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ELIZABETH CITY HEALTH AND REHABILITATION	**1075 US HIGHWAY 17 SOUTH ELIZABETH CITY, NC 27909**

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E 000	Initial Comments An unannounced COVID-19 Focused Survey was conducted on 1/7/21 to 1/19/21. The facility was found in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# UVZW11.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and complaint investigation were conducted on 1/7/21 to 1/19/21. The facility was found not to be in compliance with 42 CFR §483.80 infection control regulations and has not implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Event #UVZW11. Two of the nine allegations were substantiated with deficiencies.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of	F 580		2/9/21

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

Electronically Signed | 02/05/2021

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F 580	Continued From page 1 treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, family interview, nurse practitioner interview, and physician interview the facility failed to notify a physician and the responsible party of a resident's change in ability to swallow and eat for	F 580	F580 Preparation and or execution of this plan does not constitute admission or agreement by the Provider of the truth of	

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F 580	Continued From page 2 1 (Resident #3) of 3 residents reviewed for notification of a change in condition. Findings included: Resident #3 was admitted to the facility from the hospital on 11/16/20 with diagnoses of strokes, Parkinson's disease, depression, aphasia, dysphagia, malnutrition, blindness, and Alzheimer's disease. An admission minimum data set assessment dated 11/20/20 coded Resident #3 as cognitively impaired, requiring extensive assistance with eating, no weight loss, and no dehydration. The resident's care plan, initiated on 12/16/20, identified the resident was at risk for dehydration and nutritional decline. Staff were directed to consult with the registered dietitian, encourage fluid consumption, and monitor for dehydration. Documentation in the nursing notes revealed on 12/13/20 Resident #3 tested positive for Covid-19 and was moved to the Covid-19 unit. Documentation in a physician's follow up note for Resident #3 dated 12/19/20 revealed in the assessment and the plan, "Variable [by mouth] intake. She does not appear to be malnourished or dehydrated at this point. Nutritional recommendations are to increase caloric intake. With Covid-19 infection and dementia, however, this will be the biggest challenge. As mentioned on admission, I think the patient has a progressive decline, now with Covid-19 infection. We may need to discuss seriously advance directives, even comfort care measures on the patient. Her prognosis is fair at best. Consider follow up labs if [by mouth] intake drops off or	F 580	facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and executed solely because it is required by the provisions of State and Federal law. Resident #3 was admitted to the facility from the hospital on 11/16/20. Resident #3 was cognitively impaired and required extensive assistance with eating. On 12/13/20 Resident #3 tested positive for COVID-19. Between the dates of December 13, 2020 and residents discharge to the hospital on December 27, 2020. Resident #3 exhibited decrease nutritional intake by mouth (PO intake). Per investigation ad interviews, the Nurse Practitioner and Responsible Party state they were not notified of resident□s decrease PO intake. Resident #3 was discharged to the hospital via Emergency Management Services on December 27, 2020. On 1/18/21 physical assessments (to include, skin, lethargy, unresponsiveness, and full body system review) were completed for all residents in the facility by Licensed Nurses. All acute changes of condition were documented on a SBAR. Physicians and Responsible Parties were notified of all changes found on 1/18/21. Education for 100% of licensed staff including but not limited to, licensed nurses and nurse aides was initiated on Managing Acute Change in Conditions (to include MD & RP notification) and following Physician Orders. Any staff not in-serviced beyond 1/18/21 did not work until in-servicing was completed. On 1/18/2021 a QAPI meeting was held.	

