Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004832	A. BUILDING: ____ B. WING ____	C 01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY OF CHICAGO WEST	5130 WEST JACKSON BOULEVARD CHICAGO, IL 60644

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Investigation: 2280001/IL141954 2280073/IL142043	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210b) 300.1210c) 300.1210d)2)3)4 300.1220b)7 300.1230e) 300.1810h) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:	S9999	Attachment A Statement of Licensure Violations	

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2) All treatments and procedures shall be administered as ordered by the physician.

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

4) Personal care shall be provided on a 24-hour, seven-day-a-week basis.

Section 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

7) Coordinating the care and services provided to residents in the nursing facility.

Section 300.1230 Direct Care Staffing

e) The facility shall schedule nursing personnel so that the nursing needs of all residents are met.

Section 300.1810 Resident Record Requirements

h) Treatment sheets shall be maintained recording all resident care procedures ordered by each resident's attending physician. Physician ordered procedures that shall be recorded include, but are not limited to, the prevention and treatment of decubitus ulcers, weight monitoring to determine a resident's weight loss or gain, catheter/ostomy care, blood pressure monitoring, and fluid intake and output.

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These requirements were not met as evidenced by:

1. Based upon record review and interview the facility failed to ensure that staff are aware of resident assignments, failed to follow physician orders by not monitoring vital signs every 4 hours, and failed to address resident change in condition for one of nine residents (R1) reviewed for infection control. These failures resulted in R1's not being monitored as ordered by physican and (1/1/22) death.

Findings include;

R1 was 66 years old.

The (12/31/21) progress notes state R1's (12/30/21) Covid test result was positive.

R1's (12/31/21) POS (Physician Order Sheets) state monitor patient with Covid 19 diagnosis or suspected Covid 19 for signs of clinical deterioration, such as rapidly progressive respiratory failure and sepsis. Monitor vital signs (full vitals) every 4 hours for 14 days. Observe for evidence of deterioration. Call medical doctor/nurse practitioner as indicated.

On 1/13/22 at 2:14pm, R10 (R1's roommate) stated on New Year's eve (2021) and New Year's day (2022) the Nurse said she was the only nurse on the floor, cause of the Covid a lot of nurses called off." Surveyor inquired about R1's status on or about 12/31/21 R10 responded "I (R10) used to help him (R1) go out and smoke but when they (staff) moved him (R1) in the room (12/28/21) I didn't even recognize him (R1). When he (R1) talked you couldn't even hear him

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he (R1) talked so soft. His (R1's) face was grey, he looked like his skin sunk in like bones and everything. They should have sent him (R1) to the hospital. Every time he (R1) would call the Nurses they would come in, turn his light off and go away. He couldn't talk and tell em what he needed. The day before he died (12/31/21) she (Nurse) didn't even come in the room for vital signs or meds our door was closed all night. The next day I (R10) called the nurse, told her something was wrong with him and he was dead." R10's (11/23/21) BIMS (Brief Interview of Mental Status) determined a score of 15 (cognitively intact).

R1's (1/1/22) Certificate of Death states death occurred in a nursing home. Cause of Death Novel Corona (Covid 19) Viral Infection. Time of Death: 9:03am.

The (December 2021/January 2022) MARS (Medication Administration Records) affirm that R1's vital signs were last documented on 12/31/21 at 3:00pm therefore on 12/31/21 (7:00pm & 11:00pm) and 1/1/22 (3:00am & 7:00am) vital signs were not documented. R1's vitals summary affirms no additional vital signs were documented on or about aforementioned dates as stated. [R2's Covid 19 monitoring evaluations for 12/31/21 and 1/1/22 were entered by V2 (DON/Director of Nursing) on 1/7/22, approximately a week after he expired].

R1's progress notes state; (1/1/22) 8:36am, Upon making morning rounds writer observed resident unresponsive, pupils dilated, no pulse palpated and no vital signs obtained. No response to verbal or tactile stimuli. CPR (Cardiopulmonary Resuscitation) initiated. 911 called. Paramedics in facility take over CPR. Resident still no vital

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signs at this time. Paramedics informed writer resident has expired.

