STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235214	A. BUILDING _____ B. WING _____	07/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CAMBRIDGE NORTH HEALTHCARE CENTER	535 N MAIN CLAWSON, MI 48017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0559 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake #MI 701 Based on interview and record review, the facility failed to provide written notice of a room change for one (R#702) of three residents reviewed for admission/transfer/discharge and room transfers, resulting in R#702's responsible party not being notified and, the potential for distress due to miscommunication. Findings Include: A complaint was filed with the State Agency (SA) on 4/14/20 that alleged the facility staff moved the resident to another floor without notifying responsible party. Review of the clinical record revealed R#702 was admitted into the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed R#702 had a Brief Interview for Mental Status (BIMS) score of 6 out of 15 (severely impaired cognition). Further review of the facility's census for room location revealed R#702 resided in Room # (number redacted) on hospice on 11/15/2019 and was moved to Room # (number redacted) on 4/3/2020. Review of the Progress Notes dated 4/9/2020 17:00 (5:00 pm) revealed the following: Type: Nursing Note Text: reached out to family: daughter (Named redacted) with assurance of resident well-being in regard to the COVID (Coronavirus) outbreak. Assured her of our strict measures in place and our availability to be reached with any questions or concerns. (Name redacted) was thankful and had no questions or concerns at this time. Will continue to initiate and maintain communication . On 7/8/20 at 10:10 a.m., during a telephone interview with Social Work Tech 'G', when asked if there was documentation that R#702's responsible party was notified of their room change and if so, what was the date? Social Work Tech 'G' explained she would have to look at her notes and call back. Social Work Tech 'G' called back at 10:16 a.m. When asked if the responsible party was notified of the room change at the referenced time and why it was not documented, Social Work Tech 'G' stated, I don't see the room change. Let me check that. I'll give you a call right back. On 7/8/20 at 10:40 a.m., when queried if R#702's responsible party had been notified of the room change, Social Work Tech 'G' explained that nursing did not put it in her notes and R#702 was probably moved due to COVID. Social Work Tech 'G' further stated, No it was not noted that the family was told about the room change. An interview was conducted with Director of Clinical Services 'A' on 7/8/20 at 11:10 a.m. When asked if there was any documentation that R#702's responsible party was notified of their room change, Director of Clinical Services 'A' explained that former Director of Nursing (DON) 'H' was new to long-term care and when she (DON 'H') called the responsible party, she did not understand that she needed to say that the room had changed on 4/3/20. On 7/9/20 at 12:27 p.m. the Administrator was interviewed and asked about the facility's process for notifying facility residents' responsible party of room changes, and why R#702's responsible party was not contacted, the Administrator stated, We divided up all of the rooms and called everybody . I have looked. There was a sheet missing and she (R#702) was on that sheet. I don't know. They (Social Worker Tech 'G') was supposed to call . It didn't happen. A review of the facility's policy titled Room & Roommate Assignment revised August 2017 documented the following: POLICY . The facility will promptly notify the residents and the residents' representatives or interested family members (if known) when there is a change in room or roommate assignment . PROCEDURE . 3. Prior to making a room change, all parties involved (residents and their representatives) will be provided with a 48-hour advance notice of such change whenever possible. The notice of a change in room assignment will be in writing using the form Notification of Room Change
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake #MI 701 Based on interview and record review, the facility failed to consistently provide activities of daily living (ADLs) for one (R#702) of five residents reviewed for ADLs, resulting in staff not getting R#702 up and dressed daily and/or providing oral care. Findings Include: A complaint was filed with the State Agency (SA) on 4/14/20 that alleged the facility staff are not getting the resident dressed and out of bed and it was alleged the resident is not receiving oral care daily. Review of the clinical record revealed R#702 was admitted into the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed R#702 had a Brief Interview for Mental Status (BIMS) score of 6 out of 15 (significantly cognitively impaired) and required extensive assistance with one-person physical assist for dressing and personal hygiene. A 30-day review of the facility's daily CNA (Certified Nursing Assistant) documentation for March 2020 and April 2020 revealed there was no indication that R#702 had received ADL care for AM (morning) dressing, personal hygiene, eating, and bed mobility as follows: March 7, 8, 9, 14, 15, 16, 19, 22, 29 April 1, 3, 4, 6, 8 A review of R#702's care plans revealed the following: Date: 2/20/2020 - ADL Care: I have an ADL self-care performance deficit r/t (related to) Impaired balance, [MEDICAL