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F 580	Continued From page 3 appears dehydrated." An interview was conducted with Nurse Aide (NA) #4 on 1/11/21 at 2:17 PM who was assigned to Resident #3 primarily on the 7:00 AM to 3:00 PM shift. NA #4 stated the health of Resident #3 seemed to be failing when she was on the Covid-19 unit. NA #4 stated Resident #3 drank a little and never really ate a lot. NA #4 stated Resident #3 got to the point she was not eating or drinking at all. NA #4 stated she could not recall specific amounts of consumption for Resident #3 on specific days but accounted for the accuracy of her documentation in the medical record. NA #4 stated she did let the nurses know Resident #3 was not eating or drinking. NA #4 stated occupational and speech therapy were working with the Resident #3. An interview was conducted with NA #3 on 1/11/21 at 2:47 PM, who was assigned to Resident #3 primarily on the 3:00 PM to 11:00 PM shift. NA #3 stated the documentation she put in the medical record was accurate documentation. NA #3 stated, "If I wrote Resident #3 consumed 120 ml of fluid on my shift then Resident #3 drank 120 ml of fluid in total." NA #3 stated she did let the licensed nursing staff know when Resident #3 was not eating or drinking. An occupational therapy summary note, dated 12/23/20, noted Resident #3 on that day was coughing and spitting food and milk out while the therapist worked with her on food and fluid consumption. The therapist did note the resident requested milk but did not consume it because of coughing and spitting the milk out. The therapist noted nursing and speech therapy were notified.	F 580	The event, investigation process and corrective action plan was reviewed. In order to ensure regulatory compliance and safety of the residents, the Director of Nursing or designee will conduct a minimum of ten random change in condition and radiological orders audits per week for one month. The Director of Nursing will report all positive and negative findings with this process to the Quality Assurance Performance Improvement Team for a minimum of two consecutive meetings. The team will then determine if additional monitoring or in-servicing is necessary.	

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NA #2 was interviewed on 1/12/21 at 10:22 AM. NA #2 stated both she and speech therapy attempted to feed Resident #3 on 12/23/20 but the resident would only spit out the food. NA #2 said she attempted to provide Resident #3 with fluids with a straw, but the liquid just ran out the sides of the resident's mouth and she was coughing. NA #2 stated all the nursing staff were aware Resident #3 was no longer eating or drinking. NA #2 confirmed she told the licensed nursing staff each time Resident #3 did not eat or drink.

Documentation in a speech therapy summary of daily skilled services note dated 12/23/20 stated in part, "Nurse reported increased difficulty when drinking sips of thin liquids. Patient downgraded to Nectar thick liquids in order to decrease aspiration risk."

A nursing progress note by Nurse #3, dated 12/23/20 at 5:08 PM, noted the resident had been alert but was spitting out food, liquids, and medications. The nurse further noted the resident's feet were bilaterally cold, her feet had turned a dark pink to purple color, and the Nurse Practitioner (NP #1) was notified and visited the resident.

On 12/23/20 NP #1 documented Resident #3's presenting problem for which she was being seen was "poor circulation." NP #1 further noted the following. Resident #3 was Covid-19 positive but was otherwise asymptomatic of the Covid-19 virus. The resident had decreased perfusion to her bilateral legs. An ultrasound would be ordered for further evaluation of vascular problems and the resident would be place on Azithromycin (an antibiotic sometimes used to treat Covid-19

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F 580	Continued From page 5	F 580		

positive residents), Decadron (used to treat inflammation), and supplement pills. NP #1 made no mention of the resident's declining oral intake in the note.

NP #1 was interviewed on 1/13/21 at 11:30 AM. NP #1 stated she was notified by the nurse Resident #3 had a blue tint to her lower extremities on 12/23/20. NP #1 stated she was unaware and was not notified by the nurse on 12/23/20 Resident #3 had been spitting out food, liquids, and medications or of the diet order change to thickened liquids. NP #1 stated if she would have known she would have implemented any needed interventions such as laboratory tests or intravenous fluids. NP #1 stated she receives a report every morning from the on-call service from any changes or new orders for the residents of the facility. NP #1 stated she did not receive any reports from the on-call service for 12/25/20, 12/26/20, or 12/27/20. NP #1 stated she was not aware of why Resident #3 was sent to the hospital, but she assumed it was due to respiratory issues.

Nurse #3 was interviewed on 1/12/21 at 12:49 PM. Nurse #3 stated on 12/23/20 Resident #3 was her usual self but had gotten to the point she was spitting out medications, food, and liquids. Nurse #3 stated Resident #3 was not really in distress. Nurse #3 knew speech therapy visited Resident #3 on 12/23/20. Nurse #3 did not recall if she told NP #1 of the resident spitting out food, fluids, and liquids. Nurse #3 stated she did call the responsible party for Resident #3 to notify him of the new orders she received on 12/23/20. Nurse #3 did not recall if she told the responsible party for Resident #3 she was having trouble swallowing liquids and food on 12/23/20. Nurse

