STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235217	A. BUILDING _____ B. WING _____	05/18/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SKLD BLOOMFIELD HILLS	2975 N ADAMS ROAD BLOOMFIELD HILLS, MI 48304

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** This citation pertains to intake #s: MI 540, MI 086, and MI 463. Based on observation, interview, and record review, the facility failed to maintain an effective infection control program and follow infection control practices according to Centers for Disease Control (CDC) guidelines and facility policy for COVID-19 (Coronavirus Disease 2019) including: failing to consistently and accurately assess the respiratory status of 14 (R#s 802, 803, 806, 807, 808, 809, 810, 811, 812, 814, 815, 816, 817, and 818) of 21 residents reviewed for COVID-19, failed to don appropriate Personal Protective Equipment (PPE) for residents on droplet precautions for COVID-19, wear PPE appropriately, implement isolation precautions and monitor for signs and symptoms of COVID-19 for 5 (R#s 807, 808, 809, 810, 811) of 5 residents admitted from the hospital, ensure three residents (R#s 803, 819, and 821) without COVID-19 were isolated from residents who were positive or had an unknown status for COVID-19, and ensure staff who were assigned to a designated COVID-19 unit were not also assigned to one (R#802) resident who was not positive for COVID-19 and resided on a non-COVID unit. These deficient practices likely resulted in the spread of COVID-19, a serious and potentially [MEDICAL CONDITION], as well as the unidentified signs and symptoms of new onset COVID-19 and unidentified complications from COVID-19, that affected three residents (R#s 814, 816, and 818), who expired in the facility or the hospital after testing positive for COVID-19. The facility was found to be in Immediate Jeopardy (IJ) and all 154 residents who resided in the facility were determined to be at risk of serious harm and death. Findings include: The IJ was identified on [DATE] at 11:00 A.M. The IJ began on [DATE]. The Administrator was notified of the IJ and a request was made for a plan to remove the immediacy on [DATE] at 11:45 A.M. The immediacy was removed on [DATE] based on the facility's implementation of an acceptable plan of removal verified onsite/offsite by the surveyors. Although the immediacy was removed on [DATE], the facility remained out of compliance at a scope of widespread and a severity of potential for more than minimal harm that is not Immediate Jeopardy due to sustained compliance that has not been verified by the State Agency. On [DATE], an unannounced, onsite COVID-19 focused survey was conducted. On [DATE] at approximately 8:30 AM, an interview was conducted with the facility's Administrator and Director of Nursing (DON). It was reported that the 1 East Unit and the North side of the 2 East Unit were designated for residents who tested positive for COVID-19. The DON reported there were designated nursing staff assigned to the COVID-19 designated areas of the facility. The DON reported there were no presumptive positive cases of COVID-19 in the facility and the process for presumptive positive cases would be to identify, isolate, swab, and then move to a COVID unit if positive. The DON reported all residents were assessed for respiratory symptoms daily. When queried about PPE used throughout the facility to prevent the spread of COVID-19, the DON reported all staff wore N95 respiratory masks which were used for a couple of days. On the COVID-19 designated units, the DON reported staff must don gowns, gloves, and face shields in addition to the N95 mask and on the other units staff were required to wear N95 masks only. For residents with presumed positive COVID-19, they would be placed on droplet precautions which required the use of gown, gloves, mask, and face shield or goggles. The DON reported there were no residents in the facility as of [DATE] who were presumed or suspected to be positive for COVID-19 and the 1 East Unit and part of the 2 East unit (room numbers redacted) were designated for residents with confirmed positive tests for COVID-19. The DON reported R806 was identified as the first resident in the facility that tested positive for COVID-19. At that time, a list of all residents who currently resided in the facility and were positive for COVID-19 was requested. A list of all residents in the facility with facility acquired COVID-19 was requested at that time (this information was not provided by the facility until [DATE] at 4:49 PM). 