STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075070	A. BUILDING _____ B. WING _____	**06/11/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
APPLE REHAB SAYBROOK	**1775 BOSTON POST RD OLD SAYBROOK, CT 06475**

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interview for 5 residents (Resident #1, 3, 4, 5 and 6) reviewed for change in condition, the facility failed to ensure the resident representative was notified of an elevated temperature, hen a wanderguard was initiated and when new physician orders [REDACTED]. The findings include: 1. Resident #1's [DIAGNOSES REDACTED]. The quarterly MDS dated [DATE] identified Resident #1 had intact cognition and required supervision with walking in the room and toilet use utilizing a walker for mobility. The care plan dated 4/24/20 identified Resident #1 was exhibiting signs and symptoms of the coronavirus: fever, tiredness, cough and/or difficulty breathing. Interventions included to take vital signs as ordered, as needed and per policy. The temperature log dated 5/21/20 at 10:03 PM identified Resident #1 had an elevated temperature of 104 degrees Fahrenheit (F). A nurse's note dated 5/22/20 at 1:03 AM, written by RN #4, identified Resident #1 was febrile and Tylenol 650 milligrams (mg) was administered. Additionally, the resident denied pain, no cough or dyspnea was reported, appetite was poor and intravenous fluids (IVF) were running without difficulty. The documentation failed to reflect what the actual temperature was or whether the physician and resident representative were notified of the 104-degree F temperature. Review of an APRN progress note, written by APRN #2, dated 5/22/20, identified Resident #1 was seen for follow-up, now with lethargy and high temperatures. The resident sustained [REDACTED]. The resident is not eating or drinking. IVF started, placed on oxygen at 2 liters nasal cannula for comfort, and code status was changed to DNR/DNI per discussion with the resident representative. Interview with Resident #1's representative, (Person #2), on 6/3/20 at 1:30 PM identified that he/she did not receive a phone call from anyone at the facility when the resident had an elevated temperature of 104 F, and indicated he/she would have expected to be notified. Interview with APRN #2 and review of clinical record on 6/4/20 at 10:30 AM identified he/she was aware resident had a fever of 103 F on 5/20/20 and had fallen. Interview with RN #4 on 6/10/20 at 1:15 PM identified he/she could not recall if the resident representative was notified of Resident #1's elevated 104 F temperature on 5/21/20. Additionally, RN #4 indicated any change in condition should be reported to the physician/APRN and the resident representative. Review of the Change in Condition/Family/MD Notification policy identified when there is a significant change in the condition of a resident's physical, mental or emotional status, or in the event of an accident involving the resident, the resident's attending physician and family or resident representative shall be notified. 2. Resident #3 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED].#3 had moderately impaired cognition, required extensive 2 person assistance with transfers, extensive 1 person assistance with locomotion on unit, limited 1 person assistance with walking and toilet use and used a walker and wheelchair for mobility. The care plan dated 3/31/20 identified Resident #3 was at risk for elopement. Interventions included to apply a wanderguard, check its placement each shift, discuss with family the risks of wandering and elopement, and ensure they are aware of steps taken to ensure safety. A Nurse's Note dated 3/27/20 identified Resident #3 attempted to leave the building through the front door. The DNS redirected the resident, placed a wanderguard on the resident's right lower leg, instructed RN #4 to complete an elopement assessment and obtain an order for [REDACTED]. An Elopement Risk assessment dated [DATE] identified Resident #3 was an elopement risk. Interview with the DNS on 6/9/20 at 11:05 AM identified she applied the wanderguard for the residents safety at the time and although she did direct RN #4 to complete the assessment and obtain the order, notifying the family was overlooked and should have been done at the time. Interview with RN #4 on 6/9/20 at 3:15 PM identified although he/she was directed by the DNS to complete an elopement assessment and obtain an order for [REDACTED].#4 indicated he/she should have notified the family or directed the charge nurse to do so. Review of the Change in Resident Condition/Family/MD Notification policy identified when there is a significant change in the condition of a resident's physical, mental or emotional status, or in the event of an accident involving the resident, the family or responsible party shall be notified. 3. Resident #4 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The quarterly MDS dated [DATE] identified Resident #4 had severely impaired cognition and required limited assistance with personal hygiene and toilet use. A physician's orders [REDACTED]. The nurse's note dated 5/11/20 at 11:43 AM and 11:22 PM failed to reflect the resident representative was notified of the new physician's orders [REDACTED].#4's temperature twice a day, report any elevated temperature to supervisor and document in the clinical record. Monitor oxygen saturation every shift, report if oxygen saturation is below 90 %, and document in clinical record. Additionally, monitor for signs and symptoms of malaise (fatigue), dizziness, change in mental status, change in behavior, diarrhea, sore throat, loss of appetite and report to supervisor and document in the clinical record. The nurse's note 5/12/20 failed to reflect the resident representative was notified of new order dated 5/12/20. The care plan dated 5/13/20 identified Resident #4 was at risk of contracting the Coronavirus. Interventions included to obtain Covid-19 testing as ordered and as needed. The nurse's note dated 5/18/20 at 4:10 PM identified the resident representative was notified that the facility would be having Covid-19 Point Prevalence testing this week. [DIAGNOSES REDACTED]-CoV-2 RNA culture dated 5/20/20 identified Covid 19 was not detected. A physician's orders [REDACTED].#6 for Covid-19. The nurse's note dated 5/27/20 failed to reflect the resident representative was notified of the new order to test the resident for Covid-19. Interview and review of the clinical record on 6/4/20 at 11:05 AM with the Administrator identified she was not aware that Resident #4's physician was not notified of the Covid-19 test results and the resident representative was not notified of the new orders or Covid-19 test result dated 5/20/20. Interview with the DNS on 6/9/20 at 3:46 PM identified she was not aware of the issue. The DNS indicated the physician and APRN should have been notified of the Covid-19 test results and the resident representative should have been notified of new orders and Covid-19 test result dated 5/20/20. Review of the Change in Resident Condition/Family/MD Notification policy identified to make resident's physician and family aware of any significant change in condition. All significant change in resident's condition will be reported to physician and family. When there is a significant change in the condition of a resident's physical, mental or emotional status, or in the event of an accident involving the resident: The resident's attending physician shall be notified. The family or responsible party shall be notified. The nurse will document in the nurse's notes that the physician and family or responsible party have been notified of the change in condition. The facility staff failed to ensure the physician was notified of Covid-19 test results and failed to ensure the resident representative was notified of new physician's orders [REDACTED]. Resident #5 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The quarterly MDS dated [DATE] identified Resident #5 had severely impaired cognition and required extensive assistance with personal hygiene. A physician's orders [REDACTED]. The nurse's note dated 5/1/20 at 1:14 PM identified Resident #5 was noted with increase incontinence. The resident was evaluated by the APRN with new order for UTI watch times 3 days and CBC, BMP for Monday. The note failed to reflect the resident representative was notified of the new orders. A physician's orders [REDACTED]. Review of the nurse's note failed to reflect the resident representative was notified of the