CONDITION], HX (history) of left wrist FX (fracture), hospice care decline anticipated . I will be dressed in bed and get up before breakfast . Oral Care: I require extensive assist x (times) 1 1 (one-to-one). Date: 3/13/2020 - Repositioning: I need to have the low profile back support when sitting in the wheelchair to provide lumbar stability. Further review of the Progress Notes dated 4/2/2020 05:18 (5:18 am) revealed the following: Type: Orders - Administration Note To be up for Morning TV, Activities, Etc. Per DPOA (Durable Power of Attorney) REQUEST in the morning for ADL ref (refused) x (times) 3. However, there was no documentation or indication that R#702 had refused ADL care in March 2020 or any other date in April 2020 before their transfer to the hospital. On 7/8/20 at 1:14 p.m., during an interview with Resident Care Specialist (RCS/CNA) 'I', when queried what it meant if documentation was blank on the ADL care log, RCS/CNA 'I' stated, If it was blank, it is if she (R#702) did not have any care . I'll have to check to see if I worked that day . At 1:35 p.m., RCS/CNA 'I' returned and stated, I only worked on 4/6/20. When asked why documentation was left blank or if care was provided, RCS/CNA 'I' stated, I really don't know. It was an honest mistake. On 7/9/20 at 12:27 p.m., an interview and record review were conducted with the Administrator in regard to R#702's ADL care. When asked if staff are supposed to document when tasks are completed or where documentation could be reviewed, the Administrator stated, They (staff) have to document that they provided the care. A review of the facility's policy titled Routine Resident Care revised September 2011 revealed the following: Residents receive the necessary assistance to maintain good grooming and personal/oral hygiene. Steps are taken to ensure that a resident's capacity for self-performance of these activities does not diminish unless circumstances of the resident's clinical condition demonstrate the decline is unavoidable . GUIDELINES . 3. Daily personal hygiene minimally includes assisting or encouraging residents with washing their faces and hands, combing their hair each morning, and brushing their teeth .
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate**

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 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) **supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake #MI 104 Based on interview and record review the Facility failed to investigate a fall allegation that caused pain to both the left and right knees for one high fall risk resident (#704) of two residents reviewed for falls, resulting in the failure to determine the root cause of the allegation, and the potential for further falls, failure to provide fall interventions, injury and pain. Findings include: A complaint was filed with the State Agency that alleged the resident fell and sustained an injury on 4/1/20 and the Facility did not provide the results of the X-ray. The complainant was interviewed and indicated that R#704 reported to them that they had fallen. A survey was performed 7/7/20-7/9/20. A review of R#704's clinical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. R#704's Minimum Data Set (MDS) indicated that the resident had a Brief Interview for Mental Status Score (BIMS) of 10 (moderately impaired cognition) and required two person assist for transfers. R #704's care plan dated 3/6/20 documented in part, I am at risk for falls .unaware of safety needs .Interventions/Tasks: Anticipate and meet my needs. I am a high fall risk .follow facility fall protocol . A progress note dated 4/1/20 and authored by Nurse C read, .what I think is going on with the resident is: .resident stated she had a fall yesterday and c/o(complains of) b/l (bilateral) knee pain, vitals stable, stat (immediate) x-ray ordered . an order for [REDACTED]. An attempt to contact Nurse C was made on 7/7/20 at approximately 12:00 PM. A voice message was left for the staff. No return call was made prior to the exit. On 7/8/20 at approximately 3:00 PM, a request for the Incident/Accident (I/A) report pertaining to R#704's report of a fall with pain, the Facility reported that they did not complete an I/A. District Director of Clinical Services - Nurse A stated, We did not do an I/A because R#704 indicated that they fell and got back into bed. There would have been no way that could have happened as R#704 is a quad and would not have been able to get back into bed on their own. There was no record that indicated that R#704 indicated that they had climbed back into the bed or how the fall occurred. Nurse A was then queried as to whether the report of pain in the bilateral knees by R#704 who was assessed as a high risk for falls should have been investigated to determine if the pain was an injury of unknown origin or an actual fall had occurred, Nurse A responded, Yes. I understand what you are saying. It (an investigation) should have been done. A review of the Facility Policy titled, Fall Management (Revision date July 2017) documented, in part, the following: Policy: The facility assists each resident in attaining/maintaining his or her highest practicable level of function by providing the resident adequate supervision .the presence or absence of a resultant injury is not a factor in the definition of a fall. A fall without injury is still a fall .the facility is obligated to investigate to determine how the resident got there .