1 West Unit On [DATE] at 10:00 A.M., an observation of the 1 West Unit was conducted. Nurse C was observed preparing medications at the medication cart on the 1 West Unit. A surgical mask was observed worn below Nurse C's mouth which exposed their mouth and nostrils. Nurse C pulled the mask over their nose and did not perform hand hygiene before or after making contact with the mask. Nurse C continued to prepare medications. At approximately 10:08 AM, Nurse C was interviewed. Nurse C reported they worked in another building and it was their first time working at that facility. When queried about the use of PPE, including masks, for the 1 West Unit, Nurse C stated, I don't know. I don't work here. I work in the (city name redacted) building. Nurse C reported they did not receive training or report(s) from the previous shift about the PPE protocol for the 1 West Unit prior to starting their shift. When queried about any residents on the unit on isolation precautions, Nurse C reported they did not know. On [DATE] at 10:08 A.M., Certified Nursing Assistant (CNA) B was observed to enter the 1 West Unit. CNA B wore a N95 respirator mask that was pulled down underneath their chin and exposed their mouth and nostrils. CNA B approached the kiosk (a touch screen computer where CNAs document their care tasks). CNA B pulled the N95 mask up over their nose while touching both the inside and outside of the mask. No hand hygiene was performed before or after touching the mask. CNA B proceeded to touch the screen of the kiosk. On [DATE] at approximately 10:10 AM, CNA B was observed at the kiosk with their N95 mask pulled down underneath their chin exposing their mouth and nostrils. A second CNA was observed to be talking with CNA B. Upon approach, CNA B pulled the N95 mask up over their nose, did not perform hand hygiene, and walked away from the kiosk toward the exit doors of the unit. At approximately 10:12 AM, CNA B was interviewed. When queried about the observations of the N95 mask being positioned under their chin, CNA B stated, It's just a habit. It makes my mouth dry. When queried about the proper protocols for wearing an N95 mask and what should be done if they needed to adjust it, CNA B reported they would wash their hands and change the mask. CNA B proceeded to touch the doors, exit the unit, walk down the hallway, press the elevator buttons, and enter the elevator without performing any hand hygiene. CNA B then returned to the first floor via the elevator carrying a food tray. On [DATE] at 10:21 AM, a review of a sign hung on the doors of the 1 West Unit documented, Donning PPE .Fit flexible band to nose bridge .Fit snug to face and below chin .Fit check respirator .Safe Work Practices .Keep hands away from face .Limit surfaces touched .Perform hand hygiene . 1 East Unit On [DATE] at 10:32 AM, an observation of the 1 East Unit was conducted. The unit was designated for residents who tested positive for COVID-19. The closed double doors that led to the unit had signage that read: Attention: This unit is under strict isolation PPE must be donned prior to entering. An interview with Nurse A was conducted upon entrance to the unit. Nurse A reported the unit was designated for COVID-19 residents but, Not everyone is positive. When queried about how it would be known who was positive and who was not, Nurse A stated, There are signs on the doors. The whole unit is on isolation, but not everyone is positive. Everyone is on the same isolation. When queried about PPE use on the 1 East Unit, Nurse A reported gowns, gloves, mask, and a face shield must be worn. When queried about when gowns would be changed, Nurse A reported the same gown was worn for all residents on the unit since the whole unit was on the same isolation precautions. On [DATE] at 10:50 AM, an interview with Nurse E who was assigned to the other hallway on the 1 East Unit was conducted. Nurse E reported R819 tested negative for COVID-19 and would be moved from the unit. Nurse E reported R803 who was on the opposite hall on the 1 East Unit, did not have COVID-19 but remained on the unit because he was on hospice. Nurse E reported the whole 1 East Unit was on droplet precautions, whether or not a sign was on the door. R803's door was observed to be closed. There was no signage on the door. A bin containing gowns, stethoscope, and blood pressure cuff was observed outside of the door. 2 West Unit On [DATE] at approximately 10:20 AM, Nurse 'I' was observed collecting breakfast trays on the 2 West unit from the hall with