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) new order for a Covid-19 and RSV test dated 5/11/20. A physician's orders [REDACTED].#5's temperature twice a day, report any elevated temperature to supervisor and document in e-chart. Monitor oxygen saturation every shift, report if oxygen saturation is below 90 % to supervisor and document in clinical record (e-chart). Additionally, monitor for sign and symptoms of malaise (fatigue), dizziness, change in mental status, change in behavior, diarrhea, sore throat, loss of appetite and report to supervisor and document in the clinical chart (e-chart). The nurse's notes failed to reflect the resident representative was notified of the new orders. The care plan dated 5/13/20 identified Resident #5 was at risk of contracting the Coronavirus. Interventions included to obtain a Covid-19 test as ordered and as needed. Staff to maintain contact/droplet/airborne precautions per policy. The nurse's note dated 5/18/20 at 4:10 PM identified the resident representative was notified that Covid-19 Point Prevalence testing would be done at the facility this week. [DIAGNOSES REDACTED]-CoV-2 RNA culture dated 5/20/20 identified Covid-19 was not identified. The nurse's notes dated 5/20/20 failed to reflect the resident representative was notified of the Covid-19 culture result. A physician's orders [REDACTED].#5 for Covid-19. The Covid-19 culture test result dated 5/30/20 identified [DIAGNOSES REDACTED]-CoV-2, NAA detected. The nurse's note dated 5/30/20 at 7:29 PM identified the resident representative was updated of positive Covid-19 test, however, failed to reflect the MD/APRN was notified of the Covid-19 result. The care plan dated 5/30/20 identified Resident #5 is exhibiting signs and symptoms of the Coronavirus: fever, tiredness, cough and/or difficulty breathing. Interventions included activity as tolerated with rest period, allow to stay in bed for comfort and healing as requested/determined by nursing/MD/APRN, encourage frequent hand washing, encourage social distancing as able. Maintain contact/droplet/airborne precautions per policy. A physician's orders [REDACTED]. The nurse's notes dated 6/1/20 through 6/2/20 failed to reflect the resident representative was notified of the new orders dated 6/1/20. Interview and review of the clinical record on 6/4/20 at 11:05 AM with the Administrator identified she was not aware Resident #5's representative was not notified of the new orders for blood work, monitoring and Covid-19 testing and results. Interview with the DNS on 6/9/20 at 3:46 PM identified she was not aware Resident #5's representative was not notified of the new orders for blood work, monitoring and Covid-19 testing and results. The DNS indicated the physician/APRN should have been notified of the Covid-19 test results and the resident representative should have been notified of new orders and Covid-19 test result on 5/20/20. Review of the Change in Resident Condition/Family/MD Notification policy identified to make resident's physician and family aware of any significant change in condition. All significant change in resident's condition will be reported to physician and family. When there is a significant change in the condition of a resident's physical, mental or emotional status, or in the event of an accident involving the resident: The resident's attending physician shall be notified. The family or responsible party shall be notified. The nurse will document in the nurse's notes that the physician and family or responsible party have been notified of the change in condition. The facility staff failed to ensure the physician was notified of the Covid-19 test results and failed to ensure the resident representative was notified with new orders and the Covid-19 test result on 5/20/20. 5. Resident #6 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The quarterly MDS dated [DATE] identified Resident #6 had moderately impaired cognition and required limited assistance with personal hygiene and toilet use. A physician's orders [REDACTED]. The care plan dated 5/13/20 identified Resident #6 was at risk of contracting the Coronavirus. Interventions included to complete Covid-19 testing as ordered and as needed. The nurse's note dated 5/18/20 at 4:04 PM identified Resident #6's representative was notified that the facility would be completing Covid-19 Point Prevalence testing. Review of nurse's notes dated 5/11/20 through 5/27/20 failed to reflect Resident #6 had been tested for Covid-19 as per the order of 5/11/20. A physician's orders [REDACTED].#6 for Covid-19. Review of nurse's note dated 5/27/20 through 6/3/20 failed to reflect Resident #6 had been tested for Covid-19 as per the orders of 5/11/20 and 5/27/20. Interview and review of the clinical record with the Administrator on 6/4/20 at 11:05 AM identified she was not aware that Resident #6 did not have the Covid 19 test according to the physician's orders [REDACTED]. Interview with the DNS on 6/9/20 at 3:46 PM identified Resident #6 refused to have the Covid 19 test twice on 5/11/20 and 5/27/20. The DNS indicated the physician, APRN and the resident representative should have been notified that Resident #6 refused the Covid-19 test twice. Review of the Change in Resident Condition/Family/MD Notification policy identified to make resident's physician and family aware of any significant change in condition. All significant change in resident's condition will be reported to physician and family. When there is a significant change in the condition of a resident's physical, mental or emotional status, or in the event of an accident involving the resident: The resident's attending physician shall be notified. The family or responsible party shall be notified. The nurse will document in the nurse's notes that the physician and family or responsible party have been notified of the change in condition. The facility failed to notify the physician and the resident representative when Resident #6 refused Covid-19 testing twice.