STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235443	A. BUILDING _____ B. WING _____	06/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SHOREPOINTE NURSING CENTER	26001 EAST JEFFERSON AVENUE SAINT CLAIR SHORES, MI 48081

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

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to operationalize policies and procedures to ensure timely implementation and documentation of isolation precautions related to Covid-19 for two (Resident #'s 901 and 902) of eight Residents reviewed, resulting in enhanced isolation precautions not being implemented after Covid-19 testing completion and the potential spread of Covid-19 within the facility. Findings include: Resident #901 Record review revealed Resident #901 was originally admitted to the facility on [DATE] and most recently readmitted on [DATE] with [DIAGNOSES REDACTED]. The Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact and required limited to extensive assistance to perform Activities of Daily Living (ADLs). Additional record review revealed Resident #901 was transferred to the emergency department on [DATE] due to a change in condition. Review of the SNF (Skilled Nursing Facility) to ED (Emergency Department) Handoff Form detailed, Code Status: Full code (wanted life sustaining medical interventions) . Key Clinical Information: Slow to arouse, elevated temp, pale, lethargic. Reason for Transfer: Change in Condition . Vital Signs: BP (Blood Pressure): ,[DATE]; HR (Heart rate): 103 (Normal 60 to 100); RR (Respiratory Rate): 28 (Normal 16 to 20); O2 Stat (Oxygen Saturation) 88% (Normal 92 to 100 %) . Date/Time: [DATE] 10:25 AM . Resident #901's medical record revealed the Resident was tested for Covid-19 on [DATE] and was placed in Droplet Precautions Sputum on [DATE]. The medical record included the following progress note documentation: -[DATE] at 3:33 PM: Discipline: Nursing . Writer entered room per Therapy request @ 1030 to check patient blood pressure, patient appeared to be very pale and was unresponsive while sitting up in wheel chair at bed side, Stat was called . patient placed in bed and sternum rub performed, 1035: HR: 84, 1036: Blood Sugar: 160, @ 1037: VS: B/P: ,[DATE], TEMP: 97.7 oral, HR: 74, SPO2: 94% room air, BP: during Therapy: ,[DATE] @ 1047 contacted MD regarding unresponsive episode new orders given to monitor patient . -[DATE] at 2:34 PM: Discipline: Nursing . Resident is alert and able to verbalize needs . consumed 25% of breakfast, and about 50% of lunch. Writer at beside for meals, encouraging resident with meals . Resident had two bowel movement . Resident vitals stable, temp 100.1 . -[DATE] at 7:00 PM: Discipline: Nursing . Resident temp 100.1 Swabbed for COVID. Lab picked up Stat Sample. -[DATE] at 10:41 AM: Discipline: Medical . Late entry for [DATE] . Patient was seen for anxiety . Patient was seen today per nursing staff and patient request . Patient has been very anxious and sad since he lost his roommate (Resident #902) last night (expired) . -[DATE] at 4:13 PM: Discipline: Physician Extender . CHIEF COMPLAINT: cough and congestion . Patient seen today as per nursing staff request. Patient lying in bed, cough with congestion noted. Wheezing noted to bilateral lower lobes . ASSESSMENT AND PLAN: URI (Upper Respiratory Infection)- Will order chest X-ray to r/o (rule out) Pneumonia. Will order [MEDICATION NAME] treatments every 6 hours x 7 days . COVID-19-Results remain pending . -[DATE] at 2:43 PM: Discipline: Nursing . Resident encouraged to eat, appetite is very poor. Writer spoke with residents daughter . she stated that she was concerned with wet cough, I did let (Resident daughter) know that we swabbed for COVID last Friday and that (Resident #901) had a chest x-ray last night . -[DATE] at 10:29 AM: Discipline: Nursing . Respiratory Therapy: called to assess resident at this time. Resident found to be lethargic, difficult to arouse, Breath sounds reveal rhonchi and wheezes to LUL (Left Upper Lobe)/LLL (Left Lower lobe), Right is diminished t/o (throughout). Spo2 96% on RA (Room Air), resident has a congested cough. Temperature is 102.2. Treatment given with no relief noted. Nsg (Nursing) aware . -[DATE] at 11:23 PM: Discipline: Nursing . At 0900 writer enter room to perform VS (Vital Signs) B/P: 130/ 70, HR: 96, RR: 28, SPO2: 96% on room air TEMP was: 101.9 oral, writer contacted MD @ 0938 new orders for CBC (Complete Blood Count), BMP (Basic Metabolic Panel) and COVID-19 if not already swabbed, writer rechecked Temp@ 1008, 102.2@ 1020. 