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation refers to Intake #MI 778 Based on observation, interview and record review, the facility failed to ensure catheter care was provided in a sanitary manner for two residents (R#707 and R#708) of three residents reviewed for catheter care, resulting in the increased potential for infection to develop. Findings include: Resident #707 On 7/7/20 at 1:40 p.m., R#707 was observed asleep in bed with their catheter bag clipped to the left, side of the bed near the door of the room. There was no privacy bag covering the urine drainage bag. On 7/7/20 at 1:46 p.m., Resident Care Specialist/Certified Nursing Assistant (RCS/CNA) 'I' was asked about the location of R#707's catheter bag. At that time, RCS/CNA 'I' moved the catheter bag to the right side of the bed. A privacy bag was not covering the catheter. On 7/8/20 at 10:50 a.m., during an interview with R#707, Registered Nurse (RN) 'J' entered the room to provide water for hydration. At that time, R#707's catheter bag was observed lying flat on the floor without a privacy bag covering it. RN 'J' did not notice the catheter bag on the floor and left the room. When asked how often staff checked their catheter bag or emptied it, R#707 stated, One or two times a day. They drain it and empty it. A review on the clinical record revealed R#707 was admitted into the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. The most recent significant change MDS (Minimum Data Set) assessment dated [DATE] revealed R#707 had a BIMS (Brief Interview for Mental Status) score of 8 out of 15 which indicated moderately impaired cognition and required extensive to total assistance with one to two-person physical assist for activities of daily living. The MDS revealed R#707 had an indwelling catheter. Physician orders [REDACTED]. Monitor for potential complications of indwelling urinary catheter use such as redness, irritation, signs/symptoms of infection, obstruction, urethral erosion, bladder spasms, hematuria, or leakage around the catheter every day and night shift for catheter care. Use catheter securing device to reduce excessive tension on the tubing and facilitate urine flow. Rotate site of securement daily and PRN every day and night shift for catheter care. The facility's care plan for R#707 was reviewed and revealed the following: Date: 6/24/20 - Observe and document intake and output as per facility policy. Date: 6/25/20 - I have Indwelling Catheter: Skin Breakdown . I have (16fr) (indwelling). Position catheter bag and tubing below the level of the bladder. Date: 7/2/20 - I have a Stage 4 pressure ulcer development to coccyx/B/L (bilateral) buttocks . I am at risk for further breakdown r/t (related to) deconditioning/DM (diabetes mellitus)/weight loss/wound infection. On 7/8/20 at 11:55 a.m., during an observation of R#707's room along with RN 'J', the catheter was still flat on the floor without a privacy bag. When queried who was responsible for maintaining R#707's catheter, RN 'J' stated, It's everybody's responsibility. When asked if the catheter should have been in a privacy bag, RN 'J' stated, We have some privacy bags on order. When queried if the catheter bag should be on the floor, RN 'J' stated, No, it should be hanging on the bed. On 7/8/20 at 12:01 p.m., an interview was conducted with the Administrator and Director of Clinical Services 'A'. When asked about R#707's Catheter bag on the floor, Director of Clinical Services 'A' stated, Staff was educated last night to check for placement when residents are moved and repositioned. When asked if catheter bags should be placed on the floor, the Administrator stated, Absolutely not. It should be hanging on the bed in a privacy bag. Resident #708 On 7/7/20 at approximately 1:56 p.m. and again at 2:58 p.m., R#708 was observed in their room lying in their bed. R#708's catheter bag (plastic bag that urine drains into) was observed on the facility floor containing dark amber colored