Electronically delivered
May 1, 2020

Administrator
Parkview Manor Nursing Home
308 Sherman Avenue
Ellsworth, MN 56129

SUBJECT: SURVEY RESULTS
CCN: 245553
Cycle Start Date: Cycle Start Date: January 27, 2020

Dear Administrator:

SUSPENSION OF SURVEY AND ENFORCEMENT ACTIVITIES

The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with Memorandum QSO-20-20-All, CMS is suspending certain Federal and State Survey Agency surveys, and delaying revisit surveys, for all certified provider and supplier types.

During this time, CMS is prioritizing and conducting only the following surveys: focused infection control surveys, investigations of complaints and facility-reported incidents that are triaged at the Immediate Jeopardy (IJ) level, and revisit surveys for unremoved IJ level deficiencies. With the exception of unremoved IJs, CMS will also be exercising enforcement discretion during the suspension period. For additional information on the prioritization of survey activities please visit https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0.

SURVEY RESULTS

On April 7, 2020, a survey was completed at your facility by the Minnesota Department of Health completed a COVID-19 Focused Survey at Parkview Manor Nursing Home to determine if your facility was in compliance with Federal requirements related to implementing proper infection prevention and control practices to prevent the development and transmission of COVID-19. The survey revealed that your facility was not in substantial compliance. The findings from this survey are documented on the electronically delivered CMS 2567.

PLAN OF CORRECTION

You must submit an acceptable plan of correction (POC) for the enclosed deficiencies that were cited during the April 7, 2020 survey. Parkview Manor Nursing Home may choose to delay submission of a POC until after the survey and enforcement suspensions have been lifted. The provider will have ten

days from the date the suspensions are lifted to submit a POC. An acceptable POC will serve as your allegation of compliance. Upon receipt of an acceptable POC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. Please note that if an onsite revisit is required, the revisit will be delayed until after survey and enforcement suspensions are lifted. The failure to submit an acceptable POC can lead to termination of your Medicare and Medicaid participation.

To be acceptable, a provider's POC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- How the facility will identify other residents having the potential to be affected by the same deficient practice;
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur;
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur; and
- The date that each deficiency will be corrected.

The POC must be signed and dated by an official facility representative. Please send your POC by fax or email to:

Nicole Osterloh, Unit Supervisor
Minnesota Department of Health
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230 Cell: 218-340-3083

INFORMAL DISPUTE RESOLUTION

You have one opportunity to dispute the deficiencies cited on the April 7, 2020 survey through Informal Dispute Resolution (IDR) in accordance with 42 CFR § 488.331. To receive an IDR, send (1) your written request, (2) the specific deficiencies being disputed, (3) an explanation of why you are disputing those deficiencies, and (4) supporting documentation by fax or email to:

Nicole Osterloh, Unit Supervisor
Minnesota Department of Health
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230 Cell: 218-340-3083

An IDR may not be used to challenge any aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

An IDR, including any face-to-face meetings, constitutes an informal administrative process that in no way is to be construed as a formal evidentiary hearing. If you wish to be accompanied by counsel for your IDR, then you must indicate that in your written request for informal dispute resolution.

Parkview Manor Nursing Home may choose to delay a request for an IDR until after the survey and enforcement suspensions have been lifted. The provider will have ten days from the date the suspensions are lifted to submit a request for an IDR in accordance with the instructions above.

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES

The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at https://qioprogram.org/. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at https://qioprogram.org/locate-your-qio.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245553	A. BUILDING _____ B. WING _____	04/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW MANOR NURSING HOME	308 SHERMAN AVENUE ELLSWORTH, MN 56129

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E 000	Initial Comments A COVID-19 Focused Infection Control survey was conducted on 4/1/20 through 4/3/20, at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.73(b)(6). The facility was NOT in full compliance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Upon receipt of an acceptable electronic POC, a revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	E 000		
E 024 SS=F	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years (annually for LTC).] At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs	E 024		5/29/20

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

Electronically Signed | 05/11/2020

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E 024	Continued From page 1 during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. This REQUIREMENT is not met as evidenced by: Based on interview and policy review, the facility failed to ensure Emergency Preparedness policies and procedures addressed the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an COVID-19 outbreak. Findings include: Interview on 4/1/20 at 8:30 a.m., with the interim administrator (A) identified the facilty was in the process of hiring a new adminstrator and he assumed the position about a month ago. The A stated he had not focused on staffing needs during a COVID-19 outbreak because the business office manager position was vacated a week ago, and had assumed additional responsibilities of that position. The A confirmed a COVID-19 emergency plan was implemented,	E 024	The Pandemic Influenza, Coronavirus and other Viruses Policy will be updated by Administrator or designee to include the strategies for adequate staffing, surge needs during an emergency, and the process and role for integration of State and Federally designated health care professionals. The Pandemic Influenza, Coronavirus, and other viruses Plan will be updated by the Administrator or designee to include strategies for the use of volunteers in an emergency. Audits will be completed on the Policy and Plan monthly x 3 by the Administrator or designee. Audits will taken to the Quality Assurance Performance and Improvement meeting	

