a set of written recommendations provided to the facility. OSM #9 was informed of the observation that was conducted onsite at the facility on [DATE] and of the interview conducted with OSM # 7, nurse supervisor of (Name of City) health department and OSM # 8, epidemiologist on [DATE] at 9:35 a.m., by telephone. OSM #9 was informed of the information the facility provided from the local health department in regards to

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) residents sheltering in place (COVID positive and negative in the same room). OSM # 9 acknowledged this information did not address sheltering in place. OSM #9 stated if there is an even risk of exposure, they (local health department) are on board with putting them (residents) together, i.e. if there are two roommates who have been tested negative but with positive roommates, the two negative roommates can be moved together. OSM # 9 further stated, We can suggest that they move the exposed residents. OSM # 9 stated that she needed to locate the guidance and would send this to the LTC Supervisor and surveyor. On [DATE], at 4:55 p.m., a second telephone conference, was conducted with, OSM #9, the LTC (long term care) Supervisor, Director of OLC (Office of licensure and Certification), Assistant Director of OLC and this surveyor, regarding, CMS (Centers for Medicare & Medicaid Services), regulations and the CDC's (Centers for Disease Control and Prevention's) guidance, for cohorting residents who are positive or negative for COVID-19. OSM #9 stated that they were trying to get a feel from the early [DATE]/,[DATE] CDC guidance, Evaluate and Manage Residents with Symptoms of Respiratory Infection. OSM #9 stated that the [DATE] CDC guidance specifically stated that exposed individuals needed to be moved from the COVID-19 positive residents. OSM #9 stated that because there is an element of judgement involved, that moving the exposed resident out of the room poses more of a danger and more of a shuffling of the residents and could cause more blenderizing. I would say that is why the guidance doesn't say must or will. OSM #9 informed that facilities must ensure that they are complying with all CMS and CDC guidance related to infection control and the [DATE] CDC's guidance, which documents facilities Have a plan for how roommates, other residents and HCP (health care providers) who may have been exposed to an individual with COVID-19 will be handled. OSM #9 was informed that the word plan, on the [DATE], CDC guidance links and connects to the [DATE], CDC guidance, titled, Responding to Coronavirus (COVID-19) in Nursing Homes, Considerations for the Public Health Response to COVID-19 in Nursing Homes. The [DATE], CDC guidance** documents under the header, Resident with new-onset suspected or confirmed COVID-19, in part the following, If the resident is confirmed to have COVID-19, regardless of symptoms, they should be transferred to the designated COVID-19 care unit. Exposed residents may be permitted to room share with other exposed residents if space is not available for them to remain in a single room. OSM #9 then stated now, those seven to ten words, yes. A remote review of the Line List for COVID-19 Outbreaks, submitted by the facility for review by fax on [DATE], revealed the facility census was 130 current residents, 81 residents had tested positive for the COVID-19 virus and nine had expired. The remote review of the facility's LTC (Long Term Care) Respiratory Surveillance List (for COVID-19 Outbreaks), and a remote review of clinical records revealed the following documented entries for Residents #7, #8, #9, #10, #11, #12, #13, #14 and # 15. On the line list the following was documented, Name of resident (Resident #7), Unit (number), room(number), Onset Date, [DATE], Fever (Y/N),Y, Cough (Y/N),N, Myalgia (Y/N), Y, Shortness of Breath (Y/N), Y, COV-2 test result (+/-), + (positive), Flu Test Result (+/-).-(dash), Chest Xray (+/-),-(dash), hospitalized (Y/N), Y (yes), died (Y/N), ,[DATE]. Under the section titled Outcome During Outbreak: a handwritten note beside this documented, died in hospital. Remote review of Resident #7's clinical record revealed, Resident #7 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On the most recent MDS (minimum data set), an quarterly assessment with an assessment reference date of [DATE], Resident #7 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). A review of Resident #7's clinical record revealed a physician note dated [DATE] documenting that the resident had test for COVID-19 and was Instructed not to leave his room. RP (responsible party) informed of change in condition. Further review revealed a nurse practitioner note dated [DATE] documenting will transfer resident to hospital for further evaluation and treatment of [REDACTED]. Further review revealed a nurse note dated [DATE] documenting the resident was admitted to the hospital and RP called and updated. On the line list the following was documented, Name of Resident (Resident #8), Unit (number), room(number), Onset Date, [DATE], Fever (Y/N),Y, Cough (Y/N), not noted, Myalgia (Y/N), not noted, Shortness of Breath (Y/N), Y, COV-2 test result (+/-), + (positive), Chest Xray (+/-),-(dash), hospitalized (Y/N), Y (yes), died (Y/N), ,[DATE]. Under the section titled Outcome During Outbreak: a handwritten note beside this documented, admitted to hospital, expired. Remote review of Resident #8's clinical record revealed, Resident #8 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On the most recent MDS, a five (5) day Medicare assessment with an assessment reference date of [DATE], Resident #8 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS. A review of Resident #8's clinical record revealed a nurse's note dated [DATE] documenting that the resident had shortness of breath and oxygen saturations of 85% on 4 liters of oxygen. Resident's sister informed of his condition. Further review revealed a nurse practitioner note on [DATE] Due to resident intermittent respiratory distress/labored breathing, tachypnea, [MEDICAL CONDITION] heart rate, resident will be sent out via 911 to hospital emergency room for further evaluation. Further review revealed a nurse's note dated [DATE] Patient admitted to hospital with [DIAGNOSES REDACTED].