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235217	A. BUILDING _____ B. WING _____	**05/18/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SKLD BLOOMFIELD HILLS	**2975 N ADAMS ROAD BLOOMFIELD HILLS, MI 48304**

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

(continued... from page 1)

rooms ,[DATE]. Nurse 'I' was observed to exit a room on the hallway with a finished breakfast try. It was observed Nurse 'I' had gloves on when they exited the room. Nurse 'I' was then observed to open the door of the meal cart (with their gloves still on) and place the tray in the cart. Nurse 'I' then closed the door to the meal cart, removed their gloves, proceeded down the hall to the nursing station and disposed of their gloves in the medication cart garbage receptacle. 2 East Unit On [DATE] at 10:40 AM, an observation of the 2 East unit was conducted. A review of the staffing assignment posted at the nursing station indicated Registered Nurse (RN) 'F' was assigned to all of the rooms on the designated 2 East COVID-19 hall, (a hall on 2 East that was separated from the rest of the unit by closed double doors) as well as one room that was not on the COVID-19 unit. At approximately 10:50 AM, an interview with RN 'F' was conducted regarding their assignment. RN 'F' reported they were assigned all COVID-19 positive residents and one resident (R802) that did not reside on the COVID unit. On [DATE] from 10:45 AM, until approximately 11:30 AM, general observations and interviews of staff on the 2 East COVID-19 designated hall were conducted and the following occurred: At approximately 10:55 AM, an interview with RN 'F' was conducted and they were queried about what type of PPE should be worn when entering a COVID-19 room. RN 'F' reported that a gown, gloves, mask and eye protection should be worn, and hand hygiene should be performed upon entry and exit from the room. At approximately 11:10 AM, CNA 'I' was asked about what type of PPE should be worn in a resident's room on the unit. CNA 'I' indicated that when entering a room, a gown, mask, gloves, and 'goggles' should be worn. It was noted the room numbers for the COVID-19 hall were from ,[DATE]. During the observations, CNA 'H' and 'I' were observed to be in the hallway wearing a yellow isolation gown and an N95 mask. RN 'F' was observed to be wearing a light blue nursing uniform and an N95 mask. RN 'F' was observed to enter a room on the hall with CNA 'H'. RN 'F' was not observed to don a gown, gloves, or a face shield/eye protection upon entering the room. CNA 'H' was not observed to don a face shield/eye protection upon entering the room. RN 'F' exited the room and went to the medication cart in the hallway. At 11:08 AM, RN 'F' was observed to enter another room on the hallway. RN 'F' was not observed to don a gown, gloves, or face shield/eye protection upon entry to the room. RN 'F' exited the room approximately 2 minutes after entering. During the general observations on the unit, neither CNA 'H', CNA 'I', or RN 'F' were ever observed to don a face shield upon entering COVID-19 positive resident rooms. On [DATE] at 11:55 AM, an interview with the facility's DON was conducted regarding RN 'F's assignment and why they were assigned all COVID-19 positive residents on the second floor COVID-19 hall as well as R802 who did not reside on the COVID-19 hall. The DON indicated Licensed Practical Nurse (LPN) 'G' was supposed to be assigned R802's room and RN 'F' was supposed to only be assigned residents on the COVID-19 hallway. At that time, the DON was made aware that RN 'F' reported he had been assigned to R802's care. At approximately 12:00 PM the DON acknowledged RN 'F' had been assigned to R802 and had provided care to them earlier in the morning. The DON indicated the scheduler would be in-serviced on making the nursing assignments. R#803 R803's clinical record was reviewed and revealed the following: R803 was admitted into the facility on [DATE] to the 1 East unit (in the room they resided in on [DATE]) with [DIAGNOSES REDACTED]. An admission Minimum Data Set (MDS) assessment documented R#803 had intact