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F 580	Continued From page 6 #3 stated it was very typical for residents to lose their appetite with a diagnosis of Coronavirus. Nurse #3 stated she also cared for Resident #3 on 12/25/20. Nurse #3 stated Resident #3 remained in the same condition on 12/25/20, not eating and drinking very little. The responsible party (RP) for Resident #3 was interviewed on 1/11/21 at 1:22 PM. The RP stated about a week prior the Covid-19 diagnosis of Resident #3, he was notified by the weekend nurse Resident #3 was put on the nutritional supplement Boost due to a slow weight loss. The RP stated he was notified on 12/13/20 Resident #3 tested positive for Covid-19 with a rapid test. RP stated he was contacted on 12/23/20. He said a voice mail was left on his phone stating there was no emergency, and nothing was wrong. He stated the voice mail had no sense of urgency and the facility just wanted to update him on some medication changes. He stated he called the facility back three times to get through to the Covid-19 unit on the fourth attempt. He stated he was told his mother was being put on an antibiotic. The RP stated he did not know why she was put on the antibiotic, but he assumed it was for a urinary tract infection. The RP stated the next time he was called by the facility it was to notify him the facility was sending Resident #3 to the emergency room. The RP stated he was not made aware of any other concerns. An interview was conducted with the Director of Nursing on 1/14/21 at 10:40 AM. The Director of Nursing stated anytime there was a change in a resident or a change in the care provided to a resident, the family should be notified.	F 580		
F 880 SS=E	Infection Prevention & Control	F 880		2/9/21

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F 880	Continued From page 7 CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a	F 880		

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F 880	Continued From page 8 resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, nursing staff interview, and physician interview the facility staff failed to implement interventions for a wandering resident during a Covid-19 outbreak to prevent a resident from wandering in and out of other resident rooms to prevent the possible spread of the Covid-19 virus to herself and the resident population for 1 (Resident #1) of 1 resident reviewed for wandering behaviors. This occurred during a Covid-19 pandemic. Findings	F 880	Preparation and or execution of this plan does not constitute admission or agreement by the Provider of the truth of facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and executed solely because it is required by the provisions of State and Federal law. Resident #1 was admitted to the facility on 11/27/20. This resident was identified as a	

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F 880	Continued From page 9	F 880		

included:

Resident #1 was admitted to the facility on 11/27/20 from the emergency room with a diagnosis of dementia and aphasia.

Resident #1 resided on the 600 hall in a semiprivate room upon admission on 11/27/20.

An admission minimum data set assessment dated 12/2/20 coded Resident #1 as cognitively impaired with unclear speech and was rarely understood. Resident #1 was coded as having physical behaviors and other behaviors one to three days of the assessment period. Resident #1 was coded as having wandering behaviors 4 to 6 days of the assessment period that significantly intruded on the privacy or activities of others. The wandering behavior was coded as putting Resident #1 at risk of getting into dangerous places.

Resident #1 had a care plan problem for wandering and the use of a Wander guard initiated on 12/4/20. Some of the interventions included observing her location when out of bed and redirection as indicated implemented by nursing and nurse aides. The care plan had an additional problem area initiated on 12/4/20 for Resident #1 intruding on the other residents' privacy. One of the interventions was to assign staff to account for her whereabouts throughout the day by activities, nursing assistants, nursing, and social services.

Documentation in the nursing notes on 11/30/20 at 2:43 AM revealed, "[Resident #1] continued to ambulate throughout the unit going in and out of other patients' rooms. [Resident #1] did not

wander risk as noted in her care plan and by the placement of a wander guard.
Upon review of resident□s medical record and staff interviews, it was determined that Resident #1 had been observed wandering outside her room without supervision or proper infection control methods on multiple occasions. Resident #1 was identified as being positive for COVID-19 on December 16, 2020 following receipt of results from test samples obtained on December 14, 2020. Resident #1 was provided intermittent sitters being December 13, 2020. Resident #1 has not exhibited sign of wandering since January 10, 2021.
On January 18th, licensed nursing personnel audited all residents for mobility capabilities and a risk of wandering. Any resident with identified wandering who exhibit signs of increased risk of insufficient infection control practices due to their wandering were provided an intervention to ensure the safety of themselves and all residents.
The Director of Nursing and members of nurse management in-serviced 100% of staff, including but not limited to, licensed nurses, nurse aides, facility aides, dietary, housekeeping, administration, and clerical support regarding dementia management and wandering patients, Infection Control and Proper PPE for residents and staff. Any staff not in-serviced beyond 1/18/21 did not work until in-servicing was completed.
On 1/18/2021 a QAPI meeting was held. The event, investigation process and corrective action plan reviewed.

