STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365379	A. BUILDING _____ B. WING _____	08/03/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE LAURELS OF WALDEN PARK	5700 KARL ROAD COLUMBUS, OH 43229

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the unprecedented global pandemic that resulted in the Presidential declaration of a State of National Emergency dated [DATE], Department of Health and Human Services, Centers for Medicare & Medicaid (CMS) Memos, Nursing Home Guidance from the Centers for Disease Control (CDC), data contained on the State of Ohio's coronavirus.ohio.gov dashboard, observations, record reviews, review of the facility Coronavirus (COVID-19) policy and staff and resident interview, the facility failed to implement effective and recommended infection control practices, including the implementation of appropriate quarantine procedures to prevent the spread of COVID-19 within the facility. This resulted in Immediate Jeopardy on [DATE] when residents observed in quarantine throughout the facility were not confined to their rooms and were ambulatory throughout the facility without appropriate personal protective equipment (PPE) use. The lack of current effective infection control practices and prevalence of continued positive cases in the facility placed all residents at risk for harm, complications and/or death related to the facilities failure to control the COVID-19 outbreak. In addition, the facility failed to ensure adequate and timely infection control interventions were in place to promptly identify and isolate residents with potential exposure to staff members who tested positive for COVID-19, failed to ensure a root cause analysis was determined related to the COVID-19 outbreak in the facility and failed to ensure staff properly utilized PPE. This had the potential to affect all 174 residents residing in the facility. On [DATE] at 4:40 P.M. the Administrator, Regional Clinical Coordinator, and Clinical Transition Specialist were notified Immediate Jeopardy began on [DATE] when observations of the facility revealed residents identified to be quarantined with orders for droplet isolation precautions were residing in rooms located throughout each of the facility units among residents who were in non-isolation/non-quarantine with no evidence measures were in place to ensure these residents were confined to their rooms. On [DATE] at 12:25 P.M. and 1:20 P.M. Resident #172, who had an order for [REDACTED].M. Resident #45, who had an order for [REDACTED].#210 and Therapist #209) who tested positive for COVID-19 the facility failed to comprehensively identify and place any potentially exposed residents or staff on quarantine, did not increase resident monitoring for signs and symptoms of COVID-19 and did not timely complete any additional resident COVID testing. The Immediate Jeopardy was removed on [DATE] at when the facility implemented the following corrective actions: On [DATE], Residents #45 and #172 were re-educated on the smoking policy and the requirements of isolation. On [DATE], the DON/designee reviewed all current residents in the facility who had been admitted or readmitted to the facility in the past 14 days. 18 residents were identified as being admitted or readmitted in this timeframe. Two of these residents were admitted with a positive COVID-19 [DIAGNOSES REDACTED]. The remaining 16 residents on isolation precautions due to admission or re-admission had isolation orders verified. Orders to evaluate for signs/symptoms of COVID-19 were audited to ensure they were in place and no issues were noted. The 16 residents were evaluated for signs/symptoms of COVID-19 with no negative findings. On [DATE] by 11:59 P.M., ten of the 18 residents on isolation precautions due to admission or re-admission were moved to a dedicated quarantine area in the facility on the 200 unit to continue isolation precautions. On [DATE] at 3:00 P.M., one resident was moved to the COVID isolation unit. On [DATE], three residents in isolation due to admission/readmission remain on the secured unit for safety reasons and were separated on the unit in rooms 320 A and B and 322 A. Four residents in isolation due to admission/readmission remained on the respiratory unit due to the need for respiratory therapy intervention and were separated to an area on the unit in rooms 521 A and B, 515 A, and 523 B. Due to the specialized needs of these residents, they could not be moved to the 200 quarantine unit. On [DATE] a plan for all residents on droplet and contact precautions to have monitoring increased to three times daily was implemented. On [DATE] residents who were alert and oriented who were currently on 14-day isolation received education regarding the use of appropriate PPE when out of their room, and appropriate social distancing requirements. On [DATE] nursing staff assessed 158 residents in the facility who were not on 14 day isolation precautions were evaluated for signs/symptoms of COVID-19 with no negative findings. On [DATE] a plan for all residents in the facility to have monitoring three times daily for signs and symptoms of COVID-19 was implemented due to potential for exposure. On [DATE], the Administrator/DON and quality assurance performance improvement (QAPI) team members reviewed the infection control policy regarding COVID-19 and deemed it appropriate. On [DATE], the Administrator/DON and QAPI team reviewed the Bed Management Decision Tree for new and readmission residents and isolation precaution requirements and deemed it appropriate. On [DATE] the facility created three smoking schedules, one for guests who smoked who were not on isolation precautions and resided on the 100, 400 and 500 halls, one for residents who smoked and were not on isolation and resided on the 200 and 300 halls, and one for residents who were on isolation precautions. The facility also identified a separate wing off the 200 hall for smoking to prevent commingling of isolated and non-isolated residents. The smoking areas have also been marked with social distancing markings and will be monitored by staff to ensure social distancing. Cleansing of the smoking area will occur with an EPA registered disinfectant between smoking times. On [DATE], the Administrator/DON and QAPI team members reviewed and revised the smoking policy to include social distancing and residents on 14-day isolation precautions. The current residents in isolation for 14 days post admission would be moved to a dedicated area in the facility unless contraindicated. New and readmission residents moving forward will be admitted to the dedicated area, unless contraindicated. The smoking area has been marked with social distancing indicators for six feet distance. The smoking area will be disinfected with an EPA registered cleanser after each smoking session. Smoking sessions will be scheduled and supervised by staff members to ensure social distancing. Residents will wear masks to and from smoking area and maintain mask on their person during the smoking session. The mask will be stored in the residents' room when not out of room smoking. On [DATE] 100% of employees on duty were educated on the facility policies related to residents in isolation due to admission/readmission status and for COVID positive status, the required mask use by the residents to and from smoking sessions, and on the social distancing requirements of six feet minimum, and the appropriate use of masks and PPE by staff while on duty was completed by the DON/designee. New employees will receive the same education during new employee orientation. A plan to ensure all employees were educated prior to their next scheduled shift was implemented. On [DATE] all 44 residents who smoked were re-evaluated for smoking, all 44 residents were provided education on the new smoking policy and signed acknowledgement of understanding of the new smoking policy. On [DATE] a plan for staff to be screened at the start and the end of their shifts for temperature and for signs and symptoms of COVID-19 as a monitoring tool for COVID-19 was implemented. If staff do not pass the screening process, they will be sent home. Staff are provided with appropriate PPE for their shift and the use of PPE is monitored daily through direct observations from the DON and Nurse Managers. On [DATE] the Administrator and DON/designee will begin to conduct audits five times per week for four weeks, then three times per week for four weeks, then weekly for four weeks of smoking sessions to ensure residents are socially distanced, in proper PPE to and from smoking sessions and that isolation residents are not commingled with non-isolation residents. Any concerns will be addressed immediately. Findings will be forwarded to the QAPI committee for further review and recommendations. On [DATE] the Medical Director was made aware of the residents that were to be in isolation and were

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

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

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 1) found to be in the smoking area. On [DATE] education and the incident were reviewed in an Ad Hoc QAPI meeting 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 is 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 & Medicaid (CMS) Memo QSO ,[DATE]-ALL dated [DATE] revealed The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care 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 and suppliers 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 disease or infections should be reported (42 CFR 483.80(a)(2)(i) and (ii)). 