On 1/18/22 at 11:19am, surveyor inquired about R1's (1/1/22) 7am-3pm status V9 (Licensed Practical Nurse) stated "Upon coming onto shift I was doing my rounds and I found him unresponsive. He was laying on his stomach, he was cold and his eyes was fixed. I checked for vital signs there were none so I called a code blue and initiated CPR (Cardiopulmonary Resuscitation)." Surveyor inquired why R1's 7:00am vital signs were not obtained V9 responded "I started at like 8:30 cause they was short a nurse so they asked me to come in."

On 1/18/22 at 11:42am, surveyor inquired about the facility protocol for residents who acquired Covid 19. V2 (DON) stated, "We put in orders for vital signs and the monitoring." Surveyor inquired where vital signs are documented V2 responded, "They're documented on the MAR (Medication Administration Record) they're also documented in the monitoring tool for like a change in condition. It's under forms, Covid monitoring." Surveyor inquired about the required frequency for Covid monitoring V2 replied "Everyone (re: Covid positive residents) should be having it (referring to the electronic Covid 19 monitoring evaluation) every shift." V2 subsequently accessed R1's electronic Covid 19 Monitoring Evaluations and affirmed that she (V2) entered the (12/30/21, 12/31/21, 1/1/22) 7am-3pm assessments however additional assessments (for other shifts) were not documented. Upon further inspection all aforementioned assessments were entered on 1/7/22 (a week later).

On 1/19/22 at 10:02am, surveyor inquired about

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S9999	Continued From page 5 R1's (12/31/21) status on the 11pm-7am shift V13 (Registered Nurse) stated "I was assigned to rooms 201-214 he (R1) was assigned to someone else." Surveyor inquired which nurse R1 was assigned to V13 responded "I don't remember." R1 resided on the 2nd floor. On 1/19/22 at 10:16am, V2 presented the 2nd floor (12/31/21) 11pm-7am daily assignment sheet (as requested) which states V13 was assigned to rooms 201-230. Surveyor inquired if V13 was assigned to the entire 2nd floor on 12/31/21 (11pm-7am) V2 stated "Yes." Surveyor advised that V13 stated he was not assigned to R1 on 12/31/21, therefore R1's assessments were not documented on or about said date/time, and R1's vital signs were not documented for 16 hours (prior to his death) which were supposed to be monitored every 4 hours. V2 responded "I know he told you that but he was the nurse assigned for that night." On 1/20/22 at 3:00pm, surveyor inquired about potential harm to a Covid 19 positive resident if not monitored for change in condition and/or vital signs are not obtained as ordered. V14 (Medical Director) responded, "If the vital signs are all stable and the condition is the same than not reporting to the Physician wouldn't cause any harm but not reporting to the Physician that the condition is different or the vital signs have changed than the implications may be different depending on the circumstance. Change in condition can be anything it would depend on what the vitals was. Not having vitals is not good, we should have the vitals to make sure they are stable. We can only assess the viability if they (vital signs) are stable."	S9999		

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The abuse prevention program (reviewed 1/2019) includes; Neglect: means the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress.

(A)

300.610c)2)
300.696a)
300.696b)
300.696c)6)7)
300.1210b)
300.1210c)
300.1210d)2)3)4

Section 300.610 Resident Care Policies
c) The written policies shall include, at a minimum the following provisions:
2) Resident care services, including physician services, emergency services, personal care and nursing services, restorative services, activity services, pharmaceutical services, dietary services, social services, clinical records, dental services, and diagnostic services (including laboratory and x-ray);

Section 300.696 Infection Control

a) Each facility shall establish and follow policies and procedures for investigating, controlling, and preventing infections in the facility. The policies and procedures must be consistent with and include the requirements of the Control of Communicable Diseases Code, and the Control of Sexually Transmissible Infections Code. Each facility shall monitor activities to ensure that these

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policies and procedures are followed.

b) A group, i.e., an infection control committee, quality assurance committee, or other facility entity, shall periodically review the results of investigations and activities to control infections.

c) Each facility shall adhere to the following guidelines and toolkits of the Center for Infectious Diseases, Centers for Disease Control and Prevention, United States Public Health Service, Department of Health and Human Services, and Agency for Healthcare Research and Quality

6) Guideline for Isolation Precautions: Transmission of Infectious Agents in Healthcare Settings

7) Guideline for Infection Control in Healthcare Personnel

Section 300.1210 General Requirements for Nursing and Personal Care

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following

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and shall be practiced on a 24-hour, seven-day-a-week basis:

2) All treatments and procedures shall be administered as ordered by the physician.