urine. No privacy/barrier device was observed separating the bag from the floor. R#708's catheter tube (plastic tubing for urine to travel through) was also observed on the facility floor without any clips being utilized to prevent the tubing from touching the floor. R#708's dressing that covered their Suprapubic cite (hole in the body below the abdomen in the bladder for urine to exit through the catheter tubing) was observed to have some dried blood on it and was dated for 7/3/20. On 7/8/20 at approximately 8:45 a.m., R#708 was observed in their room lying in their bed. R#708's catheter tubing was again observed on the facility floor without any clips being utilized to prevent it from touching the floor. On 7/7/20 the medical record for R#708 was reviewed and revealed the following: R#708 was last admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. A review of R#708's MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 4/24/20 revealed R#708 needed extensive assistance with most of their activities of daily living. Section H indicated R#708 had an indwelling catheter. R#708's BIMS score (Brief interview on mental status) was 14 indicating intact cognition. A physician's orders [REDACTED]. A review of R#708's active care plan revealed the following: Focus-I have a foley (indwelling catheter attached to the penis) Catheter: [MEDICAL CONDITION] bladder .Goal-I will show no s/sx (signs/symptoms) of Urinary infection through review date .Interventions-Anchor catheter to prevent excess tension. Change catheter PRN . I have a 18f (french) foley with a 10ml (milliliter) balloon .The resident has a 18f indwelling foley. Position catheter bag and tubing below the level of the bladder .Check tubing for kinks each shift .Observe/record/report to MD (Medical Doctor) for s/sx UTI (urinary tract infection): pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, Urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns . On 7/7/20 at approximately 2:48 p.m., RCS (resident care specialist) H was shown R#708's catheter bag and tubing on the floor without the clips to hold it off the floor being utilized. RCS H indicated that was not appropriate and that R#708 should have a privacy bag covering the urine bag to conceal R#708's urine. RCS H was queried if the catheter bag and tubing should be on the facility floor and they indicated it should not and that it was a risk for infection. RCS H then reported they would have to change out R#708's catheter tubing and bag for clean ones. On 7/8/20 at approximately 12:07 p.m., during an interview with the DON (Director of Nursing), the DON was queried regarding their expectations for catheter care in the facility. The DON indicated that the staff should be utilizing the clips on the side of the bed to hold the catheter bag and tubing off the floor as well as

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F 0690 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) utilizing a privacy bag to conceal the urine. The DON was queried regarding R#708's care plan and they indicated that they had placed a generic care plan for catheters in R#708's record because they (R#708) didn't have any care plan addressing their catheter before. The DON indicated that they had thought it would have been updated to reflect the care for R#708's suprapubic catheter. The DON was queried regarding the observation of R#708's suprapubic cite dressing and they indicated that it was their expectation that it is changed on the midnight shift every night. The DON reported that they were in the process of providing education to the staff on how to appropriately care for residents requiring catheter care. A review of the facility's policy titled Indwelling Catheter Care revised December 2009 revealed the following: PURPOSE-Care and maintenance of indwelling catheters is essential to prevent infection and/or complications . The facility's policy did not address placement of the catheter (floor/bed) or privacy use.