1. Review of reporting data for the facility on the coronavirus.ohio.gov website, which reflects current and cumulative cases of COVID-19 among facility staff and residents reported to the Ohio Department of Health revealed as of [DATE] the facility had reported seven current resident cases and 47 cumulative resident cases and 5 current staff cases and 19 cumulative staff cases. Data updated as of [DATE] revealed seven current resident cases and 47 cumulative resident cases and 5 current staff cases and 19 cumulative staff cases. Current case counts are defined as residents or staff that had active COVID-19 infection during the prior week (Wednesday through Tuesday). Cumulative counts are defined as residents or staff that had active COVID-19 infection at any point from [DATE] onward. The cumulative totals do not include patients or staff who have recovered, have been hospitalized , or have passed away prior to [DATE]. During the survey process, the facility was asked to provide evidence of on-gong communication/collaboration with the local health department related to the increased number of positive cases to ensure timely communication of positive cases and to ensure any health department recommendations being made were implemented timely. On [DATE] the facility provided an email communication with the(NAME)Public Health Department which indicated the last correspondence was dated [DATE]. The facility was provided with reading material from the Centers of Disease Control (CDC) to review at that time. On [DATE] at 1:23 P.M. the local health department was contacted to obtain information related to their involvement with the facility during the COVID-19 pandemic. As of [DATE] no information had been received from the local health department. During the survey process, the Director of Nursing (DON) was asked if the facility had conducted an investigation or root cause analysis to determine the cause of the increase in number of COVID-19 cases identified to have occurred during [DATE]. On [DATE] at 11:04 A.M. the DON revealed she did not know what the root cause was for the increase in COVID positive cases within the facility. The DON stated, I guess because of staff, vendors, and new admissions coming and going in and out of the facility. If we knew where it was coming from we wouldn ' t have any corona. On [DATE] at 1:32 P.M. interview with the DON and Infection Control Nurse (ICN) #200 revealed in addition to the residents who had tested positive, there were six residents #186, #187, #188, #189, #190, and #191 who had expired from [DATE] through [DATE] related to COVID-19. In addition, Resident #184 expired on [DATE]. 2. On [DATE] from 12:10 P.M. to 3:15 P.M. onsite observations and interviews conducted at the facility revealed the following concerns: a. The facility had a COVID unit where residents who had confirmed positive COVID tests resided. There were four residents on the COVID unit at the time of the onsite observations. In addition, twelve residents (Resident #20, #45, #172, #126, #31, #155, #87, #36, #5, #138, #73, and #91) were observed to reside in nine rooms and were in droplet (isolation) precautions for COVID-19. These nine resident rooms were observed to be located throughout the entire facility on each of the facility units (excluding the COVID unit). The rooms were intermingled with resident rooms belonging to residents who did not require additional precautions for COVID-19. On [DATE] at 12:23 P.M. interview with Registered Nurse (RN) #228 verified Resident #20, #45 and #172 were in droplet isolation precautions. RN #228 revealed Resident #20 and #45 were new admissions and Resident #172 had been placed on droplet isolation precautions because Resident #45 was her roommate. On [DATE] at 12:40 P.M. interview with LPN #203 and LPN #204 revealed Resident #31, #126, and #155 were on droplet precautions due to being new admissions. On [DATE] at 12:49 P.M. interview with State tested Nursing Assistant (STNA) #205 revealed Resident #87 was on droplet precautions due to being a new admission. On [DATE] at 1:41 P.M. interview with LPN #208 revealed Resident #138, #73 and #91 were on droplet precautions due to being new admissions. On [DATE] at 5:09 P.M. interview with the DON revealed the new admission/re-admission residents were placed in isolation due to an unknown COVID status at the time of admission. The DON revealed the facility was not able to cohort the residents under a quarantined status together because of availability. The DON revealed that was the goal but it became too hard to keep them together. The DON revealed the facility tried to keep residents in need of the same type of precautions together in the same room. Review of email from Medical Director #217 dated [DATE] at 9:54 A.M. revealed it was not appropriate to have quarantined individuals mixed with other residents and it was not appropriate to have quarantined individuals moving about the facility. On [DATE] at 9:25 A.M. interview with the DON again confirmed the facility did not set up a quarantine unit in the facility. The DON stated, it just got crazy. The DON confirmed there were not designated staff assigned to care for only those rooms of residents who were currently under droplet isolation precautions/quarantine status. On [DATE] at 1:15 P.M. interview with Licensed Practical Nurse (LPN) #216 verified Resident #45 and Resident #172 remained in droplet isolation