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F 880	Continued From page 10 remove any items from rooms and was redirected with intermittent periods of increased irritation. Patient rested for short periods of time in room then returned to ambulating unit. [Resident #1] attempted on numerous occasions to exit facility and had to be redirected." The nurse who wrote the documentation on 11/30/20 at 2:43 AM was Nurse #4. Nurse #4 was interviewed on 1/8/20 at 3:00 PM. Nurse #4 stated she worked every other weekend from 7:00 AM to 11:00 PM on the 600 hall. Nurse #4 stated Resident #1 would wander in the 600 hall unit and wander the halls of the facility all night. Nurse #4 stated Resident #1 did not have a sitter but occasionally a staff member would follow her. Nurse #4 stated Resident #1 could not be contained to one hall or one unit. Nurse #4 stated Resident #1 was definitely an infection control risk because she could not be monitored all the time. Documentation in the nursing notes on 12/1/20 at 3:06 PM revealed Resident #1 was wandering around the facility and had to be redirected from entering other residents' rooms at times. Nurse #3 wrote the documentation in the nursing notes on 12/1/20 at 3:06 PM. An interview was conducted with Nurse #3 on 1/7/21 at 4:25 PM. Nurse #3 stated she usually worked on the 7:00 AM to 3:00 PM shift. Nurse #3 stated Resident #1 spent only a short period of time in her room and was constantly wandering around and in other residents' rooms on the 600 hallway. Nurse #3 stated that other staff members from the other halls would bring Resident #1 back when she wandered to other halls and sometimes the nursing staff would have to look for her around	F 880	On 1/26/21, the Regional Clinical Manager in-serviced the Administrator, Director of Nursing and Staff Development Coordinator regarding infection control processes and procedures, including but not limited to, managing the spread of infection by resident to resident transmission. This training also included completion of a Root Cause Analysis. In order to ensure regulatory compliance and safety of the residents, the Director of Nursing or designee will ensure wandering assessments are completed for all new admissions to identity potential of wandering. For a minimum of one month, the Director of Nursing, Administrator or designee will review daily nurses notes Monday through Friday to ensure there is no evidence of residents wandering or exhibiting behaviors that could result in the spread of infections. Any identified concerns will be addressed immediately. The Director of Nursing will report all positive and negative findings with this process to the Quality Assurance Performance Improvement Team for a minimum of two consecutive meetings. The team will then determine if additional monitoring or in-servicing is necessary.	

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the facility. Nurse #3 stated Resident #1 would not wear a mask and did not understand the necessity to do so. Nurse #3 stated Resident #1 would go into open doors and would have to be guided with any tasks such as hand hygiene or wearing of a mask.

Documentation in the nursing notes on 12/1/20 at 5:34 PM revealed Resident #1 was wandering the hallways into other residents' rooms.

Nurse #2 wrote the documentation in the nursing notes on 12/1/20 at 5:34 PM. An interview was conducted with Nurse #2 on 1/7/21 at 4:00 PM. Nurse #2 stated she usually worked on the 3:00 PM to 11:00 PM shift. Nurse #2 indicated Resident #1 never slept and just wandered around the entire shift and became combative at times when redirected. Nurse #2 said that Resident #1 wandered around the entire facility and she would have to go and look for her on the other hallways. Nurse #2 indicated Resident #1 was placed on the isolation when she first arrived, but she could not recall if there were any Covid-19 positive residents on the hallway at that time. Nurse #2 stated the nursing staff were constantly trying to put a mask on Resident #1, but she kept removing it or pulling it down. Nurse #2 stated one night, Resident #1 went into another resident's room on the 600 hall and urinated on the floor and then sat in a chair and defecated on the chair.

Documentation in the nursing notes on 12/2/20 at 8:40 AM revealed Resident #1 was wandering into other residents' rooms. The nurse who wrote this documentation was not available for interview.

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	345036	A. BUILDING _____ B. WING _____	C 01/19/2021

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Documentation on 12/2/20 at 9:40 PM revealed Resident #1 was "wandering in and out of residents' rooms taking off clothes urinating and defecating in residents' rooms on floor and furniture." This documentation in the nursing notes was written by Nurse #2.