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E 024	Continued From page 2 but no strategies were included in the plan to address staffing needs if there was an COVID-19 outbreak at the facility. Interview on 4/1/20 at 10:30 a.m., with the dierector of nursing (DON) identified the facility discussed staffing once during a manager meeting. The DON verified no strategies were in place to address surge or staffing needs during a COVID-19 outbreak. The DON planned to contact nurse and nurse aid staffing agencies if staffing needs developed. No additional strategies were in place and no staffing agencies had been contacted to implement strategies during a COVID-19 outbreak. Review of the 3/6/20, Pandemic Influenza, Coronavirus and Other Viruses policy identified all staff were encouraged to continue filling their assigned shifts. The resident population would continue to need care provided by staff in all departments. Changes in staffing level or needs were to be determined by the administrator, DON, and the nursing home board if needed. The plan made no mention of how the facility would ensure adequate staffing and surge needs during a COVID-19 outbreak. Review of the 3/24/20, COVID-10 pandemic plan identified processes and stratigies to implement during a COVID-19 outbreak. The plan made no mention of strategies address to use of volunteers in an emergency, or other emergency staffing strategies, to address staffing needs during a COVID-19 outbreak.	E 024	(QAPI) to be in compliance.	
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control survey	F 000		

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F 000	Continued From page 3 was conducted 3/30/20 through 4/1/20, at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was determined NOT to be in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, a revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 880 SS=F	Infection Prevention & Control 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	F 880		5/29/20

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F 880	Continued From page 4 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 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	F 880		

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F 880	Continued From page 5 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 observation, interview, and document review, the facility failed to ensure staff performed appropriate transmission based precaution (TBP) intervention, ensure active screening was performed at the point of entry, and source control masks were used by staff in accordance with Centers for Disease Control (CDC) and Centers for Medicare and Medicaid Services (CMS) guidelines for COVID-19. This had the potential to affect all 28 residents in the facility. Findings include: TRANSMISSION BASED PRECAUTIONS & SOURCE CONTROL Observation at 8:05 a.m. after entering the facility and proceeding to the conference room, identified 6 staff were observed walking in the hallway without wearing source control masks. Interview on 4/1/20 at 8:10 a.m., with the director of nursing (DON) identified there were no residents with confirmed COVID-19 at the	F 880	R1 no longer has signs/symptoms of COVID 19. Residents are monitored twice daily for signs & symptoms as recommended by CDC. If staff becomes aware of signs/symptoms of a potential COVID-19, then staff will immediately report to Charge Nurse. Charge Nurse or designee immediately will place correct signage on the residents room door that is in isolation to inform staff of what type of isolation precaution is needed and what types of PPE are required. Charge Nurse or designee will place appropriate PPE and supplies in resident room and outside of resident room. Washable gowns were obtained on 4-09-20 to be used for isolation rooms. At the end of each shift, the CNAs will ensure that there is a sufficient amount of	

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F 880	Continued From page 6 present time, and no residents were on precautions. The facility had two entrances: the front entrance and the rear entrance. Staff entered through both entryways. The facility had not designated an entrance for staff to enter. The main parking lot was located at the front entrance. Most staff entered through the front entrance. The DON identified staff were not wearing source control masks at the present time as they had no active cases of COVID-19 in the facility. She expected staff to implement personal protective equipment (PPE) if residents developed respiratory symptoms. Interview on 4/1/20 at 8:20 a.m., with director of nursing (DON) identified resident (R1) experienced an elevated temperature, headache and body aches and was on transmission based precautions by nursing staff. Interview on 4/1/20 at 8:30 a.m., with housekeeper (H)-A identified she was unaware of any resident with potential COVID-19 symptom. Infections were to be communicated verbally at daily morning meetings, and by the nurses. Source control masks were not worn by any staff at that time. R1's 4/1/20 at 8:32 a.m., progress note identified R1 experienced a temperature of 100.8 degrees Fahrenheit (F) complaints of a headache and body aches earlier that morning and was reported to the oncoming nurse. There was no mention what tranmission based precautions (TBP) were implemented at that time.	F 880	PPE available for the next shift outside of the residents doors who are on isolation. Non-critical care equipment will be designated to that resident on isolation. Example: blood pressure cup, lift, commode, etc. If equipment is not available for individual use, then it is cleaned & disinfected according to manufacturers instructions using an EPA registered disinfectant for healthcare setting prior to use on another resident. Entrance doors will be locked. Signs will be placed at front & back entrance doors. Upon arrival, staff calls facility to be let into the building. Staff are directed to enter through the front entrance door only. Staff will be evaluated in entryway of building. Face mask will be in place prior to entering the building. Staff will then be evaluated for signs/symptoms of illness per CDC guidelines and will be recorded on a sheet in the binder. Each staff person reports to the Charge Nurse at the beginning of their shift. Morning meetings for all staff to discuss the residents with positive cases, negative cases, and with signs/symptoms. Each staff person is responsible to check with the Charge Nurse through out their shift for any new updates with residents with or without symptoms. Staff will be educated on the importance of using face masks, face shields,	