precautions as of this date. On [DATE] at 1:40 P.M. interview with State tested Nursing Assistant (STNA) #222 verified Resident #31 remained under droplet isolation precautions due to being a new admission. On [DATE] at 1:42 P.M. interview with Unit Manager #223 revealed Resident #155 remained on droplet isolation precautions due to being a new admission. On [DATE] at 1:55 P.M. interview with RN #224 verified Resident #36 was on droplet isolation precautions. Review of the Centers for Disease Control (CDC) Responding to Coronavirus (COVID-19) in Nursing Homes, Cohorting Residents, dated [DATE] revealed the facility should create a plan for managing new admissions and readmissions whose COVID-19 status is unknown. Options include placement in a single room or in a separate observation area so the resident can be monitored for evidence of COVID-19. Review of Centers for Disease Control (CDC) guidance, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated [DATE] revealed: As a measure to limit health care personnel (HCP) exposure and conserve personal protective equipment (PPE), facilities could consider designating entire units within the facility, with dedicated HCP, to care for patients with suspected or confirmed [DIAGNOSES REDACTED]-CoV-2 infection. Dedicated means that HCP are assigned to care only for these patients during their shift. Limit transport and movement of the patient outside of the room to medically essential purposes. b. On [DATE] at 12:25 P.M. Resident #172, who was identified to be in droplet isolation precautions was observed at the nurse ' s station talking with staff. The resident had a mask on, however the mask was pulled down under her chin area at the time of the observation. Review of the facility policy titled Coronavirus (COVID 19), revised ,[DATE] revealed a guest/resident should wear a facemask or cloth covering when out of the room or in the doorway, if tolerated (per CDC guidance). c. On [DATE] at 12:33 P.M. three residents, Resident #60, #121, and #180 were observed seated together at a table in the common area of the 200 unit talking to each other. The residents were not seated six foot apart and none of the three residents were observed to have properly applied masks in place. Each residents mask was observed under their chin area. Review of the facility policy titled Coronavirus (COVID 19), revised ,[DATE] revealed a guest/resident should wear a facemask or cloth covering when out of the room or in the doorway, if tolerated (per CDC guidance). d. On [DATE] at 12:46 P.M., Resident #110 was observed walking down the hallway with a surgical mask under his chin. On [DATE] at 1:50 P.M., Resident #17 was observed sitting in the common area outside of Unit 3 with a cloth mask over his mouth, however, the mask did not cover his nose. On [DATE] at 1:56 P.M., Resident #110 was observed walking down the hallway with a surgical mask under his chin. Review of the facility policy titled Coronavirus (COVID 19), revised ,[DATE] revealed a guest/resident should wear a facemask or cloth covering when out of the room or in the doorway, if tolerated (per CDC guidance). e. On [DATE] from 1:20 P.M. to 1:35 P.M. observation of the independent smoking patio revealed four residents, Resident #60, #121, #175, and #34, who were identified to be independent smokers, were sitting around a square table smoking cigarettes and talking. None of the residents were wearing masks. On three separate occasions, Resident #45 (who was identified to be in droplet isolation precautions for COVID-19) was

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 2) observed to approach the table with the other residents and start talking. Resident #45 was not wearing a mask and did not maintain a six foot distance from the other residents. Resident #172 (who was also identified to be in droplet isolation precautions for COVID-19) was also observed in the smoking patio area and was not wearing a mask. On [DATE] at 1:25 P.M. interview with Resident #172 on the smoking patio revealed the resident did not wear a mask while she was smoking. During the interview, the resident revealed she was aware she was in droplet isolation precautions and knew she was supposed to stay in her room unless she was going outside to smoke. The resident did not indicate any changes or requirements had been made related to smoking related to COVID-19 precautions. On [DATE] at 1:35 P.M. Resident #172 and Resident #45 were observed to enter the dining room area together from the smoking patio. Neither resident had a mask covering their nose or mouth. Both residents had a mask, however the mask was observed under their chins. Both residents proceeded to walk from dining room area to the 100 unit. During the observation, no staff including nursing or housekeeping staff were observed cleaning or disinfecting the door handles or frequently touched surfaces around the doors leading out to the smoking patio. On [DATE] at 2:31 P.M. interview with the Regional Nurse #201 revealed the