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for 1 resident (Resident #6) reviewed for infection control, the facility failed to revise the plan of care to address the resident's refusal of a Covid-19 test. The findings include: Resident #6 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The quarterly MDS dated [DATE] identified Resident #6 had moderately impaired cognition and required limited assistance with personal hygiene and toilet use. A physician's orders [REDACTED]. The care plan dated 5/13/20 identified Resident #6 was at risk of contracting the Coronavirus. Interventions included to complete Covid-19 testing as ordered and as needed. The nurse's note dated 5/18/20 at 4:04 PM identified Resident #6's representative was notified that the facility would be completing Covid-19 Point Prevalence testing. Review of nurse's notes dated 5/11/20 through 5/27/20 failed to reflect Resident #6 had been tested for Covid-19 as per the order of 5/11/20. A physician's orders [REDACTED].#6 for Covid-19. Review of nurse's note dated 5/27/20 through 6/3/20 failed to reflect Resident #6 had been tested for Covid-19 as per the orders of 5/11/20 and 5/27/20. Interview and review of the clinical record with the Administrator on 6/4/20 at 11:05 AM identified she was not aware that Resident #6 did not have the Covid 19 test according to the physician's orders [REDACTED]. Interview with the DNS on 6/9/20 at 3:46 PM identified she was aware that Resident #6 refused the Covid-19 test twice, however she was not aware that staff did not revise the care plan with interventions to address the resident's refusal of Covid 19 testing. Additionally, the DNS identified staff should have revised the care plan with interventions to address the resident's refusal of Covid-19 testing. The facility failed to revise the plan of care to include interventions such as resident and family education when Resident #6 twice refused to be tested for Covid-19.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for 3 residents (Resident #4, 5 and 6) the facility failed to monitor temperature/oxygen saturations according to the physician's orders [REDACTED]. Resident #4 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The quarterly MDS dated [DATE] identified Resident #4 had severely impaired cognition and required limited assistance with personal hygiene and toilet use. A physician's orders [REDACTED].#4's temperature twice a day, report any elevated temperature to supervisor and document in the clinical record. Monitor oxygen saturation every shift, report if oxygen saturation is below 90 %, and document in clinical record. Additionally, monitor for signs and symptoms of malaise (fatigue), dizziness, change in mental status, change in behavior, diarrhea, sore throat, loss of appetite and report to supervisor and document in the clinical chart (e-chart). The care plan dated 5/13/20 identified Resident #4 was at risk of contracting the Coronavirus. Interventions included to obtain Covid-19 testing as ordered and as needed. Review of the Medication Administration Record [REDACTED]. Review of the treatment administration record dated May 2020 failed to reflect the temperatures or oxygen saturation had been monitored. Review of the oxygen saturation vital summary dated 5/13/20 through 5/18/20, 5/21/20, and 5/23/20 through 5/30/20 temperatures or oxygen saturation had been monitored. Review of the temperature vital sign summary dated 5/13/20 through 5/31/20 identified Resident #4's temperature was monitored once a day. The temperature vital summary failed to reflect Resident #4's temperature was monitored twice a day as ordered. Review of the medication and treatment administration records dated 6/1/20 through 6/11/20 failed to reflect that temperatures or oxygen saturation had been

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) monitored according to the physician's orders [REDACTED]. Interview with the DNS on 6/9/20 at 3:46 PM identified she was not aware the license staff were not following the physician's orders [REDACTED]. The DNS indicated it is the responsibility of the license staff to follow the physician's orders [REDACTED].#4's temperature and oxygen saturation according to the physician's orders [REDACTED]. Resident #5 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The quarterly MDS dated [DATE] identified Resident #5 had severely impaired cognition and required extensive assistance with personal hygiene. A physician's orders [REDACTED].#5's temperature twice a day, report any elevated temperature to supervisor and document in e-chart. Monitor oxygen saturation every shift, report if oxygen saturation is below 90 % to supervisor and document in clinical record (e-chart). Additionally, monitor for signs and symptoms of malaise (fatigue), dizziness, change in mental status, change in behavior, diarrhea, sore throat, loss of appetite and report to supervisor and document in the clinical chart (e-chart). Review of the temperature vitals summary dated 5/13/20 through 5/18/20 and 5/28/20 failed to reflect the resident's temperature was monitor as ordered. The care plan dated 5/13/20 identified Resident #5 was at risk of contracting the Coronavirus. Interventions included to obtain Covid-19 testing as ordered and as needed. Staff to maintain contact/droplet/airborne precautions per policy. Review of the oxygen saturation vital summary dated 5/12/20 through 5/18/20, 5/21/20, and 5/23/20 through 5/30/20 failed to reflect the oxygen saturation was monitored every shift as ordered. Review of the medication and treatment administration records for the month of May 2020 and June 2020 failed to reflect the resident's temperature or oxygen saturation was monitored as ordered. Interview and review of the clinical record with the Administrator on 6/4/20 at 11:05 AM identified she was not aware the license staff were not following the physician's orders [REDACTED]. Interview with the DNS on 6/9/10 at 3:46 PM identified she was not aware the license staff not following the physician's orders [REDACTED]. Resident #6 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The quarterly MDS dated [DATE] identified Resident #6 had moderately impaired cognition and required limited assistance with personal hygiene and toilet use. A physician's orders [REDACTED].#6's temperature twice a day, report any elevated temperature to the supervisor and document in the clinical record. Monitor oxygen saturation every shift, report if oxygen saturation is below 90 % to the supervisor and document in clinical record. Additionally, monitor for signs and symptoms of malaise (fatigue), dizziness, change in mental status, change in behavior, diarrhea, sore throat, loss of appetite and report to supervisor and document in the clinical record. Review of the temperature vitals summary dated 5/12/20 through 5/16/20 failed to reflect the resident's temperature was monitor as ordered. The care plan dated 5/13/20 identified Resident #6 was at risk of contracting the Coronavirus. Interventions included to complete Covid-19 testing as ordered and as needed. Review of the temperature vital summary dated 5/17/20 through 5/31/20 identified resident's temperature was monitored once a day. The temperature vital summary failed to reflect Resident #6 temperature was monitored twice a day as ordered. Review of the oxygen vital sign summary dated 5/12/20 through 6/4/20 failed to reflect oxygen saturations were consistently monitored every shift as ordered. Interview and review of the clinical record on 6/4/20 at 11:05 AM with the Administrator identified she was not aware that staff were not monitoring the vital signs, including the temperature and oxygen saturations for Resident #6 as per the physician's orders [REDACTED].#6 as per the physician's orders [REDACTED].#6's temperature and oxygen saturation according to the physician's orders [REDACTED].