cognition for decision making. R803's physician's orders [REDACTED]. There was no order for droplet precautions. Further review of R803's clinical record revealed a COVID-19 test was not performed as of [DATE]. Respiratory Symptom Evaluations for R803 from [DATE] through [DATE] were reviewed. At the top of the assessment form instructions documented, OBTAIN AND DOCUMENT TEMPERATURE AND PULSE OXIMETRY AT TIME OF SCREENING. A review of the Respiratory Symptom Evaluations revealed the following: Respiratory Symptom Evaluations were not completed on [DATE], and [DATE]. A Respiratory Symptom Evaluation dated [DATE] at 10:01 PM (signed and locked on [DATE]) documented Most recent O2 Sats (Oxygen Saturation) from [DATE] at 4:17 AM. Respiratory Symptom Evaluations dated [DATE] and [DATE] documented O2 Sats from [DATE]. A Respiratory Symptom Evaluation dated [DATE] documented O2 Sats from [DATE]. Respiratory Symptom Evaluations dated [DATE] and [DATE] documented O2 Sats from [DATE]. Respiratory Symptom Evaluations dated [DATE], [DATE], [DATE], [DATE], and [DATE] documented O2 Sats from [DATE]. Respiratory Symptom Evaluations dated [DATE], [DATE], and [DATE] documented O2 Sats from [DATE]. As of [DATE], the last date O2 Sats were assessed for R803 was on [DATE] as indicated on the above Respiratory Symptom Evaluations and a review of the O2 Sats Summary. R803's progress notes were reviewed and documented the following: On [DATE] a nursing progress note documented, Late entry for ,[DATE]: Pt noted with change in condition, he appears to be more confused and irritable, which is new for this resident. Also noted SOB (shortness of breath), with RR (respiratory rate) ,[DATE], PO2 <sic> (oxygen saturation) on r/a (room air) fluctuates between ,[DATE]%. Supplemental O2 initiated at 2L (liters) at first, then increased to 4L. PO2 <sic> went up to 93%. (Agency name redacted) hospice contacted to report. With small emesis after breakfast and after lunch. There was no documented respiratory assessment for R#803 since [DATE]. On [DATE], a progress note written by Nurse Practitioner (NP) U documented, .[MEDICAL CONDITION] (low blood oxygen) and lethargy. Somewhat irritable .somewhat more disoriented .Will monitor closely . On [DATE], a social service progress note documented R803 wished to remain a full code. On [DATE], NP U documented, .Increased confusion and lethargy. Pt has been having fevers. Pt is likely COVID (positive). No swab as patient is hospice. Will treat him as he is positive . On [DATE], NP U documented, .Confusion, [MEDICAL CONDITION](increased heart rate), dyspnea (difficulty breathing) .Likely has COVID-19. Not tested due to hospice. Isolated and treated as if he had it . A Care Plan dated [DATE] documented, At risk for anxiety .easily upset by room changes .limit room changes . There were no progress notes that documented a conversation about a room change with R803 or documented anxiety exhibited by R803 pertaining to a room change. On [DATE] at 3:00 PM, an interview was conducted with the DON and the Infection Control Preventionist (ICP) via the telephone. The ICP and DON reported that daily Respiratory Symptom Evaluations were to be completed by the nurse for all residents who resided in the facility. When queried about why R803 resided on a unit designated for residents who were positive for COVID-19, the DON reported they were on hospice and did not want to move to another room. The DON reported risks versus benefits of remaining on a unit with residents who were positive for COVID-19 were discussed with R803 and they did not want to change rooms. When queried about whether the hospice agency was involved in the discussion, the DON did not offer a response. At that time, all hospice documentation and the risks vs benefit form for R803 was requested. On [DATE], hospice paperwork was reviewed for R803. The paperwork provided by the facility included the hospice plan of care, but did not include any hospice visits or discussion regarding R803 remaining on a unit designated for residents with COVID-19 or that R803 was presumed positive as documented in NP Us progress note mentioned above. On [DATE], an unsigned Risk Benefit Assessment (emailed by the DON and not included in the clinical record) documented the DON was the assessor on [DATE] and [DATE] and communication was had with R803 and family members. The assessment documented the