STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235487	A. BUILDING _____ B. WING _____	08/26/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SKLD WEST BLOOMFIELD	6950 FARMINGTON RD WEST BLOOMFIELD, MI 48322

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility (a designated facility that provides care to residents with COVID discharged from hospitals or from other facilities) failed to increase monitoring of COVID-19 positive ill residents to identify changes in condition per Centers for Disease Control (CDC) protocol including continued assessment of symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory examination, at least three (3) times daily to identify and quickly manage serious infection concerns for three residents, #806, #807 and #808; and failed to ensure newly admitted and/or readmitted residents were monitored for evidence of COVID-19 for 14 days after admission and cared for using all recommended COVID 19 PPE (personal protection equipment) for R#810 who was placed on a non-monitored transition unit from [DATE]-[DATE] and developed COVID-19, resulting in Immediate Jeopardy (IJ). These deficient practices placed ill COVID-19 positive residents, residents residing on R#810's unit and Health Care Personnel (HCP) staff who cared for the residents on (R#810's) unit at risk for serious harm, injury and/or death related to COVID-19. Findings include: The IJ began on [DATE], it was identified by the survey team on [DATE] and the facility was notified of the IJ on [DATE]. On [DATE], the State Agency completed onsite verification that the Immediate Jeopardy was removed on [DATE], however the facility remained out of compliance at a scope of pattern and severity of potential for more than minimal harm that is not Immediate Jeopardy due to sustained compliance that has not been verified by the State Agency. Failure to Increase Monitoring for COVID Positive Residents #806, #807 and #808 The Centers for Disease Control (CDC) Guidelines Preparing for COVID-19 in Nursing Homes (updated [DATE]) documents in part, .Residents with known or suspected COVID-19 should be cared for using all recommended PPE (personal protective equipment), which includes use of an N95 or higher level respirator (or facemask if a respirator is not available), eye protection (i.e. goggles or a face shield that covers the front and sides of the face), gloves and gowns .Increase monitoring of ill residents, including assessment of symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam, to at least 3 times daily to identify and quickly manage serious infection . R#806 A review of R#806's clinical record documented that the resident was admitted to the Facility's COVID-19 HUB unit on [DATE] with [DIAGNOSES REDACTED]. Further review of the resident's Minimum Data Set (MDS) documented that the resident had a Brief Interview for Mental Status (BIMS) score of ,[DATE] (severely cognitively impaired) and required extensive one/two person assist for most Activities of Daily Living (ADL). A Fall Risk Assessment form dated [DATE] indicated R#806 was at high risk for falls. It was documented that R#806 expired at the Facility on [DATE] at approximately 8:20 PM. Continued review of R#806's clinical record, documented, in part, the following: Admission progress note (dated [DATE]): Received (R#806) from Hospital (name redacted) .Admitting dx (diagnosis) +COVID-19 hx(history) of falls .lung sounds CTA (clear to auscultation, meaning normal lung sounds), non-labored breathing, no SOB (shortness of breath) .No distress or discomfort noted . Medical Practitioner Note (dated [DATE]. 22:35) .Pt (patient) tested positive for COVID .had no symptoms related to COVID .Advised 14 day isolation, no other acute symptoms or workup was necessary .PT had some respiratory distress during hospital stay .oxygen was added .Today, pt. is alert, able to answer simple questions .trying to climb out of bed and a fall risk .Plan .droplet isolation, monitor for respiratory distress . Medical Practitioner Note (dated [DATE] 13:04), .has c/o (complaint of) feeling like there is congestion in his lungs but .cough is not strong enough to clear .DIAGNOSIS/STATUS/PLAN .3. Acute cough .will order .inhaler 2 puff TID (three times per day) . Medical Practitioner Note (dated [DATE] 14:09): .Pt had a fall yesterday in room .states he is tired .sleeping but awakes spontaneously .has a small abrasion noted to the bridge of nose and slight [MEDICAL CONDITION] to left posterior eye .still has c/o congestion that is unable to clear with cough .O2 96% .will order Chest X-ray to r/o (rule out) infectious process . General Progress Note (dated [DATE]: 19:57): Pt c/o of pain in L(left) arm and asks to go to hospital . General Progress Note ([DATE] -19:58): Chest x-ray concludes mild left lower lobe pneumonia . Medical Practitioner Note ([DATE] 11:44): .increased number of falls. Pt seen recently .CXR(x-ray) ordered for increased congestion .today pt has som<sic> increased congestion .coughing and having a hard time bringing it up .pulse ox is 93% . Skilled Nursing ([DATE] : 1:12): Writer on coming to shift resident viewed by writer during nursing rounds .Around 8pm writer checked on resident still sleeping .8:40 PM writer alerted by staff upon care no breathing noted .cpr (cardiopulmonary resuscitation) initiated . resident not transf. (transfer) to hosp.