facility had not made any revisions to their smoking policy related to or since the COVID pandemic had started. The regional nurse stated there should have been X ' s marked on the patio to ensure distancing and any residents under droplet precautions were to smoke at different times from any other residents. However, no X ' s were observed during the observations made on [DATE]. On [DATE] at 2:17 P.M. interview with Resident #60 revealed the resident was a smoker and smoked independently. The resident revealed he enjoyed socializing with other residents. During the interview, the resident revealed he recalled meeting the surveyor on [DATE] and shared he had been sitting with Resident #121 and Resident #180 at that time in the common area of his unit as usual. The resident also recalled sitting outside on the smoking patio with Resident #34, #121, and #175 at a table talking and smoking. The resident stated he also talked to Resident #172 and Resident #45, daily when outside on the patio. The resident stated the residents do not wear masks outside on the patio. On [DATE] at 1:20 P.M. observation of the independent smoking patio revealed Residents #20, #45, #172, #121, and #162 were sitting outside together to the left of the door leading onto the patio. None of the residents were wearing masks at time of the observation. Red markers were observed on the patio for distancing, however, the residents were not spaced out at the markers. Residents #45 and #172 were verified to be on droplet precautions. Review of the facility policy titled Coronavirus (COVID 19), revised ,[DATE] revealed a guest/resident should wear a facemask or cloth covering when out of the room or in the doorway, if tolerated (per CDC guidance). f. On [DATE] at 12:20 P.M. LPN #202 who was working on the 100 unit was observed wearing only a surgical mask. Interview with the LPN confirmed she was only wearing a surgical mask. LPN #202 stated she usually wore an N95 mask but she was not going onto the COVID unit today so therefore, only wore a surgical mask. Observation revealed there were residents residing on the 100 unit who were in droplet isolation precautions for COVID-19. On [DATE] at 12:59 P.M. observation of LPN #206 revealed the LPN was wearing a surgical mask under her KN95 mask. The surgical mask was observed across her face with blue showing on both sides underneath of the KN95 mask. Interview with the LPN at the time of the observation revealed she does not typically wear two masks but her face was sweating under the KN95 mask today. On [DATE] at 1:02 P.M. Medical Records #207 was observed on Unit 2 wearing a cloth mask underneath her KN95 mask. The cloth mask was observed across her face with black showing on both sides underneath of the KN95 mask. Medical Records #207 was observed passing lunch meal trays on the unit at the time of the observation. Interview at the time of the observation revealed she confirmed she was assisting with passing meal trays on the unit and the was wearing a cloth mask under a KN95 mask. Medical Records #207 revealed the KN95 mask made her skin rashy. On [DATE] at 1:05 P.M. STNA #207 was observed wearing a surgical mask underneath her KN95 mask. The surgical mask was observed across her face with blue showing on both sides underneath of the KN95 mask. Interview with the STNA at the time of the observation revealed the KN95 mask was very tight on her face. On [DATE] at 3:12 P.M. STNA #215 was observed wearing a surgical mask under his KN95 mask. The surgical mask was observed across his face with blue showing on both sides underneath of the KN95 mask. Interview with the STNA at the time of the observation revealed the STNA stated, I thought I was getting more protection. On [DATE] at 3:14 P.M. LPN #214 was observed wearing a hazmat suit. The suit was observed to have a tear on the right hip area. At the time of the observation, interview with LPN #214 revealed the LPN indicated he did not realize the tear was there. On [DATE] at 9:25 A.M. interview with the DON revealed she did not instruct staff to wear a surgical mask or cloth mask under their N95/KN95 masks. On [DATE] at 2:56 P.M. the facility provided an email from Mask Manufacturer #219 in regards to the use of masks under KN95 masks. The email revealed since you asked about the desire from some of your healthcare professionals wearing surgical masks underneath KN95 masks for added protection, please note the air seal of the KN95 needs to be maintained against the skin at the perimeter of the mask for maximum protection. Given the flexibility of the surgical masks, the users should ensure that the surgical mask is tucked inside of the KN95 so that the edges of the KN95 touch the face. On [DATE] at 4:37 P.M. interview with the DON revealed the facility did not have a policy in place regarding staff wearing two masks or the use of a cloth or surgical mask under a KN95 mask. 3. During the survey process review of two employee's, LPN #210 and Therapist #209, who had tested positive for