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interview for 2 residents (Resident #1 and 7) reviewed for accidents, the facility failed to ensure appropriate supervision was in place to prevent a fall, and the facility failed to provide adequate supervision and conduct an assessment when the resident's behavior changed to prevent the accidental ingestion of mouthwash. The findings include: 1. Resident #1's [DIAGNOSES REDACTED]. The quarterly MDS dated [DATE] identified Resident #1 had intact cognition, and required supervision with walking in the room and toilet use utilizing a walker for mobility. The care plan dated [DATE] identified Resident #1 was exhibiting signs and symptoms of the coronavirus: fever, tiredness, cough and/or difficulty breathing. Interventions included to provide assistance to meet all care needs because the resident may be too weak to complete. Additionally, the care plan indicated to keep the bedroom door closed, as able, to prevent the spread of infection. The care plan also identified Resident #1 was a fall risk with interventions to provide a well-lit, clutter free environment, and ensure call bell was within reach. A Reportable Event Form dated [DATE] identified Resident #1 had an unwitnessed fall in the room at 5:00 PM. Resident #1 was found by a nurse side lying at the bedside on the floor, indicating he/she slid out of the chair. An assessment at that time indicated no apparent injury. Neurologic and vital signs were stable and the APRN and resident representative were notified. An intervention to remove extra blankets on patient's chair was implemented to prevent further falls. A Reportable Event Form dated [DATE] identified Resident #1 had an unwitnessed fall at 9:30 AM. The investigation identified NA #6 went in to check on the resident in the room and found him/her on the floor in a prone push up position. Resident #1's pain assessment identified mild grimacing but no verbalized discomfort. Skin assessment identified a laceration on the bridge of the nose and bruising to the right side of the mouth and cheek. Treatment was provided immediately, ice and pressure applied to bridge of nose and bleeding stopped. The Interdisciplinary Fall assessment dated [DATE] identified contributing factors of change in functional ability and cognitive status with recent confusion secondary to Covid-19 illness. Conclusion of the internal investigation identified Resident #1 was weak, slightly confused secondary to Covid-19 diagnosis, and the resident did not call for help as he/she usually did. APRN #2 was called and evaluated the resident and ordered to send to the resident to the hospital for evaluation and treatment of [REDACTED].#1 was admitted to the hospital on [DATE] with a [DIAGNOSES REDACTED]. The clinical record indicated on [DATE], the facility received a report that Resident #1 expired at the hospital at 1:47 PM. Interview with RN #1 on [DATE] at 10:30 AM identified that Resident #1 was receiving oxygen therapy, intravenous fluids and had been running fevers on and off. Additionally, Resident #1 was physically weak with increased confusion. RN #1 identified he/she had assisted the resident to the bathroom and back to the bedside chair about 8:00 AM. RN #1 indicated staff were instructed to keep the bedroom doors of residents who tested positive for Covid-19 closed to contain and prevent the spread of the infection. RN #1 identified Resident #1 was at a higher risk for falls due to his/her Covid-19 diagnosis, increased confusion, weakness and having oxygen and intravenous fluids. Further, Resident #1 also had an unwitnessed fall just 2 days prior, on [DATE]. RN #1 indicated if the resident's door had been open, he/she (Resident #1) may have called out to staff for help, or the resident could have been observed trying to get up unassisted, which may have prevented the fall. Interview with NA #6 on [DATE] at 10:45 AM identified he/she was the regular nurse aide for the unit and knew Resident #1 well and had seen the resident between 7:45 AM and 8:00 AM. Resident #1 was left sitting in the bedside chair and the resident's door was closed. NA #6 identified instructions to keep the doors closed were written on the droplet precautions Covid-19 signage on the doors. At 9:30AM when checking on the resident to obtain vital signs, NA #6 found the resident lying in prone position on the floor with blood near his/her face. NA #6 identified the resident was awake but appeared dazed. NA #6 indicated he/she stayed with the resident and assisted RN #1. Interview with the DNS on [DATE] at 11:05 AM identified that although staff were advised to keep the bedroom doors closed for resident's with Covid-19 to try and contain the infection, Resident #1's fall may have been prevented had the door been open. The DNS identified the resident had increased confusion, weakness and had fallen 2 days prior to this fall, placing her at a higher risk. Additionally, the DNS indicated the residents risk should have been assessed prior to keeping the door closed. Review of the Falls: Minimizing Risk of Injury identified each time a resident experiences a fall, an interdisciplinary fall assessment tool will be completed in order to identify the potential causes of the fall. 2. Resident #7 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The quarterly MDS dated [DATE] identified Resident #7 had severely impaired cognition, required limited assistance with transfers and personal hygiene, and was independent with eating and locomotion on the unit. The care plan dated [DATE] identified Resident #7 was at risk for dehydration related to general deconditioning with interventions that included to obtain blood work per physician's orders [REDACTED]. Additionally, have the dietitian estimate fluid needs, complete a hydration assessment per facility policy, and offer and encourage water. Further, the care plan identified Resident #7 had chronic/progressive decline in intellectual functioning characterized by: deficit in memory, judgment, decision making and thought process related to [MEDICAL CONDITION]. Interventions included to gently redirect when exhibiting inappropriate actions/behaviors, observe for and report changes in cognitive status to the physician and provide reality orientation. A physician's orders [REDACTED]. A nurse's note dated