#9), Unit (number), room(number), Onset Date, no notation, Fever (Y/N), no notation, Cough (Y/N), no notation, Myalgia (Y/N), no notation, Shortness of Breath (Y/N), no notation, COV-2 test result (+/-), + (positive), Flu Test Result (+/-). No notation, Chest Xray (+/-), no notation, hospitalized (Y/N), Y (yes), died (Y/N), Y (yes). A handwritten note beside this documented, Hospital expired of vascular. Remote review of Resident #9's clinical record revealed, Resident #9 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On the most recent MDS, a 5 day Medicare assessment with an assessment reference date of [DATE], Resident #9 was coded as having no cognitive impairment for making daily decisions, having scored 14 out of 15 on the BIMS. A review of Resident #9's clinical record revealed a nurse's note dated [DATE] documenting that the resident had a change in condition with abdominal pain or [MEDICAL CONDITION], decrease in fluid/food intake and nausea/vomiting with Temperature of 97.1. Further review revealed a nurse's note dated [DATE] documenting Therapy notified nurse of resident left lower extremity feeling cold to the touch. Further review revealed an activities aide note dated [DATE] documenting virtual family visit with resident and son, she was actively engaged in video chat with him. Further review revealed a nurse's note dated [DATE] documenting Resident transferred to medical center. On the line list the following was documented, Name of Resident (Resident #10), Unit (number), room(number), Onset Date, [DATE], Fever (Y/N),Y, Cough (Y/N),N, Myalgia (Y/N), Y, Shortness of Breath (Y/N), Y, COV-2 test result (+/-), + (positive), Flu Test Result (+/-).no notation, Chest Xray (+/-), N, hospitalized (Y/N), N (no), died (Y/N), ,[DATE]. Under the section titled Outcome During Outbreak: COV test pending, admitted to hospital CVOID +, expired in hospital. Remote review of Resident #10's clinical record revealed, Resident #10 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On the most recent MDS, a 5-day Medicare assessment with an assessment reference date of [DATE], Resident #10 was coded as having severe cognitive impairment for making daily decisions, having scored 01 out of 15 on the BIMS. A review of Resident #10's clinical record revealed a nurse practitioner note dated [DATE] documenting that the resident had test for COVID-19 with pending results and fever of 102.8 on [DATE] afebrile since then. Further review revealed a nurse's note dated [DATE] Resident has a low grade temp 99.6 call placed to on call service, unable to contact RP (responsible party) at this time. Further review revealed a social services note dated [DATE] Contacted RP to clarify resident's code status. RP states resident is to be a FULL CODE. Covid droplet precautions remain. Further review revealed a nurse's note dated [DATE] Resident alert but not responding as usual. Oxygen saturation 89% on two liters of oxygen. Resident transported to the hospital for further evaluation. On the line list the following was documented, Name of Resident (Resident #11), Unit (number), room(number), Onset Date, no notation, Fever (Y/N), no notation, Cough (Y/N), no notation, Myalgia (Y/N), no notation, Shortness of Breath (Y/N), no notation, COV-2 test result (+/-), + (positive), Flu Test Result (+/-). No notation, Chest Xray (+/-), no notation, hospitalized (Y/N), Y (yes), died (Y/N), Y (yes). A handwritten note beside this documented, died in hospital. Remote review of Resident #11's clinical record revealed, Resident #11 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On the most recent MDS, a 5-day Medicare assessment with an assessment reference date of [DATE], Resident #11 was coded as having moderately impaired cognition for making daily decisions, having scored 9 out of 15 on the BIMS. A review of Resident #11's clinical record revealed a nurse practitioner note dated [DATE] documenting that the resident recently had been hospitalized for [REDACTED]. Further review revealed a nurse's note dated [DATE] documented Resident in respiratory distress, oxygen saturations at 47% on two liters of oxygen, temp 100.9 BP (blood pressure) ,[DATE]. Oxygen increased to four liters with no increase in oxygen saturation. Nurse Practitioner notified and RP notified. RP wanted resident transferred to the emergency room . Further review revealed a nurse's note dated [DATE] documented emergency room informed that resident was admitted for COVID 19. On the line list the following was documented, Name of Resident (Resident #12), Unit (number), room(number), Onset Date, no notation, Fever (Y/N),Y, Cough (Y/N), no notation, Myalgia (Y/N), no notation, Shortness of Breath (Y/N), no notation, COV-2 test result (+/-), + (positive), Flu Test Result (+/-).-(dash), Chest Xray (+/-),-(dash), hospitalized (Y/N), Y (yes), died (Y/N), ,[DATE]. Under the section titled Outcome During Outbreak: a