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F 880	Continued From page 7 R1's current face sheet identified he had comorbidities of type 2 diabetes and kidney failure which placed him at increased risk for contraction of COVID 19. Observation and interview on 4/1/20 at 9:00 a.m., with nurse aide (NA)-A and NA-B of R1's room identified there was a chair set outside of R1's room with a box of gloves, face masks, and a bottle of hand sanitizer on it. There were no gowns on the chair. There was also no signage on R1's door or chair to inform staff what type of isolation precautions were required. NA-B was inside the room providing care to R1. NA-A proceeded to the entrance of R1's room, sanitized her hands, knocked on door and entered. NA-B could be overheard advising NA-A she needed to have put on additional personal protective equipment (PPE) before she had entered the room. NA-A then exited room. Upon exit, NA-A advised the PPE had not been there earlier this morning and had not been aware R1 was on precautions or showed symptoms of COVID-19. NA-B exited R1's room wearing her contaminated face mask and gloves without removing and performing hand hygiene as R1 was on isolation precautions. NA-B pushed a commode used by R1 across the hallway to the utilities room for disinfection and touched the door handle of the soiled utility room with her contaminated glove. Neither NA-A nor NA-B had performed appropriate PPE donning and doffing for R1 who had potential COVID symptoms and was on isolation precautions. Observation on 4/1/20 at 9:30 a.m., of the facility's PPE inventory in the supply room with	F 880	handwashing, and hand sanitizer use whether the facility has positive or negative case of COVID in the building. Staff will also be educated on the required PPE and supplies needed inside the resident room and outside the resident room. Staff education will be completed by May 27, 2020 on COVID 19, handwashing, PPE, and hand hygiene. Director of Nursing or designee updated the Isolation: Categories of Transmission based precautions policy. Director of Nurses or designee will update the Flu, Coronavirus Pandemic Policy. Audits of the stock supply/inventory of PPE will be done weekly x 2, Monthly x 1, and as needed. Audits will be completed on Staff education weekly x 2. Director of Nurse or designee will monitor regularly PPE use to identify when supplies will run low. Prior to shortages occurring residents care and treatment activities will be bundled to minimize entries into residents rooms. Extended use of face masks, and face shields will be used for the care of more than one resident. Nobles County Emergency Management will also be contacted for assistance with shortages of PPE.	

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F 880	Continued From page 8 the DON identified the facility had 15 boxes of 50 each disposable face masks with tie strings at the facility. There was no plan in place for source control masking for facility staff. Staff were not expected to wear masks until a resident developed symptoms of COVID-19. PPE was to be initiated when a resident was discovered only with respiratory symptoms. Staff were to initiate TBP for R1 when symptoms were identified and educate staff about the type of precautions needed. Masks were placed outside of R1's room and were to be worn. Gowns were not implemented for use with R1. Staff were not instructed to don gowns when in R1's room. Gowns had been depleted from an outbreak of influenza at the beginning of March 2020 and she was unable to restock the facility supply. There were 2 boxes labeled "Isolation". The boxes contained numerous cloth gowns and several pairs of goggles. The DON was unaware of the cloth gowns in those boxes. She identified she had not performed a complete inventory of supplies. In the absence of disposable gowns, the DON identified staff could use the cloth gowns for PPE until disposable gowns had arrived. The DON agreed there was an ample supply of masks with appropriate re-use as source control masks. During observation and interview on 4/1/20 at 9:40 a.m., of R1's doorway and room with housekeeper (H)-A identified she would be notified of anyone requiring TBP by her supervisor. R1's room had no waste basket inside door of room for staff to discard PPE before exiting the room. There were no disinfecting wipes located in or near R1's room for staff to disinfect multiple-resident use	F 880	Audits will betaken to the Quality Assurance Performance Improvement Meeting (QAPI) to be in compliance.	

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F 880	Continued From page 9	F 880		

equipment. Equipment would have to be brought across the hall into the soiled utility room for disinfection.