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

4) Personal care shall be provided on a 24-hour, seven-day-a-week basis.

These Requirements were not met as evidenced by:

1. Based upon observation, interview and record review the facility failed to ensure that all staff wear required PPE (Personal Protective Equipment) while in the building, failed to ensure that all staff were mask fit tested, failed to ensure that all residents wear a mask while outside their room, failed to ensure that contact/droplet precaution signs were posted on all Covid 19 positive residents rooms, failed to ensure that Covid 19 positive resident room doors were closed, failed to ensure that PPE is doffed/discarded prior to exiting isolation rooms and/or quarantined areas, failed to ensure that doffing stations/biohazard bins are located inside the quarantined area, failed to ensure that all Covid 19 positive residents were isolated from asymptomatic residents and failed to maintain 6 feet social distancing (in the elevator) in an effort to prevent the spread of infectious microorganisms including COVID 19. These

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failures resulted in a Covid 19 outbreak throughout the facility on or about 12/20/21 which affected 166 residents and 51 staff that tested positive for Covid 19.

Findings include;

The (1/10/22) census includes 187 residents.

On 1/10/22 at approximately 1:00pm, surveyor inquired if any residents in the facility are Covid positive V1 (Administrator) affirmed there was a recent Covid outbreak that affected 2nd, 3rd and 4th floor residents which are currently positive. Surveyor inquired about the required PPE (Personal Protective Equipment) for staff V1 stated "N95 and the face shields. Full PPE; gloves, gown and N95 if we go into the rooms."

On 1/10/22 at 2:01pm, V5 (CNA/Certified Nursing Assistant) was observed in the 4th floor hallway wearing 2 surgical masks. Surveyor inquired why an N95 mask was not in use V5 stated "I sometimes feel like I can't breathe with that one on so I just put 2 masks on." Surveyor inquired if V5 was mask fit tested V5 responded "I didn't get fitted yet. I missed my day to get it fit so I guess they'll do em again." The (1/10/22) log of current Covid positive residents includes rooms 429 and 430 however there were no contact/droplet precaution signs posted on and/or near either door. Surveyor inquired if the residents in room 429 and/or 430 were Covid positive V5 responded "No, nobody told me they was isolation."

On 1/10/22 at 2:07pm, V6 (CNA) was observed in the 4th floor hallway wearing 2 surgical masks. Surveyor inquired which masks she (V6) was wearing V6 stated "The regular mask." Surveyor

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inquired which mask she (V6) was required to wear due to Covid outbreak throughout the facility V6 responded "I know we supposed to have the N95. I can't breathe with it on. I have 2 of the other one (referring to the surgical mask) though." V6 then proceeded to open the (closed) double doors and entered the quarantined area without an N95 mask on.

On 1/10/22 at 2:10pm, R7 was observed ambulating throughout the 4th floor hallway without wearing a mask. Surveyor inquired why R7 was in the hallway without a mask on V5 stated "He just walked outta his room and he ain't gonna put it on anyway. When somebody ask him, he say no" and provided no redirection and/or mask to R7. R8 subsequently exited the elevator with V7 (LPN/Licensed Practical Nurse) however R8's mask was on her chin. Surveyor inquired about the location of R8's mask V7 stated "We encourage them (residents) as much as possible to keep em on" and provided no redirection to R8. R9 was subsequently observed in the hallway without wearing a mask. Surveyor inquired why R9 was in the hallway without a mask on V8 (LPN) stated "She's had one on 4 times. She keeps taking it off, that's what she does" and provided no redirection and/or mask to R9.

On 1/10/22 at 2:26pm, 3 residents were observed in the 4th floor dining room not wearing masks. Surveyor inquired about infection control concerns with the residents currently in the dining room V4 (Infection Control Nurse) stated "They're not masked." Surveyor inquired about required PPE for residents while not in their rooms V4 responded "They need to keep their mask on but nobody up here is going to keep their mask on." Surveyor inquired why none of the 3 residents

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(currently in the dining room) have a mask available V4 replied "We constantly offer them masks" however masks were not provided to said residents at this time.

On 1/10/22 at 2:28pm, surveyor inquired if anyone posted contact/droplet precaution signs on and/or near the door of rooms 429 and 430 (as warranted) V4 inspected both rooms and stated "No, we did not."