F 0698

Level of harm - Actual harm

Residents Affected - Few

Past noncompliance - remedy proposed

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

This citation pertains to Intake #MI 104 Based on interview and record review, the Facility failed to ensure Resident #704 was transported to outpatient [MEDICAL TREATMENT] per their physician ordered schedule/plan of care and ensure ongoing communication between the [MEDICAL TREATMENT] center and the facility was completed for one (R#704) out of two reviewed for [MEDICAL TREATMENT] services, resulting in R#704 missing [MEDICAL TREATMENT] services on at least two occasions, an emergency transfer via EMS to the hospital, [MEDICAL CONDITION] (elevated potassium level that can lead to [MEDICAL CONDITION]), and emergent [MEDICAL TREATMENT] provided at the Hospital. Findings include: A complaint was filled with the State Agency that alleged that facility staff failed to ensure R#704 received their [MEDICAL TREATMENT] resulting in hospitalization . The complainant reported that the Facility failed to provide a hoyer lift strap on [DATE] resulting in R#704 missing a [MEDICAL TREATMENT] treatment and failed to resend R#704 to the [MEDICAL TREATMENT] center on the next scheduled day ([DATE] or [DATE]) and that they reported their concern to the physician and was later informed that R#704 was sent to the Hospital due to a change in condition. The complainant reported that the resident expired in the Hospital on [DATE]. A survey was conducted on [DATE]-[DATE]. A review of R#704's clinical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. R#704's Minimum Data Set (MDS) indicated that the resident had a Brief Interview for Mental Status Score (BIMS) of 10 (moderately impaired cognition) and required two-person assist for transfers. R#704's care plan documented the following: I have an ADL (activities of daily living) self-care performance deficit .Interventions . I require (extensive assistance) by (1) staff to move between surfaces with Hoyer lift .I need [MEDICAL TREATMENT] .Tu/TR/SAT (Tuesday, Thursday and Saturday) @ (Name Redacted) P/U (pick-up) 10 AM . Interventions [MEDICAL TREATMENT] Communication Record is sent to the [MEDICAL TREATMENT] center with each appointment, and return form is ensured after appointment is completed . An order dated [DATE] documented, Must be sitting on Hoyer Sling When Going to [MEDICAL TREATMENT] . A nurse note dated [DATE] (10:47) and authored by Nurse C documented, in part, resident loa (leave of absence) to [MEDICAL TREATMENT] . A nurse note dated [DATE] (14:15) and authored by Nurse D documented, in part, the following: Resident was awaiting Transportation to [MEDICAL TREATMENT] unit, upon investigation I was informed the w/c (wheelchair) transportation companies are no longer transporting residents from this facility to and from (name redacted) [MEDICAL TREATMENT] units .Dr. (name redacted) notified and suggested sending her to hospital for [MEDICAL TREATMENT] .spoke with (name redacted) daughter .she does not want R#704 going to hospital today . A provider note authored by Nurse Practitioner (NP) B dated [DATE] (14:57)documented, in part, the following: Chief complaints . pt. (patient) daughter noticed pt. mental status appeared alerted via phone, will assess for infectious process vs missing HD (Hemo-[MEDICAL TREATMENT]), as pt has missed 2 HD appointments d/t transportation A SBAR (situation, background, assessment and recommendation) note dated [DATE] (19:05) and authored by Nurse D documented, in part, the following, .O2 (oxygen level) 60% .Appearance of resident is: The resident has missed her [MEDICAL TREATMENT] appointments and I think the toxins and excess fluid was building causing her breathing to be unmanageable. Causing tachypnea (rapid breathing) .Ambulance called .Resident transferred out of facility . A review of R#704's Hospital records documented, in part, the following: A facility Transfer/Discharge Report dated [DATE], .Chief complaint . R (respiratory) ,[DATE], T(temp) 97.6, O2 (60) . miscellaneous information .she hasn't had [MEDICAL TREATMENT] since [DATE]. Continued Hospital records documented, in part, .PT presents to (name redacted) Hospital for SOB (shortness of breath) .Pt states I was fine and suddenly I could barely breathe .While in ED (emergency department), pt found to be hypoxic . she received [MEDICAL TREATMENT] (in hospital) and had 2L removed during [MEDICAL TREATMENT] .her [MEDICAL CONDITION] improved and her oxygen requirements improved . Hospital lab work indicated .Abnormal Result . Potassium 9.4 (Ref range 3.5 -5.2) . Glucose .743 . Orders placed . Emergent [MEDICAL TREATMENT] treatment . On [DATE] at approximate 11:00 AM, [MEDICAL TREATMENT] Nurse E from (name redacted) [MEDICAL TREATMENT] center was interviewed via phone. [MEDICAL TREATMENT] Nurse E reported that according to the Center's records the last [MEDICAL TREATMENT] treatment provided by the center was on [DATE]. Nurse E was asked if R#704 needed the Facility to provide a sling used for transfer to the [MEDICAL TREATMENT] chair and reported that they did and indicated that