COVID-19 revealed the following concerns: a. LPN #210's last date worked was on [DATE]. The nurse was scheduled to be off from [DATE] through [DATE]. Review of Questions for employee who has tested positive COVID dated [DATE], for LPN #210 revealed the nurse last worked on [DATE]. The form revealed the LPN had been in contact with all residents on Units 1 and 3, including Resident #8, #84 and #184, and a total of 18 staff. On [DATE] at 3:30 P.M. interview with LPN #210 confirmed her last day of work was [DATE]. The nurse stated while she was at home she started not feeling well with a fever, headache, muscle pain, nausea, and diarrhea and decided to call off from work (on [DATE]) and go to the emergency room . The nurse was tested for COVID-19 and was confirmed to be positive on [DATE] at the hospital. LPN #210 stated on [DATE] she worked the odd side on Unit 1 and had assisted all of the residents on that side of the unit. The nurse stated some of the residents on the unit wore a mask and some of the residents did not wear a mask. The nurse was scheduled to return work on [DATE] and denied having any signs or symptoms of illness. On [DATE] at 2:45 P.M. interview with DON revealed after receiving notification of LPN #210 ' s positive COVID-10 test, the facility did not place any of the potentially exposed residents or staff on quarantine, did not increase monitoring, or complete any additional COVID testing. The DON stated, there was not any reason to do. The DON stated the facility continued with their regular protocol of monitoring residents daily with a respiratory screen and vital signs. Staff were screened prior to working a shift and at the end of their shift. b. Review of an undated Questions for employee who has tested positive COVID for Therapist #209 revealed the therapist last worked on [DATE] and was confirmed positive for COVID-19 on [DATE]. The contact tracing documents revealed Therapist #209 had been in close contact with a total of eight staff and 51 residents, including Resident #8, within a 14 day period of testing positive for COVID-19. On [DATE] at 3:50 P.M. interview with Therapist #209 confirmed she did test positive for COVID-19 on [DATE]. The therapist stated her last day worked was on [DATE]. The therapist reported to work on this date with some dizziness but did not have a fever or any other symptoms at that time. The therapist stated her dizziness worsened and she left work around 11:00 A.M. on [DATE]. The therapist stated she went from work to be tested at a pop-up testing site for COVID-19. During the interview the therapist revealed she had worked with Resident #8 and Resident #8 had refused to wear a mask. The therapist stated she was aware Resident #8 had a roommate, Resident #58. The therapist then stated, I know a lot of people on Unit 1 ended up with COVID. On [DATE] at 2:45 P.M. interview with DON revealed after receiving notification of Therapist #209's positive COVID-10 test, the facility did not place any of the potentially exposed residents or staff on quarantine, did not increase monitoring, or complete any additional COVID testing. The DON stated, there was not any reason to do. The DON stated the facility continued with their regular protocol of monitoring residents daily with a respiratory screen and vital signs. Staff were screened prior to working a shift and at the end of their shift. 4. Review of Resident #8's medical record revealed an admission date of [DATE]. The resident had [DIAGNOSES REDACTED]. Review of Resident #8's progress notes, dated [DATE] through [DATE] documented the resident refused to wear a mask. Record review revealed the resident was tested for COVID on [DATE]. However, the medical record did not include why a COVID test was completed at this time and/or any evidence the resident was moved from his room located in the general population to a quarantine unit or COVID unit at the time testing was completed. On [DATE] the facility received positive COVID-19 test results for Resident #8. At that time (on [DATE]) the resident was moved to the COVID unit. Review of Resident #8's Medication Administration Record [REDACTED]. The resident's vital signs on [DATE] revealed the resident's oxygen level dropped from 93% in the morning to 88% at lunch and at night. On [DATE] at 4:09 P.M. interview with the DON revealed Resident #8 had been identified as having possible exposure to COVID-19 from Therapist #209. The DON confirmed the facility did not place Resident #8 in quarantine/isolation when he was first identified as being possibly exposed. The DON revealed they continued monitoring the resident as normal and did not do any initial increased monitoring. The DON revealed the resident agreed to be tested on [DATE] but denied the resident was

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 3) having any symptoms at that time. The DON verified no additional precautions were taken until [DATE] when the resident was placed on droplet isolation precautions and monitoring with respirat