Further interview on 4/1/20, at 10:30 a.m., with the DON identified she was responsible for the facility's infection control program (ICP). Staff were instructed not to wear masks until there was an active case of COVID-19 in the facility. The DON stated she reached out to area clinics and hospitals for recommendations on when to initiate source control masks. She had also worked with the regional Emergency Preparedness representative on implementation of COVID-19 practices. The DON was aware of CDC and CMS guidance for healthcare workers to wear source control masks. The administrator received the memos would routinely update managers and staff of changes to COVID-19 infection control practices.

Interview on 4/1/20 at 10:45 a.m., with the administrator identified he received the QSO memos, the facility had not implemented use of source control masks. The facility's plan was to conserve the existing ample supply of masks to use until a resident had symptoms of COVID-19, or an active case occurred in the facility. PPE was currently on backorder. He had just received additional masks from the southwest coalition last evening.

Later interview on 4/1/20 at 11:40 a.m., with NA-B identified R1 had no designated commode. NA-B would remove the soiled commode, return to the soiled utility, disinfect it and place the commode in the common storage area. NA-B was aware of the TBP placed on R1.

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PARKVIEW MANOR NURSING HOME	308 SHERMAN AVENUE ELLSWORTH, MN 56129

(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) COMPLETION DATE
F 880	Continued From page 10 Interview on 4/1/20 at 11:40 a.m., with DON identified her expectation was staff were to place signage on the door of a resident in isolation to inform and instruct staff of what type of isolation precaution was needed and what types of PPE were required. All equipment unable to be designated for the isolation resident was to be disinfected before it left that resident's room. The DON had not performed any training recently with regard to isolation precautions and correct PPE usage. The DON identified there were no written policies in place for masks to be used for source control. Interview on 4/1/20 at 12:50 p.m., with NA-C identified she had not received training on donning and doffing PPE recently amid the COVID pandemic. SCREENING Observation on 4/1/20 at 8:00 a.m., identified the entrance to the facility had signs posted visitors were to refrain from entering to prevent COVID-19 exposure to residents. Interview on 4/1/20 at 8:30 a.m., with housekeeper (H)-A identified staff were to enter through the front entrance and report to the nurses station to be screened for fever, cough, and shortness of breath prior to clocking into work before every shift. If the nurse was not at the desk, staff would search the facility for her to screen them prior to the start of their shift. Observation on 4/1/20 at 8:30 a.m., identified a sign was posted at the staff time clock in the north wing near the rear entrance of the facility	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 11	F 880		

instructing staff to check in at the nurses' station for COVID-19 screening before beginning their shift.

Interview on 4/1/20 at 8:37 a.m., with trained medication aid (TMA)-A identified when staff entered through the back facility door and identified she had trouble finding nurses to screen her after she had arrived to work.

Interview on 4/1/20, at 10:30 a.m., with the DON identified was aware of CDC and CMS guidance requiring healthcare facilities to actively screen visitors and staff prior to entrance to the facility.

Review of the 3/6/20, Pandemic Influenza, Coronavirus and other viruses, identified the facility would attempt to minimize the spread of any serious viral illness among its residents and staff. Residents were to be isolated the first sign of respiratory illness, including cough, lethargy, or muscle aches. Staff were to be encouraged to wear gowns, masks and gloves for all patient interactions. A tight fitting facial mask should be worn at minimum for respiratory protection. In the event of a pandemic or other viruses, the facility was to follow protocols for isolation measures, disinfection measures for environmental surfaces and monitoring for outbreak.

Review of the October 2018, Isolation - Categories of Transmission-Based Precautions, identified TBP were additional measures that protected staff and residents from becoming infected and determined by the pathogen. The CDC maintained a list of diseases, modes of transportation and recommended precautions. When a resident was placed on TBP, notification

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F 880	Continued From page 12 was to be placed on the room entrance door and the front of the resident's medical record so staff was aware of the need and type of precaution. When TBP were in effect, non-critical resident care items were to be dedicated to a single resident. If re-used for another resident, the item was to be disinfected according to current guidelines before use on another resident. A resident on droplet precautions identified staff were to wear masks when entering the room. Gloves, gowns, and goggles were to be worn if a risk of spraying secretions. Review of the 3/6/20, Influenza, Coronavirus, and Other Viruses Protocol, identified when a resident within the facility exhibited symptoms of coronavirus or other like illness, affected residents were to be isolated to their rooms when symptoms were noted. Masks and gowns were to be available for staff to wear when caring for residents. Coronavirus symptoms listed were fever cough and shortness of breath. There was no mention the list of symptoms had been updated to align with current symptoms identified by the CDC.	F 880		