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) [DATE] at 3:52 PM identified Resident #7 was lethargic and drank 240 ml of fluids. A physician's orders [REDACTED]. Norma Saline at 60cc an hour time 1-liter VIA IV peripheral line. Review of the clinical infusion nursing documentation dated [DATE] at 12:30 AM identified infusion [DIAGNOSES REDACTED]. Notes: Very restless. A nurse's note dated [DATE] at 10:10 AM identified Resident #7 was alert and lethargic. Resident #7 pulled peripheral line from right arm, no bleeding, and area benign. APRN and supervisor updated. New order to re-insert peripheral line and start D5 Normal Saline at 60cc an hour. Review of the clinical infusion nursing documentation dated [DATE] at 11:45 PM identified infusion [DIAGNOSES REDACTED]. Insertion procedure peripheral IV insertion right forearm. Notes: Very restless. Resident already trying to rip off upon securing. The nurse's note dated [DATE] at 6:22 AM identified Resident #7 is [AGE] years old. The APRN had ordered 1 liter of D5 Normal Saline IV hydration Resident #7 has received approximately 150ml of IV fluids. Resident #7 is restless and has pulled out 3 IV sites and 4th site infiltrated immediately after placement. Resident #7 has had 3 episodes of diarrhea since 11:00 PM. Staff has attempted to encourage fluid, but he/she is not tolerating, complained of nausea after a few sips of water. APRN notified of all the above and new order to send Resident #7 to the hospital for IV hydration. Subsequent to the POA notification, Resident #7 to be do not resuscitate, do not hospitalize and comfort measures only. APRN was updated and order for [MEDICATION NAME] 0.25mg by mouth time one now for restlessness. Will continue to offer fluids for comfort. A nurse's note dated [DATE] at 1:57 PM identified Resident #7 was alert and lethargic, poor intake, afebrile, no respiratory distress. Pulled IV site out of right forearm. APRN and resident representative aware. A physician's orders [REDACTED]. A physician's orders [REDACTED]. Comfort Measures Offer (CMO). Consult with hospice - admit if appropriate. A physician's orders [REDACTED]. Give 0.25 ml sublingual (sl) every 4 hour as needed for pain and shortness of breath. Review of a Reportable Event Form dated [DATE] at 7:00 PM identified Resident #7 was behaving odd, getting bed linens off, moving around the room, hopping from bed to bed and turning self noticeably. Listerine bottle found in room. Resident #7 was alert and confused. After the event Resident #7 was alert and confused, ambulatory with unsteady gait. Multiple bruises on both knees, right wrist and forehead. Poison Control notified, APRN notified with new order to transfer to hospital for evaluation. Family notified. The Reportable Event Form identified a nurse aide found an empty 8 oz. bottle of Listerine cool mint in Resident #7's room and the resident reported he/she had drank the Listerine because his/her family member said it was good stuff. Resident #7's representative indicated the Listerine was brought into the facility sometime in February 2020. Subsequently, the resident was sent to the hospital. Review of an Investigation Staff Statement dated [DATE] identified Resident #7 had erratic behavior, and an empty Listerine bottle found in the room. Review of the SBAR Communication Form dated [DATE] identified Resident #7 had a change in mental status, with erratic behavior reported. Poison control contacted. Resident #7 to be evaluated in the hospital. A nurse's note dated [DATE] at 12:38 AM identified Resident #7 was acting strange, had been throwing the pillows around the room, taking linens off the bed, removing clothing, and jumping from bed to bed to chair. Interview with LPN #5 on [DATE] at 1:34 PM identified she worked on [DATE] on the evening shift. LPN #5 indicated she had gotten report that Resident #7 had been acting strange for the last couple of days, and after receiving report she went to Resident #7's room. LPN #5 indicated Resident #7's room was in a disarray and Resident #7 was going from bed to bed taking off the linen of the beds. LPN #5 indicated she notified the 2 nurse aides on the unit to keep an eye on Resident #7 to make sure he/she was safe. LPN #5 indicated sometime around 4:30 PM, one of the nurse aides reported an empty bottle of Listerine was found in the resident's room. LPN #5 indicated she reported the incident to RN #4 and they both went to the resident's room, and Resident #7 was very hard to redirect. LPN #5 indicated she remained with Resident #7 while RN #4 went to make the phone calls. Interview on [DATE] at 2:50 PM with NA #11 identified he worked on [DATE] during the evening shift. NA #11 indicated the facility is always short of staff, and no one has an assigned assignment. NA #11 indicated that evening the West unit had 2 nurse aides, and the East unit only had 1. NA #11 indicated he had to go and help the nurse aide on the East unit with a difficult resident. NA #11 indicated during 1st rounds, at 3:30 PM, Resident #7 was in bed sleeping and at approximately 4:00 PM and 4:30 PM Resident #7 was still asleep but the room was in disarray. NA #11 indicated he saw pillows on the floor, blankest on the floor and that was out of character for Resident #7 and he immediately reported it to LPN #5. NA #11 indicated when he went to report it to the nurse, Resident #7 was sleeping in the bed. NA #11 indicated LPN #5 went to Resident #7 room and he continued with care for other residents. NA #11 indicated LPN #5 indicated Resident #7 told her that he/she had drink the Listerine and LPN #5 said she was going to contact the poison control. NA #11 indicated he went back to Resident #7 room and observed a bottle of lotion with the cap off and shampoo that had the cap off and some of the shampoo had spilled on the table. NA #11 indicated he removed the 2 bottles which were full, out of the room and he reported it to LPN #5. NA #11 indicated he does not remember where LPN #5 was at that time and he proceed to go and give care to other residents. NA #11 indicated he was not the one who stayed and monitored the resident until he/she left for the hospital. NA #11 indicated he does not know who stayed with the resident. Interview with RN #4 on [DATE] at 3:50 PM indicated she was making rounds around 6:30 PM and 7:00 PM and she noticed Resident #7's room had pillows all over the room, sheets off the beds, his/her shirt was disheveled and Resident #7 was hoping from bed to bed and to the chair. RN #4 indicated she asked LPN #5 when did this behavior started. RN #4 indicated LPN #5 showed her an empty bottle of Listerine. RN #4 indicated she called the Poison control because of the alcohol content. RN #4 indicated she informed the staff to stay with Resident #7. RN #4 indicated she notified the resident representative who stated that he/she brought the Listerine to the facility in February 2020. RN #4 indicated she then notified the APRN and called EMS. RN #4 indicated that EMS informed her that staff needed to bring the resident out of the building when they arrive due to Covid-19 in the facility. RN #4 indicated they brought the resident to the front lobby and waited until the ambulance came and then pushed the resident outside to EMS. RN #4 indicated she was aware that NA #10 switched to the East unit with NA #12 (went to West unit). RN #4 indicated NA #12 was tired because she worked by herself on her unit the night before. RN #4 indicated NA #10 was on the East unit by herself on [DATE] during the evening shift. Several attempts were made to contact NA #12 on [DATE] and [DATE]. Although Resident #7 had newly diagnosed dehydration, was receiving IV fluids and was exhibiting odd behaviors, the facility failed to provide adequate supervision to prevent the resident from consuming a bottle of Listerine.