On 1/10/22 at 2:30pm, a "Doffing Station" sign was observed on the (4th floor hallway) wall with 2 red bins below it however the designated area was (outside) the closed double doors (quarantined area). Surveyor inquired where staff are required to doff PPE V4 stated "We enter one way and exit the other (referring to the quarantined area), they are supposed to be doing it here in the soiled utility room." Surveyor inquired about the location of the doffing station and red bins V4 responded "They're supposed to be back there" (referring to the soiled utility room) however the soiled utility room was also located outside the quarantined area.

On 1/10/22 at 2:33pm, a sign stating "Please practice social distancing, maintain 6 feet from others" was posted (outside the elevator) however V4 entered the elevator with 2 people already in it and stood approximately 2 feet away from them. Surveyor inquired how many people are allowed in the elevator if maintaining 6 feet social distancing V4 stated "It's 3 people that's allowed for the building."

On 1/10/22 at 2:36pm, surveyor inquired where (3rd floor) staff doff PPE V10 (LPN) stated "You go in (referring to the quarantined area) with your PPE on and there's a doffing over there (referring

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to the hallway outside the plastic sheets/quarantined area). Surveyor inquired about infection control concerns with the location of the 3rd floor doffing station V10 replied "It's in the hallway" and affirmed it was outside the quarantined area.

On 1/10/22 at 2:44pm, surveyor inquired about the location of (2nd floor) Covid positive residents V9 stated "I believe it's certain rooms in the back and front units" and affirmed there was no specific quarantined area on 2nd floor due to recent outbreak. [The 1/10/22 log of current Covid positive residents includes twelve 2nd floor rooms throughout the unit]. Surveyor inquired where (2nd floor) staff doff PPE V9 responded "The doffing station is over there" (referring to 2 red bins located in the hallway near room 217). Surveyor inquired about infection control concerns with the location of the 2nd floor doffing station V9 replied "We're coming outside in the hall" however the "contact precaution" signs posted on quarantined residents doors state "Discard gown before room exit."

R4's (12/29/21) care plan states resident has confirmed Covid 19 infection, intervention: follow policy & procedure for contact and droplet precautions. Place in private room or cohort with resident with same symptoms/Covid 19 confirmation however he was placed in R3's room. The census affirms that R3 has resided in current room since 2/18/21. R4 was moved to R3's room on 12/31/21 [2 days after confirmed Covid 19 infection]. The Covid 19 resident tracking affirms R3 sustained "covid acquired in facility" date of symptom onset 1/4/22 [4 days after aforementioned room change].

On 1/10/22 at 2:51pm, contact/droplet precaution

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signs were posted on R4's door however the door was wide open.

On 1/10/22 at 3:00pm, contact/droplet precaution signs were posted on R5's door however the door was wide open.

On 1/10/22 at 3:12pm, a sign posted (inside the elevator) stated "attention use of the elevator is limited to 3 people" however there were 4 people observed inside the elevator. Surveyor inquired how many people are allowed on the elevator V11 (CNA) stated "3."

On 1/11/22 at 2:00pm, V1 (Administrator) presented the facility elevator measurements; length: 7 feet, width: 5 feet 6 inches, diagonal: 8 feet 9 inches. Surveyor inquired if 3 people are allowed in the elevators V1 stated "Right now were allowing 2 diagonally in the elevator."

On 1/12/22 at 12:50pm, surveyor inquired if Covid positive residents room doors are supposed to be open or closed V4 stated "closed." Surveyor inquired when the Covid outbreak started V4 responded "The 1st case we got was December 20" (2021). Surveyor inquired how many people tested positive for Covid 19 V4 replied "Almost everyone 166 residents and 51 staff."

On 1/13/22 at 1:41pm surveyor inquired about R3's room assignment V12 (Social Service) stated "He's been in that room since basically when he was admitted." Surveyor inquired why R4 was placed in (R3's room) on 12/31/21. V12 responded "He (R4) was likely positive for Covid 19 that's why he was likely moved." Surveyor inquired why R4 (who was Covid positive) was placed in R3's room V12 replied "I believe he

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(R3) was positive too." Surveyor inquired who was responsible for making room assignments V12 stated "We (staff) all worked as a team we put people who were positive together and tried to take people that were negative and put them together. I did talk to some of the residents who refused rooms but we did talk to them educated them about the importance of moving rooms because of the protocols." Surveyor inquired if it was appropriate for R4 to be placed in R3's room on 12/31/21 knowing that he (R4) was positive for Covid and R3 was asymptomatic V12 replied "We can't make them move, it's their right." Surveyor inquired about resident safety V12 replied "Safety is important but rights supersede safety."