following: .Your overall risk rating - Low Medium or high - is based on our judgment about whether the BENEFITS of the activity or opportunity outweigh the risks . The Activity documented, Resident is receiving Hospice services for end of life care. He is in a room that is private and has a large patio door where the facility has placed patio furniture so his parents and children can visit daily. It was documented R803 would benefit psychologically from visiting family through the patio door. It was documented family was not permitted and did not want to enter the facility to visit R803. The Potential Risks were documented as Contracting COVID-19. There was no language that explained what could happen as a result of contracting COVID-19, including death. The Precaution in place to reduce the risk documented, Resident is placed at the end of the hall. Resident is in a private room. Resident has a separate isolation cart specified for his unit (room) only. It was documented R803 was at Minimal risk. Resident's condition has been stable. Upon further review of R803's clinical record it was discovered that a COVID-19 test was conducted on [DATE] and the results were positive. On [DATE] at 10:50 AM during an interview with the DON and ICP via the telephone, it was reported that the 1 East Unit was turned into a designated unit for residents who were positive for COVID-19 on [DATE], 2 East was a COVID-19 designated unit as of [DATE], and as of [DATE] the 2 East unit was split and only specific rooms were designated for residents who tested positive for COVID-19. It should be noted the Resident entered into the 1 East unit on or about [DATE] and remained on the unit when it was turned into a designated unit for positive COVID-19 residents despite determination of COVID status. R#806 A review of the facility's respiratory illness line listing for [DATE] and [DATE] was conducted. The line listing identified a COVID-19 test was performed for R806 on [DATE]. R806 had onset of symptoms on [DATE] and tested positive for COVID-19. It was documented R806 was hospitalized , returned to the facility, and could come off of 14-day isolation on [DATE]. A note on the line listing documented, ready to move. On [DATE], R806 was observed to reside on the 2 East unit which was designated for residents who tested positive for COVID-19. A review of R806's clinical record was conducted and revealed the following: R806 was admitted into the facility on [DATE], transferred to the hospital on [DATE], and readmitted on [DATE] with [DIAGNOSES REDACTED]. The census documented R806 resided on the 1 East Unit until they were transferred to the hospital on [DATE] and was readmitted on to the 2 East Unit on [DATE] (which was a designated unit for residents who tested positive for COVID-19). R806's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235217	A. BUILDING _____ B. WING _____	05/18/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SKLD BLOOMFIELD HILLS	2975 N ADAMS ROAD BLOOMFIELD HILLS, MI 48304

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	(continued... from page 2) physician's orders [REDACTED]. an order for [REDACTED]. On [DATE] there was a physician's orders [REDACTED]. A review of COVID-19 tests for R806 revealed positive results on [DATE] and [DATE]. Respiratory Symptom Evaluations for R806 were reviewed from [DATE] until [DATE] and they revealed the following: There were no Respiratory Symptom Evaluations completed on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. A Transfer Form dated [DATE] documented R806 was transferred to the hospital for a fever. Blood pressure, pulse, respiratory rate, and O2 Sats were documented from the previous day ([DATE]). Temperature was documented as 103 degrees Fahrenheit (F) on [DATE] at 11:36 AM. Progress notes were reviewed for R806 and revealed the following: On [DATE], a nursing progress note documented, Covid 19 swab collected this morning per medical director order and for fever, cough symptoms. Pt was started on droplet precautions . At 10:32 AM a progress note documented R806 had a temperature of 101.3 degrees F, a cough, and chest irritation with pain with inhalation. It was documented their temperature increased to 103 degrees F and they were transferred to the hospital. R806 returned to the facility on [DATE] and was placed on the COVID-19 unit. A progress note written by Physician W on [DATE] documented