F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interview for 1 resident (Resident #3) reviewed for hydration, the facility failed to ensure fluid intake and output were consistently monitored and evaluated for a resident at risk for dehydration related to Covid-19 infection. The findings include: Resident #3 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A Nutritional assessment dated [DATE] identified Resident #3's estimated fluid needs were 1580 cubic centimeters (cc) daily. The admission MDS dated [DATE] identified Resident #3 had moderately impaired cognition, required supervision with eating and was on a mechanically altered diet. The care plan dated 3/31/20 identified Resident #3 was exhibiting signs and symptoms of the coronavirus: fever, tiredness, cough and/or difficulty breathing (dated 5/20/20). Interventions included to encourage fluids up to fluid restriction, if applicable, to prevent dehydration and monitor intake and output per policy. A physician's orders [REDACTED]. Additionally, obtain a stat chest x-ray to rule out infiltrate (2 views) and administer [MEDICATION NAME] (medication for nausea and vomiting) 8 mg every 8 hours as needed for nausea/vomiting for 3 days. Review of the facility's Intake/Output (I&O) documentation dated 5/21/20 through 5/27/20 failed to reflect fluid intake was monitored. Review of the Nurse's Notes dated 5/21/20 through 5/27/20 identified only 2 nurse's notes (both dated 5/22/20) which indicated Resident #3 was taking fluids well however did not indicate the actual amount consumed. No other documentation regarding fluid intake was found. Interview with the DNS on 6/9/20 at 11:05AM identified the following; all Covid-19 positive residents should be on intake and output monitoring. The charge nurses are responsible to initiate the intake and output monitoring flow sheet with the resident's name and the nurse aides are responsible to document the fluid intake from meals and any other fluids taken. The charge nurse then adds the amount they've provided during the shift and totals the amount for their shift. The 3:00 PM - 11:00 PM charge nurse is responsible for totaling the fluid amount for the 24 hours. This amount should be evaluated and compared to the resident's 24-hour fluid goal. Interview with APRN #1 on 6/9/20 at 1:45 PM identified that all Covid-19 positive residents should be monitored for fluid intake and output to ensure adequate hydration. APRN #1 identified he/she would often bring in and administer fluids to residents when assessing them, in order to provide residents with extra fluid. Additionally, APRN #1 identified when a resident appears dehydrated, he/she orders blood work. APRN #1 did order blood work for Resident #3 on 5/26/20, which was to be drawn on 5/27/20, the morning resident was sent to hospital for evaluation. Review of the Dehydration/Prevention policy identified residents deemed to be at risk of dehydration will be placed on intake and output until adequate hydration status is achieved. Attending physicians shall be notified of potential dehydration after 3

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	075070	A. BUILDING _____ B. WING _____	06/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
APPLE REHAB SAYBROOK	1775 BOSTON POST RD OLD SAYBROOK, CT 06475

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

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F 0692 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 4) consecutive days of fluid intake less than 1000cc. Residents experiencing a change in condition which may alter hydration status shall be placed on I&O for a minimum of 3 days or until condition is re-stabilized.
F 0725 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** Based on observation, review of facility documentation, facility policy, and interviews, for 1 of 3 nursing units, the facility failed to maintain sufficient staffing to supervise residents and ensure measures to prevent the transmission of Covid-19. The findings include: Interview on 6/3/20 at 9:21 AM with the Administrator identified the facility capacity is 120 and the census was 68. The Administrator indicated she was aware of the insufficient staff which resulted in the need for the DNS and ADNS to have to work in the capacity of charge nurse on the unit, and that there was not a dedicated Infection Control Nurse (ICN). The Administrator indicated the facility is in the process of attempting to hire new employees. Review of the daily attendance report for the day shift dated 6/3/20 (7:00 AM -3:00 PM) and a tour at 11:30 AM with the Social Worker identified the following: The East unit (positive Covid-19 unit) with a census of 24 residents. Observation identified the staffing as following; 1 LPN and 2 nurse aides. Additionally, 1 nurse aide was on orientation. The Northeast unit had a census of 17 residents. Observation identified the staffing as following; 1 RN working in the capacity of both charge nurse and RN Supervisor and 2 nurse aides. The West unit (positive Covid-19 unit) had a census of 26 residents. Observation identified the staffing as following; 1 LPN and 3 nurse aides. Review of the daily attendance report for the evening shift dated 6/3/20 (3:00 PM - 11:00 PM) and a tour at 3:10 PM with the Social Worker identified the following: The East unit had a census of 24 residents. Observation identified the following staffing; 1 LPN, 1 nurse aide and on nurse aide on orientation. The Northeast had a census of 17 residents. Observation identified the following staffing; 1 LPN and 2 nurse aides. The West unit (positive Covid-19 unit) had a census of 26 residents. Observation identified the following staffing; the DNS acting in the capacity of charge nurse and 1 nurse side. Interview on 6/3/30 at 3:11 PM with the DNS identified because of insufficient staffing, she is scheduled to work on the unit this evening as the charge nurse. The DNS indicated due to staffing issues, she also worked a double shift yesterday, 6/2/20, during the 7:00 AM - 3:00 PM and 3:00 PM - 11:00 PM in the capacity of charge nurse. The DNS indicated staffing is an issue in the facility. Interview on 6/3/20 at 3:20 PM with NA #9 identified she is the only nurse aide on the West unit, which has 26 residents. NA #9 indicated staffing is an issue in the facility. Subsequent to surveyor inquiry an LPN was found to act in the capacity of charge nurse during the for the 3:00 PM - 11:00 PM shift so the DNS can act in the capacity of the RN Supervisor. Review of the daily attendance report for the day shift (7:00 AM - 3:00 PM) dated 6/4/20 and a tour at 10:30 AM with the Social Worker identified: the facility census to be 66. The staffing identified 3 LPN's and 7 nurse aides. Additionally, there were 4 nurse aides on orientation. Interview on 6/4/20 at 10:45 AM with the Administrator identified the MDS Coordinator (RN #3) is the RN supervisor for this shift, however, interview on 6/4/20 at 11:00 AM with RN #3 identified she is not the RN supervisor on duty. Interview on 6/4/20 at 11:05 AM with the Administrator identified the MDS Coordinator is the only RN in the facility today because both the DNS and ADNS were out. The Administrator indicated staffing is an issue. The Administrator indicated the Regional Corporate staff member and herself are working on the staffing issues for the facility. Review of the Interim Staffing Contingency Plan policy identified the facility will ensure that adequate staffing is provided per State and Federal guidelines, in a pandemic the facility has the back up with an in house pool agency that will assist the facilities to meet staffing needs. Other initiative include but are not limited to: Employee referral bonuses for all internal recruiting. Use of internal pool agency to fill shifts. Please refer to F684, F689 and F880.