On 1/20/22 at 2:57pm, surveyor inquired about potential harm if a Covid 19 positive resident is placed in a room with an asymptomatic resident V14 (Medical Director) stated "The asymptomatic patient would have the potential risk for exposure and may contract the infection."

The coronavirus 2019 policy (revised 3/11/21) states facility is focused on containing the spread and mitigating the impact of Coronavirus. Covid 19 is spread from person to person by respiratory droplets between people who are in close contact with one another (about 6 feet). Outbreak definition of Covid 19 (one lab confirmed case of Covid 19). Procedure: while at work, the employee must don a facemask. All employees must wear a mask during their shift to protect residents [N95 is not inclusive]. Facility will follow its policies and procedures developed related to Coronavirus 2019 prevention and management based on State Health Department and or CDC (Centers for Disease Control) Interim guidance.

2. Based upon record review and interview the

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facility failed to follow policy & procedures, failed to ensure that assessments were documented accurately, failed to ensure that (R4's) physician orders were transcribed on the MAR (Medication Administration Record), failed to follow physician orders for five of five residents (R1, R3, R4, R5, R6) reviewed for Covid infection and failed to cohort all Covid 19 positive residents, these failures resulted in R3 sustaining a positive Covid 19 test result and hospitalization due to hypoxia/bradycardia.

Findings include;

On 1/3/22 and 1/4/22, IDPH (Illinois Department of Public Health) received allegations that Covid 19 positive residents were placed in rooms with Covid 19 negative residents. The following was identified;

R4's diagnoses include Covid 19 (12/29/21). R4's (12/29/21) care plan states resident has confirmed Covid 19 infection, intervention: Place in private room or cohort with resident with same symptoms/Covid 19 confirmation.

The census affirms that R3 has resided in current room since 2/18/21. R4 was moved to R3's room on 12/31/21 [2 days after confirmed Covid 19 infection].

The Covid 19 resident tracking affirms R3 sustained "covid acquired in facility" date of symptom onset 1/4/22 [4 days after aforementioned room change].

On 1/13/22 at 1:41pm surveyor inquired about R3's room assignment V12 (Social Service) stated "He's been in that room since basically when he was admitted." Surveyor inquired why

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R4 was placed in (R3's room) on 12/31/21. V12 responded "He (R4) was likely positive for Covid 19 that's why he was likely moved." Surveyor inquired why R4 (who was Covid positive) was placed in R3's room V12 replied "I believe he (R3) was positive too." Surveyor inquired who was responsible for making room assignments V12 stated "We (staff) all worked as a team we put people who were positive together and tried to take people that were negative and put them together. I did talk to some of the residents who refused rooms but we did talk to them educated them about the importance of moving rooms because of the protocols." Surveyor inquired if it was appropriate for R4 to be placed in R3's room on 12/31/21 knowing that he (R4) was positive for Covid and R3 was asymptomatic V12 replied "We can't make them move, it's their right." Surveyor inquired about resident safety V12 replied "Safety is important but rights supersede safety."

On 1/20/22 at 2:57pm, surveyor inquired about potential harm if a Covid 19 positive resident is placed in a room with an asymptomatic resident V14 (Medical Director) stated "The asymptomatic patient would have the potential risk for exposure and may contract the infection."

R3's (1/5/22) POS (Physician Order Sheets) state monitor patient with Covid 19 diagnosis or suspected Covid 19 for signs of clinical deterioration, such as rapidly progressive respiratory failure and sepsis for 14 days. If positive call MD (Medical Doctor/NP (Nurse Practitioner). Monitor vital signs (full vitals) every 4 hours for 14 days. Observe for evidence of deterioration. Call MD/NP as indicated.

R3's vitals summary affirms vital signs were obtained on 1/9/22 at 3:24pm however they were

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not documented on 1/9/22 (7pm and 11pm) and on 1/10/22 (3am, 7am, and 11am) as ordered therefore roughly 23 hours transpired without an assessment.