there had been times when the Facility did not always provide the sling and that [MEDICAL TREATMENT] would be rescheduled for either later in the day or the next day so as to avoid a long delay in treatment. A review of documentation provided by the (name redacted) [MEDICAL TREATMENT] Center documented that R#704's last treatment was on [DATE] and that the resident had missed treatments scheduled on [DATE] and [DATE] due to transportation issues. An attempt to contact Nurse C via phone was made on [DATE] and a voice message was left. No return call was made by the end of the survey. A phone call was made to NP B and a voice message was left on [DATE]. No return call was made by the end of the survey. On [DATE] an interview was conducted with Nurse D regarding R#704. When queried as to why R#704 did not receive [MEDICAL TREATMENT] treatment on [DATE] and [DATE], Nurse D replied that they were told that the transportation company used to take R#704 to [MEDICAL TREATMENT] was no longer providing services due to COVID-19. Nurse D was not sure when the failure to provide services started, but knew it was not available on [DATE]. When queried as to whether R#704 could have been sent via ambulance to [MEDICAL TREATMENT], Nurse D indicated that it was not an option. Nurse D stated they wanted to send R#704 to the hospital earlier, but family member did not want the resident going to the Hospital due to COVID-19. R#704 was noted as Full Code and no evidence was found in the clinical record that R#704 would have denied Hospital treatment or that the family member was legally able to make treatment decisions. An interview with the Administrator was conducted on [DATE] at approximately 10:20 AM. When queried as to why R#704 missed two [MEDICAL TREATMENT] appointments ([DATE] and [DATE]) and was sent to the hospital via EMS on [DATE], the Administrator reported that the contracted transportation service (name redacted) shut down its services due to COVID-19. When asked for the exact day, time and documented record as to date of shutdown, the Administrator reported that she did not have any documentation, but remembered that the Service representative (name redacted) came to the Facility and reported that they were not going to provide services. A phone call was made to the transportation service representative who indicated that services were stopped due to COVID-19 but could not provide an exact date or documentation. When queried as to whether the Facility had a back-up transportation service it could have used or utilized EMS, the Administrator reported that it did have a second transportation service contract, but it was also was not providing services and reported that she made arrangements with (name redacted) transportation and has been using that service currently. When asked if the reason R#704 did not receive [MEDICAL TREATMENT] services on [DATE] was due to a facility failure to provide a sling to get R#704 out of the wheelchair, the Administrator indicated that she did not believe R#704 required the sling and was not sure why the [MEDICAL TREATMENT] appointment was missed. A request was made for all [MEDICAL TREATMENT] communication forms for R#704 from admission ([DATE]) through [DATE]. The Facility was able to provide records for the following dates: [DATE], [DATE] (with recommendation/follow-up from [MEDICAL TREATMENT] center: please bring sling under pt. Pt. rescheduled for tomorrow 11 am [DATE]., [DATE] and two additional forms that were not dated or completed. A second request for [MEDICAL TREATMENT] communication forms was made. No further forms were provided by the end of the survey. A review of the Facility's policy titled, [MEDICAL TREATMENT], Care of Residents (Revised [DATE]) documented, in part, the following: The facility provides residents with safe, accurate, and appropriate care, assessments and interventions consistent with the Comprehensive Care Plan and the resident's goals and preferences .Admission and General Care: Review and ensure orders upon admission are received for follow-up [MEDICAL TREATMENT] center appointments .A [MEDICAL TREATMENT] Communication Record is initiated and sent to the [MEDICAL TREATMENT] center for each appointment. Ensure it is received upon return . A review of the Facility Policy titled, Referral to Outside Agencies (Revised Date [DATE])documented, in part, the following: The facility ensures that residents receive treatment and care from outside agencies .FUNDAMENTAL INFORMATION .Referrals are made for the following outside agencies/services .[MEDICAL TREATMENT]

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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 0698 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 3) services . Procedure: .6. If services are not provided at the facility, the facility arranges transportation to and from the outside agency .Appointments and transportation arrangements are communicated to direct staff .8. Information/forms required for the resident's appointment are prepared by social services and nursing. The packet includes: .[MEDICAL TREATMENT] Communication Form .