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of facility documentation, facility policy and interview, the facility failed to ensure appropriate screening practices were in place for staff and visitors entering the building, failed to ensure appropriate signage on the doors for residents on a Covid dedicated unit, and failed to ensure an acting Infection Control Nurse was available full time to monitor and implement measures to prevent and control the spread of Covid-19, and for 1 resident (Resident #6) the facility failed to ensure Covid-19 infected residents were cohorted in accordance with CDC recommendations. The findings include: 1. Observation upon entering the facility on 6/3/20 at 9:15 AM identified a sign at the front desk that read; Staff, Vendors, and Consultants: A reminder, use hand sanitizer upon entering our building. Fill out illness screen and check your temperature. Interview with LPN #1 on 6/3/20 at 9:15 AM indicated the surveyors must take their own temperatures and complete the staff screen questionnaire form at the desk. LPN #1 indicated she has been taking her own temperature since 3/20/20. Interview with the Social Worker on 6/3/20 at 9:17 AM identified she has been taking her own temperature in the morning since March 2020 and identified staff are responsible to take their own temperatures. Interview with the Administrator on 6/3/20 at 9:20 AM identified indicated the receptionist would be the staff member responsible to take the staff temperatures during her working hours of Mondays through Fridays from 9:00 AM to 5:00 PM. The Administrator indicated the receptionist has been out of work for a week. Additionally, the Administrator could not identify who is responsible to screen staff at other times. Interview with the Director of Admissions on 6/3/20 at 9:22 AM identified she has been taking her own temperature in the morning. Interview with the Scheduler on 6/3/20 at 10:03 AM identified she has been taking her own temperature since 3/20/20. She indicated the staff are responsible to take their own temperatures in the lobby and the service entrance. Review of the staff screen questionnaire on 6/3/20 at 10:10 AM with the Scheduler at the service entrance desk identified a questionnaire dated 6/3/20 was incomplete. The incomplete form failed to have a temperature. Interview with Cook #1 on 6/3/20 at 10:28 AM identified she came in at 5:00 AM and entered the building through the service entrance and completed the staff screen questionnaire and did not document the temperature. Cook #1 attempted three times to take her temperature and the thermometer was not working, however, she did not report it to the supervisor. Cook #1 indicated she went into the kitchen and started working and forgot about it. Interview with the Dietary Manager on 6/3/20 at 10:29 AM identified she was not aware that Cook #1 did not take her temperature prior to her shift and indicated the expectation is that all kitchen staff are to take their temperature before reporting to the kitchen. The Dietary Manager indicated if the thermometer was not working the nursing supervisor should have been notified. Interview with Housekeeper #1 on 6/3/20 at 11:26 AM identified she came into the facility this morning through the service entrance at 5:30 AM and the thermometer was not working. Housekeeper #1 indicated she walked to the front lobby to the receptionist area and used the thermometer to take her own temperature. Interview with NA #1 on 6/3/20 at 11:22 AM identified she came into the facility this morning through the front lobby and took her own temperature and filled out the staff screen form. NA #1 indicated she has been taking her own temperature since 3/11/20. Interview with LPN #2 on 6/3/20 at 11:28 AM identified she came into the facility this morning through the front lobby and took her own temperature and filled out the staff screen form. LPN #2 indicated she has been taking her own temperature since 3/20/20. Interview with APRN #1 on 6/3/20 at 11:33 AM identified she came into the facility this morning through the front lobby and took her own temperature and filled out the staff screen form. Interview with Hospitality Aide #1 on 6/3/20 at 11:34 AM identified she came into the facility this morning through the front lobby and took her own temperature and filled out the staff screen form. Hospitality Aide #1 indicated she usually take her own temperature. Interview with NA #2 on 6/3/20 at 11:42 AM identified he came into the facility this morning through the East unit entrance and took his own temperature and filled out the staff screen form on the unit at the nurse's desk. NA #2 indicated he has been taking his own temperature since 3/20/20. NA #2 was unable to find the staff screen form he had filled out this morning. Interview with Housekeeper #3 on 6/3/20 at 1:09 PM identified she came into the facility this morning through the service entrance and took her own temperature and filled out the staff screen form. She indicated she has been taking her own temperature since 3/20/20. NA #3 was unable to find the staff screen from that she had filled out this morning. Interview with RN #1 on 6/3/20 at 1:11 AM identified she came into the facility this morning through the front lobby and took her own temperature and filled out the staff screen form. RN #1 indicated she has been taking her own temperature since 3/20/20. Interview on 6/3/20 at 1:28 PM with the Administrator identified she was not aware the staff were entering the facility through the unit entrances. The Administrator indicated there are 2 locations for staff screening through the front entrance and the service entrance. Interview on 6/9/20 at 3:46 PM with the DNS identified she was not aware the staff were entering the facility through the unit entrances. The DNS indicated there are 2 locations for staff to enter the building and take their own temperature and