R3's (1/10/22) 2:08pm progress notes state upon entering the room resident observed wheezing stating "I can't breathe." Writer applied oxygen 2 liters per nasal cannula, saturation 87%. Nurse Practitioner called gave order to send resident out 911. Resident admitted for hypoxia related to Covid positive and sinus bradycardia (R3's pulse was 52 at 2pm per vitals summary).

R1's progress notes state (12/30/21) Covid test result was positive.

R1's (12/31/21) POS states monitor patient with Covid 19 diagnosis or suspected Covid 19 for signs of clinical deterioration, such as rapidly progressive respiratory failure and sepsis. Monitor vital signs (full vitals) every 4 hours for 14 days. Observe for evidence of deterioration. Call medical doctor/nurse practitioner as indicated.

The (December 2021/January 2022) MARS (Medication Administration Records) affirm that R1's vital signs were last documented on 12/31/21 at 3:00pm therefore on 12/31/21 (7:00pm & 11:00pm) and 1/1/22 (3:00am & 7:00am) vital signs were not documented. R1's vitals summary affirms no additional vital signs were documented.

On 1/18/22 at 11:42am, surveyor inquired about the facility protocol for residents who acquired Covid 19 V2 (DON/Director of Nursing) stated "We put in orders for vital signs and the monitoring." Surveyor inquired where vital signs are documented V2 responded They're

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documented on the MAR (Medication Administration Record) they're also documented in the monitoring tool for like a change in condition. It's under forms, Covid monitoring." Surveyor inquired about the required frequency for Covid monitoring V2 replied "Everyone (re: Covid positive residents) should be having it (referring to the electronic Covid 19 monitoring evaluation) every shift." Surveyor requested R1, R3, R4, R5 and R6's Covid 19 monitoring evaluations however nothing was received for R4, R5, and/or R6. R1's (12/30/21, 12/31/21 and 1/1/22) evaluations were entered by V2 on 1/7/22 (a week later) additional entries (for evening and night shifts) were not documented. R3's (1/5/22 and 1/6/22) Covid 19 monitoring evaluations were entered by V2 on 1/7/22 (days later) additional entries for night shift were not documented.

On 1/20/22 at 10:52am, V2 affirmed that there were no Covid 19 monitoring evaluations documented for R4, R5 and R6 (prior to inquiry). Surveyor relayed concerns with the assessments V2 documented roughly a week after (R1) expired. V2 replied "I know I made a mistake and entered something in there."

The Covid 19 tracking log affirms R4 sustained facility acquired Covid 19 on 12/30/21. R4's (12/30/21) POS states monitor vital signs (full vitals) every 4 hours for evidence of deterioration for 14 days (end date 1/13/22). R4's (December 2021) MAR was reviewed however every 4 hour vital sign orders were not inclusive. R4's (12/29/21-1/31/21) vital signs summary affirms vital signs were not documented.

The Covid 19 tracking log affirms R5 sustained facility acquired Covid 19 on 12/30/21. R5's (12/30/21) POS states monitor vital signs (full

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vitals) every 4 hours. Observe for evidence of deterioration (end date 1/13/22). R5's (12/29/21-1/31/22) vital sign documentation includes one (1) entry on 1/11/22 for pulse, respiration and temperature [blood pressure and oxygen saturation is not inclusive]. No additional entries were documented.

The Covid 19 resident tracking log affirms R6 sustained facility acquired Covid 19 on 12/29/21. R6's (12/29/21) POS states monitor vital signs (full vitals) every 4 hours. Observe for deterioration (end date 1/12/22). R6's (12/27/21-1/12/22) vital sign documentation includes one (1) entry on 12/29/21 for blood pressure, pulse, respiration and temperature [oxygen saturation is not inclusive]. No additional entries were documented.

On 1/12/22 at 12:54pm, surveyor inquired why R6's vital signs were not documented every 4 hours as ordered. V4 (Infection Control Nurse) stated "I was just looking back to see what happened because the orders are definitely there."

The coronavirus 2019 policy (revised 3/11/21) states if patients have been screened and their testing is positive for Covid 19: cohort with another symptomatic/positive patient. Vitals (temperature, heart rate, respirations) and pulse oximetry every 4 hours. Blood pressure every 8 hours.

The change in resident's condition (reviewed 6/21) states nursing will notify the resident's physician or nurse practitioner when: there is a significant change in the resident's physical, mental or emotional status. It is deemed necessary or appropriate in the best interest of

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