911 called per DON (Director of Nursing), 911 departed facility @ 1027 . Review of Physical Therapy documentation for Resident #901 revealed documentation indicating the Resident did not have isolation precautions in place until [DATE]. Resident #902 Record review revealed Resident #902 was originally admitted to the facility on [DATE] and most recently readmitted on [DATE] with [DIAGNOSES REDACTED]. The Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact and required supervision to extensive assistance to perform Activities of Daily Living (ADLs). The medical record revealed Resident #902 passed away on [DATE]. Review of Resident #902's medical record revealed the Resident has a Covid-19 diagnostic test on [DATE] with positive results for [MEDICAL CONDITION]. Resident #902's medical record included the following progress note documentation: -[DATE] at 7:21 PM: Discipline: Nursing . Writer received (Resident #902) . arriving by ambulance with Two EMT'S at 4:50 PM . DX(Diagnoses): Low Oxygen Level, SOB (Shortness of Breath) . -[DATE] at 3:37 PM: Discipline: Physician Extender . CHIEF COMPLAINT: Wheezing . Patient seen today as per nursing staff request. Patient sitting in wheelchair . Wheezing noted in right upper lobe . [MEDICAL CONDITION]: No cough, SOB, + wheeze . Assessment and Plan: URI (Upper Respiratory Infection) -Will schedule Nebulizer treatments 4x a day . -[DATE] at 10:40 AM: Discipline: Medical . patient was discharged from the hospital with oxygen which is new for them. Patient complains of weakness, generalized and moderate and causing difficulty walking . -[DATE] at 10:35 AM: Discipline: Nursing . LOA (Leave of Absence) with (Family) to cardiology apt (appointment) . -[DATE] at 3:31 PM: Discipline: Physician Extender . CHIEF COMPLAINT: Rash, Wheezing, Cough, abnormal labs . Patient seen today as per nursing staff request. Patient lying in bed, cough with congestion noted, decreased lungs sounds lower lobes . Assessment and Plan: URI-Will order Chest X-ray to r/o (rule out) Pneumonia. Continue Nebulizer treatments. O2 therapy as needed . -[DATE] at 6:10 PM: Discipline: Nursing . Wet cough noted, wheezing noted, SOB noted. NP (Nurse Practitioner) present, stat chest X-Ray ordered. Resident has orders for breathing treatments in place Q (every) 4 (hours) . 2L (Liters) of O2 (oxygen) in place . -[DATE] at 10:17 PM: Discipline: Nursing . CXR (Chest X-Ray) results . pneumonia. MD notified . New orders for [MEDICATION NAME] (antibiotic) 500 mg (milligrams) QD (everyday) x7 days . -[DATE] at 10:21 AM: Discipline: Medical . Patient was seen today due to a new [DIAGNOSES REDACTED]. This morning patient is not feeling very well due to shortness of breath and weakness . Assessment and plan: Healthcare acquired pneumonia was started on [MEDICATION NAME] for seven days continue to monitor closely . -[DATE] at 2:44 PM: Discipline: Nursing .Resident has orders for breathing treatments in place Q4. Resident . C/O (complain of) poor appetite. 2L of O2 in place. Resident temp 101.2 UM (Unit Manager) notified . -[DATE] at 7:00 PM: Discipline: Nursing . Resident temp 100.7 at 2 PM, 101.2 at 2:30 pm. Swabbed for COVID. Lab picked up Stat Sample. -[DATE] at 4:18 AM: Discipline: Nursing . temp HS (bedtime) 99.0 . Expiratory wheeze present . -[DATE] at 1:28 AM: Discipline: Nursing . Writer administered breathing treatment back to back per doctor order. (Physician) also order 40 mg of [MEDICATION NAME] (diuretic) IM (Intramuscularly) and increase O2 to 5 liter . 