R806 was weak, tired, had poor oral intake, and experienced shortness of breath with minimal exertion. Physician W documented, .Continue droplet isolation until the patient is symptom free for at least 3 days and more than 14 days since the day of sickness . On [DATE], R806 was transferred to the hospital with abdominal pain and was admitted . R806 returned to the facility on [DATE]. A COVID-19 test was performed in the hospital and R806 tested positive. R806 was readmitted into a room on the COVID unit. A progress note written by NP U on [DATE] documented, .PT recently retested positive for covid 19. Will keep in isolation . On [DATE], NP U documented R806 developed a cough over the weekend . Lungs with crackles and rhonchi to right lung . There was no documentation of any fevers or respiratory concerns after R806's readmission into the facility on [DATE] prior to [DATE]. A review of admissions into the facility within the past 14 days ([DATE] through [DATE]) were reviewed and revealed R807, R808, R809, R810, and R811 were admitted into the facility within that timeframe and resided on the 1 West Unit (non-COVID-19 Unit). R#807 On [DATE] a tour of the 1 West unit (Non COVID-19 unit) was conducted. It was observed R807 had a private room and there were no signs or isolation equipment in the area that indicated R807 was on any type of isolation precautions. On [DATE] a review of R807's clinical record was conducted and revealed R807 originally admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Continued review of the record indicated R807 discharged out to the hospital and re-admitted to the facility on [DATE], into their same room from the prior admission. A review of a respiratory assessment document in the electronic medical record titled RESPIRATORY SYMPTOM EVALUATION was conducted and the assessment forms contained the directions that read, .A. OBTAIN AND DOCUMENT TEMPERATURE AND PULSE OXIMETRY (oxygen saturation of the blood) AT TIME OF SCREENING . A review of R807's RESPIRATORY SYMPTOM EVALUATION assessment forms was conducted and revealed the following: assessment dated [DATE] at 7:50 AM, it was noted the temperature and pulse oximetry were dated to be obtained on [DATE] at 2:53 AM. assessment dated [DATE] at 8:10 AM, the pulse oximetry was documented as obtained on [DATE] at 1:20 AM. assessment dated [DATE] at 8:05 AM, the temperature was documented as obtained on [DATE] at 12:40 AM. assessment dated [DATE] at 7:54 AM, the temperature documented as obtained on [DATE] at 12:16 AM. assessment dated [DATE] at 6:52 AM, the temperature documented as obtained on [DATE] at 10:32 PM. assessment dated [DATE] at 5:55 AM, the temperature and pulse oximetry documented as obtained on [DATE] at 12:48 AM and 12:49 AM. Continued review of R807's RESPIRATORY SYMPTOM EVALUATION assessment forms also included assessments missing for the following dates: [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE] thru [DATE]. R#808 On [DATE] a tour of the 1 West unit (Non COVID-19 unit) was conducted. It was observed R808 had resided in a room on the 1 West unit. R808's room did not have any signs or isolation equipment in the area that indicated they were on any type of isolation precautions. On [DATE], a review of R808's clinical record was conducted and revealed an admission date of [DATE] from the hospital. R808's [DIAGNOSES REDACTED]. A review of a nursing note dated [DATE] at 4:20 PM was conducted and read, .arrived at facility from hospital. admitted to (room # redacted), on s <sic> non-covid unit . A review of R808's physician's orders [REDACTED]. An order on [DATE] (three days after admission) to monitor R808's vital signs every shift. Continued review of the record revealed R808's first RESPIRATORY SYMPTOM EVALUATION assessment form was dated [DATE], two days after their admission to the facility. It was further discovered R808 did not have any documented vital signs for [DATE]. R#809 On [DATE], R809 was observed to be in their room on the 1 West Unit. There was no sign on R809's door that indicated the resident was on isolation precautions. A review of R809's clinical record was conducted and revealed the following: R809 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. R809's physician's orders [REDACTED]. R#810 On [DATE], R810 was observed to be in their room on the 1 West Unit. There was no sign on R810's door that indicated