Documentation on 12/4/20 at 10:02 AM revealed Resident #1 "continues to ambulate independently throughout the unit, in and out of other resident's rooms unable to redirect at times." The nurse who wrote this documentation was not available for interview.

Documentation on 12/5/20 at 3:59 PM revealed Resident #1 continues to wander all over the facility and into other resident's rooms. This documentation in the nursing notes was written by Nurse #3.

Documentation on 12/9/20 at 3:12 PM revealed Resident #1 was wandering around the facility during the whole shift. This documentation in the nursing notes was written by Nurse #3.

Resident #1 had Covid-19 test taken on 12/10/20 with a negative result.

Census information in the medical record revealed Resident #1 was moved on 12/11/20 to a private room on the 600 hall closer to the nursing desk.

Documentation on 12/12/20 at 3:48 AM revealed Resident #1 was wandering around the unit, was difficult to redirect, and required multiple attempts to keep the resident from entering other resident rooms.

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The documentation on 12/12/20 at 3:48 AM was written by Nurse #1. Nurse #1 was interviewed on 1/7/21 at 3:45 PM. Nurse #1 stated she worked on the 11:00 PM to 7:00 AM shift when Resident #1 was first admitted to the facility on the 600 hall. Nurse #1 stated Resident #1 walked independently and wandered on her own. Nurse #1 stated it was a challenge for the two nurse aides and herself to monitor Resident #1 and "keep an eye on her." Nurse #1 stated the nursing staff tried to keep Resident #1 out of other residents' rooms, but she may have entered a resident room when they were not looking.

Nurse #4 was interviewed on 1/8/21 at 3:00 PM. Nurse #4 stated she worked every other weekend from 7:00 AM to 11:00 PM on the 600 hall. Nurse #4 stated she was working on the 600 hall on 12/12/20. Nurse #4 stated on 12/12/20 two Covid-19 positive residents were moved to the end of the 600 hall on her shift. Nurse #4 stated on her shift the fire doors to the hallway were not closed and there was no barrier of any kind put up on the 600 hallway. Nurse #4 stated Resident #1 was up and down the 600 hallway and all over the building going into and out of the resident rooms. Nurse #4 stated she did not know if Resident #1 went into the rooms with the Covid-19 positive residents because Resident #1 could not be contained or monitored all the time. Nurse #4 stated the facility did not have dedicated staff working on the 600 hall on 12/12/20. Nurse #4 stated staff members went on and off the 600 hall during her shift. Due to infection control concerns Nurse #4 stated she did not return to the facility to work on 12/13/20.

Documentation on 12/13/20 at 6:46 AM revealed Resident #1 "required frequent redirection away

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from service hallway, front lobby and courtyard." The nurse who wrote this documentation was not available for interview.

Documentation in the nursing notes on 12/13/20 at 1:32 PM revealed Resident #1 was ambulating in her room with a sitter present. This was the first documentation in the nursing notes of a sitter being present with the resident.

The documentation on 12/13/20 at 1:32 PM was written by Nurse #7. Nurse #7 was interviewed on 1/12/21 at 9:45 AM. Nurse #7 stated she was assigned to work on the 600 Hall of the facility from 7:00 AM to 11:00 PM on 12/13/20. Nurse #7 stated she had to pass out medications and monitor Resident #1 who required frequent redirection. Nurse #7 stated she would put a mask on Resident #1 and Resident #1 would take it off. Nurse #7 stated Resident #1 was hard to redirect because of her diagnoses and Resident #1 did not and could not be made to understand the situation. Nurse #7 stated she did not know if Resident #1 went into any of the rooms with the Covid-19 positive residents but it was a good possibility. Nurse #7 stated it was not uncommon for Resident #1 to go into other resident rooms. Nurse #7 stated in the afternoon of 12/13/20 she assigned a nurse aide to be a sitter for Resident #1 because it was impossible to keep up with who Resident #1 encountered that day.

A facility social worker (SW #1) was interviewed on 1/12/21 at 11:20 AM. SW #1 stated she thought a sitter was assigned to watch Resident #1 and she did not remember her wandering around on 12/13/20. SW #1 stated she left the facility at approximately 12:00 PM on 12/13/20.

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Resident #1 had Covid-19 test results reported on 12/16/20 as positive from a test taken on 12/13/20.

Census information in the medical record revealed Resident #1 was moved to the 300 hallway on 12/16/20 at 1:26 PM. The 300 hallway was designated a Covid-19 unit on 12/16/20.