93% on 5 liter . -[DATE] at 11:47 PM: Discipline: Nursing . pt (patient) is unresponsive and no pulseless, CPR initiated, defibrillator applied at 1126 (PM) and no shock advised, CPR continued, paramedics arrived at 1136 and pt was intubated at 1143. (Physician) notified at 1145. Review of Resident #902's medical record revealed the Resident was placed on droplet isolation precautions on [DATE]. Review of facility provided Covid-19 Resident Tracking Document revealed Three Residents were placed due to signs and symptoms of Covid-19 on [DATE]. An interview was conducted with the Director of Nursing (DON), Infection Control Nurse B and Registered Nurse (RN) J on [DATE] at 11:00 AM. During the interview, the DON revealed they had been off work and RN J had covered and assisted during their leave. When queried regarding Resident #902, RN J stated, They passed at the facility. When queried when Resident #902 was

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) placed in isolation precautions, the DON and RN J revealed the medical record included documentation with a date of [DATE]. Infection Control Nurse B then stated, Pneumonia precautions started on ,[DATE] (for Resident #902). With further inquiry regarding when Resident #902 began to display signs and symptoms of Covid-19, Infection Control Nurse B reviewed the Resident's medical record and replied, Cough on ,[DATE] and temp on ,[DATE]. When asked what pneumonia precautions included, staff indicated standard precautions and that no personal protective equipment (PPE) is utilized. When queried regarding facility policy/procedure pertaining to isolation precautions when Residents are suspected to have Covid-19 infection including when a diagnostic Covid-19 test is completed due to Resident signs/symptoms, the DON stated, If swabbed, (complete Covid-19 test) then should be put in Droplet (isolation precautions) as a PUI (Person Under Investigation). When asked why Resident #902 did not have droplet precautions implemented, the DON and RN J reviewed the Residents medical record and revealed they were unable to locate documentation indicating the Resident had been placed in isolation precautions. When queried if Resident #902 was in a single room, RN J revealed Resident #902 shared a room with Resident #901. When asked if Resident #901 developed Covid-19, RN J indicated the the Resident had passed away. With further inquiry related to signs and symptoms of Covid-19 for Resident #901, RN J stated, Resident #901 had started with lethargy on ,[DATE] and that respiratory symptoms started on ,[DATE]. When queried regarding Resident #901 being tested for Covid-19 on [DATE], the DON stated, Both (Resident #901 and Resident #902) met criteria for testing on ,[DATE]. The staff were then asked when Resident #901 was placed in isolation precautions and RN J replied, No precautions ordered until ,[DATE]. When asked why both Residents were not placed in isolation precautions at the same time upon being tested for Covid-19, the staff were unable to provide an explanation. Review of facility policy entitled, Novel Coronavirus Prevention and Response (No Date) revealed, 6. Interventions to prevent the spread of respiratory germs within the facility . c. Monitor Residents for fever or respiratory symptoms . ii. In general, for care of Residents with undiagnosed respiratory infection use Standard, Contact, and Droplet Precautions with eye protection . 7. Procedure when Covid-19 is suspected or confirmed . d. Limit the number of people who enter the resident's room. Maintain a log of all people who enter the room . f. Implement standard, contact, and droplet precaution . Review of facility provided policy/procedure entitled, Charting Requirements: Covid-19 (No Date) revealed, Each Resident (positive or pending) must be documented on every 8 hours . Verify isolation orders are on the Resident record with appropriate signage on the door . 'Patient remains in isolation and precautions are maintained' must be included with every progress note . If it's not documented, it didn't happen .