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	075070	A. BUILDING _____ B. WING _____	**06/11/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
APPLE REHAB SAYBROOK	**1775 BOSTON POST RD OLD SAYBROOK, CT 06475**

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

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 5) that is through the front entrance and the service entrance. The DNS indicated an in-service/education will be given to all facility staff. Review of the Staff Screen policy identified please in-service your screen staff of the below that any yes on the screen must be reviewed by IP/DNS/Designee immediately before staff or visitor proceed into the facility. Review of the Center for Disease Control (CDC) guidelines in response to Covid-19 identified that upon entry into the facility all visitors will be screened for fevers over 100.0 degrees Fahrenheit and questioned about possible symptoms and exposure to Covid 19. 2. Interview on 6/3/20 at 9:30 AM with the Administrator identified the DNS has been overseeing the position of Infection Control Nurse (ICN), and the facility is in the process of hiring a Registered Nurse for the ICN position. The Administrator indicated she is aware staffing is an issue in the facility. Interview on 6/3/20 at 12:34 PM with RN #2, the previous ICN, indicated her last day at the facility was in the beginning of February 2020. RN #2 indicated she worked as the ICN, wound nurse, staff development, supervisor and charge nurse on the floor. RN #2 indicated since January 2020 she has not been able to do the ICN duties due to staffing issues in the facility. RN #2 indicated she was pulled in many different directions and could not do the ICN role. RN #2 indicated she worked on the floor as a nurse and supervisor most days and was not able to work in her job as an ICN. RN #2 indicated she left the job due to staffing issues at the facility. Interview on 6/3/20 at 3:16 PM with the DNS identified she oversees the infection control program and the DNS position. The DNS indicated she had been overseeing the infection control program since the previous ICN left sometime in February 2020. The DNS indicated the line list had not been updated because she has been on the floor working as a nurse. 3. Observation on 6/3/20 at 11:30 AM with the Social Worker identified 2 of 16 rooms on the East unit, a Covid -19 positive unit, were lacking isolation signage. One of the 17 rooms on the West unit, a Covid-19 positive unit, was lacking isolation signage. Interview with the Administrator on 6/3/20 at 1:30 PM identified she was not aware that rooms on the dedicated Covid positive units lacked appropriate signage. Interview with the DNS on 6/3/20 at 3:11 PM identified she was not aware that signs were missing on the Covid positive unit. The DNS identified that all Covid-19 positive rooms are required to have visible precaution signs present to identify the need to take appropriate precautions for Covid-19 positive residents. The DNS indicated an in-service would be given to the nursing staff. Although a facility policy for signage related to transmission-based precautions was requested, none was provided. Subsequent to surveyor inquiry, the DNS posted the required signage. 4. Review of the census list identified the facility capacity is 120 beds, and Resident #6 has been assigned to the same room since 10/1/19. Resident #6 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Facility census information identified Resident #6 has been residing in the same room since admission. The quarterly MDS dated [DATE] identified Resident #6 had moderately impaired cognition, and required limited assistance with personal hygiene and toilet use. A physician's orders [REDACTED]. A physician's orders [REDACTED]. Additionally, monitor oxygen saturation every shift, report if oxygen saturation is below 90 % to supervisor and document the findings. Additionally, monitor for signs and symptoms of malaise (fatigue), dizziness, change in mental status, change in behavior, diarrhea, sore throat, loss of appetite and report to supervisor. A nurse's note dated 5/18/20 at 4:04 PM identified the resident representative was notified that the facility would be undergoing Covid-19 Point Prevalence testing this week. A physician's orders [REDACTED].#6 for Covid-19. Facility documentation dated 5/30/20 identified that Resident #6's roommate was diagnosed with [REDACTED]. Interview on 6/3/20 at 3:11 PM with the DNS indicated she was aware that Resident #6's roommate tested positive for Covid-19 on 5/30/20, and despite the newly confirmed with Covid-19 infection, a room change was not made. The DNS indicated Resident #6 had been exposed to the roommate, and the facility was to monitor Resident #6 for sign and symptoms of Covid-19. Additionally, the DNS indicated Resident #6 refused twice to be tested for Covid-19. The DNS indicated both residents were placed on droplet precautions, and staff were in-serviced to pull the privacy curtain in between the beds. Interview on 6/4/20 at 11:05 AM with the Administrator indicated she was not aware that Resident #6 refused to be tested twice for the Covid-19. The Administrator indicated the expectation was for staff to follow the CDC guideline and facility policy regarding cohorting related to Covid-19 residents. Observations on 6/3, 6/4, 6/6 and 6/11/20 identified Resident #6 continued to share a room with his/her roommate who had tested positive for Covid 19 infection on 5/30/20. Review of the facility census report dated 5/28/20 through 6/11/20 identified the facility had a minimum of 48 empty beds available, that could have been assessed to be used for appropriate cohorting of Resident #6's roommate, who was Covid-19 infected. Review of the Interim Infection Prevention and Control recommendations for patients with suspected or confirmed coronavirus disease (Covid-19) policy identified transmission-based precautions are designed for patients documented or suspected to be infected with highly transmissible microorganisms for which additional precautions beyond standard precautions are needed to interrupt transmission in the facility. If the facility has positive Covid-19 resident(s): Transmission based precautions are initiated. Resident (s) placed in a private room or cohorted with another Covid-19 positive resident. If the Covid-19 positive resident was roomed with a roommate, isolate roommate for 14 days or till results are received, if tested . Review of the Covid-19 Protocol policy identified the following serves as a guideline for any facility that has a positive Covid-19 resident: Follow facility policy for contact and droplet precautions. Place positive Covid-19 resident in a private room. If roommate is there isolate roommate for 14 days or if tested positive. The facility failed to cohort Resident #6's roommate, who was newly diagnosed with [REDACTED].#6 who did not have a [DIAGNOSES REDACTED].