Documentation on 12/18/20 at 8:00 AM revealed Resident #1 was ambulating in the hallways unable to be redirected, coughing and wiping her nose onto clothing or attempting to wipe on staff when attempting to assist or redirect the resident.

Documentation on 12/21/20 at 9:06 PM revealed, "[Resident #1] is continuously wandering up and down hall, attempting to go out exit, resident continues to wander into other resident's room, unable to redirect for more than a few seconds at time, resident does not follow directions or commands."

Documentation in a nurse practitioner progress note dated 12/21/20 revealed Resident #1 had tested positive for Covid-19 but was asymptomatic. The progress note stated in part, "Patient frequently [roams] the halls, enters other patients' rooms, and even reportedly will drink from [their] water pitchers. Patient is confused at baseline as she has a significant [prior medical history] of dementia. Patient is at high risk to spread virus due to frequent wandering and lack of wearing mask. Patient has been moved to a separate side of the building and a barrier has been placed in an effort to keep patient to one area with other Covid positive patients. Patient is difficult to redirect but will ensure she either stays in her room or behind barrier. Patient may need a

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sitter/safety partner to prevent her from entering other patients' rooms."

Documentation in the nursing notes on 1/1/21 at 6:35 AM revealed, "[Resident #1] continues to wander about facility and will go into other rooms, often when redirected resident will become agitated. Incontinent care given when resident allows."

Documentation on 1/5/21 at 2:53 PM revealed Resident #1 was wandering in the halls with a personal care assistant.

An interview was conducted with NA #1 on 1/7/21 at 12:49 PM. NA #1 stated that before the 300 hallway was closed off with plastic for isolation purposes, Resident #1 would wander up and down the hallways and into resident rooms without a mask on. NA #1 stated Resident #1 was supposed to have a sitter, but it seemed like she was always alone.

An interview was conducted with NA #2 on 1/7/21 at 4:17 PM. NA #2 stated she always worked on the 600 hallway on the 3:00 PM to 11:00 PM shift. NA #2 stated Resident #1 was into and out of resident rooms constantly because not all the residents wanted to keep their doors shut. NA #2 confirmed Resident #1 wandered around the facility on all the halls. NA #2 recalled Resident #1 was in the resident bathrooms, in the hallways, and in the sitting room. NA #2 indicated it was difficult to monitor Resident #1 all the time.

An interview was conducted with the Infection Control Specialist and the DON on 1/7/21 at 2:00 PM. The infection control specialist revealed Resident #1 was admitted to the facility isolation

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unit on 11/27/20 for a period of 14 days from 11/27/20 to 12/11/20 for monitoring of Covid-19 symptoms. The DON indicated that the facility staff did their best to redirect and put a mask on Resident #1 because she could not be locked up. The DON indicted the staff would redirect Resident #1 back to her room and confirmed at times she would not go but was for the most part compliant. The DON stated before Resident #1 tested positive for Covid-19 the facility was trying to find appropriate placement for her but when Resident #1 contracted Covid-19 that was put on hold. The DON confirmed Resident #1 did go into and out of Residents' rooms but was unsure if any of the rooms Resident #1 entered were Covid-19 positive residents. The DON did not think Resident #1 wandering or going into other resident rooms was a significant event because she did not touch anything.

An interview was conducted with the medical director and the physician for Resident #1 (MD #1) on 1/8/21 at 8:14 AM. MD #1 indicated it was a difficult situation with Resident #1 wandering the facility. MD #1 stated he could not say for certain if the wandering of Resident #1 contributed to her testing positive for Covid-19 or the current outbreak in the facility. MD #1 stated when Resident #1 was first admitted to the facility he recognized she needed to be in locked unit but sadly nobody was willing to admit her. MD #1 stated fortunately Resident #1 recovered from Covid-19.

An interview was conducted with the Administrator on 1/8/21 at 3:44 PM. The Administrator confirmed the facility started looking for alternate placement for Resident #1 on 12/2/20 but no other facility will take her due to

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F 880	Continued From page 18 the fact she did not have a payer source. The Administrator stated the facility had sufficient staff to monitor Resident #1 and staff were assigned to monitor on an as needed basis on different shift depending on the resident's behavior. The Administrator stated Resident #1 has always had someone available to monitor her since her admission.	F 880		