the resident was on any isolation precautions. A review of 810's clinical record was conducted and revealed the following: R810 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. physician's orders [REDACTED]. Respiratory Symptom Evaluations for R810 were completed on [DATE] only, as of [DATE]. Progress notes were reviewed for R810 and revealed the following: On [DATE], NP U documented, .Pt had some [MEDICAL CONDITION] while under sedation for her reduction. CXR (Chest X-ray) demonstrated some pneumonia. Covid negative . On [DATE], Physician W documented, .Chest x-ray showed pneumonia because patient was hypoxic, but COVID was negative (in the hospital) . On [DATE], a progress note documented, .Resident states she has no family / only a boyfriend who is sick with COVID in the hospital . Hospital records for R810 were reviewed and revealed the following: The Admission referral to the facility documented a secondary [DIAGNOSES REDACTED]. A History of Physical dated [DATE] documented, .Her CXR showed bilateral airspace disease concerning for atypical/[MEDICAL CONDITION] pneumonia. A COVID-19 swab was sent and is pending .Covid 19 resulted as negative swab .Assessment/Plan: Active Hospital Problems .Pneumonia due to infectious organism .Suspected COVID-19 Virus Infection . A COVID-19 test was conducted in the hospital on [DATE] and was negative. R810 was admitted into the facility on [DATE] (four days after the test). R#811 On [DATE], R811 was observed in their room located on the 1 West Unit. There was no sign that indicated R811 was on droplet precautions. There was no PPE available on the unit. Staff were observed to wear surgical and N95 masks. A review of R811's clinical record was conducted and revealed the following: R811 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. physician's orders [REDACTED]. A review of R811's Medication Administration Record [REDACTED]. One Respiratory Symptom Evaluation was completed for R811 on [DATE], it was noted R811 was admitted four days prior to the evaluation. Progress notes for R811 were reviewed and revealed the following: On [DATE], a progress note written by NP X documented, .Hospital course complicated by worsening low back pain and [MEDICAL CONDITION]- CXR showed patchy bibasilar interstitial opacities .Pt reports acute dry cough . On [DATE] at 3:00 PM, an interview was conducted with the ICP and the DON via the telephone regarding residents admitted or readmitted from the hospital. The DON reported residents who tested positive in the hospital would remain in droplet isolation on the COVID-19 unit at the facility until seven days after they tested positive and they were asymptomatic for 72 hours without the use of fever reducing medications. When queried about the facility's process for residents who were admitted or readmitted from the hospital whose COVID-19 status was unknown, the DON reported the facility only began accepting residents who were negative for COVID-19 six or seven days ago. The DON further reported that the resident had to have two negative tests in the hospital (one test within at least 72 hours of discharge from the hospital) prior to coming to the facility and would be placed on one of the units designated for residents who did not have confirmed COVID-19. The DON was asked about the guidance the facility followed to determine the above decision and reported it came from the physician, the hospital epidemiologist, and CDC guidance. The DON further reported that the residents who came from the hospital had a Respiratory Symptom Evaluation completed daily to monitor any new signs and symptoms of COVID-19, but they were not placed in a transitional or observation unit and were not placed on droplet precautions. When queried about R807, R808, R809, R810, and R811, the DON reported they all tested negative in the hospital and therefore did not require 14-day monitoring when they were admitted into the facility. At that time, any documentation of negative tests as explained by the DON for R807, R808, R809, R810, and R811 were requested, in addition to the facility policy that included the above guidance for monitoring and isolation for residents who were admitted from the hospital. A list of all residents who were in the facility on [DATE] who were currently positive for COVID-19 and a list of all residents who were in the facility on [DATE] who contracted COVID-19