(hospital) expired .body released to (name redacted) funeral home . R#806's Respiratory Symptom Evaluations (RSEs) were reviewed and revealed the following: [DATE] (one evaluation completed), [DATE] (no evaluations completed), [DATE] (one evaluation completed), [DATE] (one evaluation completed), [DATE] (two evaluations completed), [DATE] (two evaluations completed), [DATE] (two evaluations completed), [DATE] (no evaluations completed), [DATE] (one evaluation completed). [DATE] (the last evaluation completed by facility nursing staff E was completed at 11:00 AM, no evaluations/vitals were completed by Facility staff between 11:00 AM and 8:20 PM. It should be noted that R#806 expired on or about 8:20 PM. O2 Sats Summary from [DATE]-[DATE] were reviewed and documented: [DATE]: 98% (9:08 AM); 96% (08:23 PM) [DATE]: 95% (10:20 AM); 95% (11:04 PM) [DATE]: 96% (8:58 AM) [DATE]: 98% (9:07 AM); 92% (8:02 PM) [DATE]: 93% (11:00AM) An interview with Nurse E was conducted on [DATE] at approximately 2:30 PM. Nurse E reported that they had been employed at the Facility for almost one month. When queried as to what units they were generally assigned to, Nurse E indicated that they primarily were assigned to the COVID-19 unit. When asked if they had received any training by the Facility as to monitoring COVID-19 residents including resident's with declining conditions, Nurse E reported that they completed respiratory/vitals one time per shift and indicated that nurses work 12 hour shifts. It should be noted that R#806 last set of vitals was taken on [DATE] at 11:00 AM. O2 Sats were noted to be 93%. On [DATE] at approximately 10:35 AM, an interview was conducted with Physician M. When queried as to treatment of [REDACTED]. Physician M indicated that she would recommend at least every four hours. When queried as to R#806 who had shown a decline (coughing and confirmed pneumonia), Physician M indicated that the nursing staff should have increased monitoring for the resident and stated, It is nursing 101 to increase monitoring. R#807 A review of R#807's clinical record documented that the resident was admitted to the Facility's COVID-19 HUB unit on [DATE] with [DIAGNOSES REDACTED]. Further review of the resident's MDS documented that the resident had a BIMS score of ,[DATE] (severely cognitively impaired) and required extensive one person assist for most Activities of Daily Living (ADL). It was documented that R#807 expired at the Facility on [DATE] at approximately 12:20 PM. Continued review of R#807's clinical record documented, in part the following: Admit/Readmit note dated [DATE] (5:47 pm): Pt. admitted to facility ., Pt has 20 staples to L hip . Medical Practitioner Note dated [DATE] (3:21pm): .(R#807) at facility after hospitalization recently for COVID pneumonia . Medical Practitioner Note dated [DATE] (12:30 pm): .Pt resting in bed .is frail .joints are stiff .no lethargy noted .full passive ROM (range of motion) . Medical Practitioner Note dated [DATE] (5:41 pm): .Pt. is planning on Dc (discharge) home with son after 2nd negative Cosid <sic>test .however 2nd test results reported positive today. Pt. is to remain on droplet precautions with monitoring temp and O2 every 6 hours while in isolation . Medical Practitioner Note dated [DATE] (7:31 pm): .Pt. is to remain on droplet precautions with monitoring temp and O2 every 6 hours while in isolation . Medical Practitioner Note dated [DATE] (11:26 am): .decreased alertness .resting in bed mouth breathing .unable to take rx per nursing .drinking minimal fluids . General Progress Note

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 -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) dated [DATE] (2:58 pm): .Pt had previously been signed onto Hospice and taken off within 24 hours due to cost . General Progress Note dated [DATE] (4:05 pm): .Nurse verified with director of nursing that resident was not on hospice .at 4:00 pm resident received a dose of PRN (as needed) [MEDICATION NAME] and gurgling noted . General Progress Note dated [DATE] (12:34 pm): .Nurse was notified by cna (certified nursing assistant) that pt was unresponsive. Nurse assessed. Pt DNR (do-not-resuscitate). RN (registered nurse) called death at 12:20 PM. R#807's RSEs were reviewed. No evaluations were noted from [DATE]-[DATE]. RSEs from [DATE] through [DATE] revealed the following: [DATE] (one evaluation completed), [DATE] (one evaluation completed), [DATE] (two evaluations completed), [DATE] (two evaluations completed), [DATE] (one evaluation completed), [DATE] (one evaluation completed), [DATE] (one evaluation completed), [DATE] (no evaluations completed), [DATE] (one evaluation completed, [DATE] (one evaluation completed, [DATE] (two evaluations completed, [DATE] (two evaluations completed), [DATE] (one evaluation completed), [DATE] (two evaluations completed). The last set of vitals taken were taken on [DATE] at 4:49 PM and documented O2 SATS at 94% and Temp. 97.4 F. R#807 expired at the Facility on [DATE] and was pronounced dead at 12:20 PM. No evidence was noted that R#807 was monitored every 6 hours for O2 SATS or temps as ordered by the physician [DATE] as well as following CDC Guidelines that indicated Increase monitoring of ill residents, including assessment of symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam, to at least 3 times daily to identify and quickly manage serious infections . R#808 R#808 was admitted into the facility COVID unit on [DATE] with the single [DIAGNOSES REDACTED]. The resident Clinical Census documented that the resident expired on [DATE]. A review of the clinical record revealed the following: A Nursing noted dated [DATE] at 11:13 am, documented in part . Day 1 admit, Aox1 (alert and oriented, times one), confused and agitated. VS (Vital Signs) stable and recorded. Pt (patient) shows no facial grimaces of pain at this time. Pt has a <sic> order for IV (intravenous) Abt (antibiotic) for pneumonia and will be started on that today . A Medical Practitioner Note dated [DATE] at 15:33 (3:33 pm) documented in part . Pt had a fall . She is COVID+ on ,[DATE] . she has sutures above L (left) eyebrow with dried blood . very weak . A Nursing note dated [DATE] at 19:56 (7:56 pm) documented in part . Writer notified by staff while doing room rounds around 7:15pm resident unresponsive. Writer entered room, writer observed no rise and fall noted, sternum rub done no response, no vitals noted. Resident is DNR (Do Not Resuscitate) compass hospice notified, hospice states they will be in facility to pronounce TOD (Time of Death) and will notify family and make arrangements . The vital sign log was reviewed and revealed the facility failed to complete assessments per CDC's guidance for COVID in the nursing homes. The log documented the following: On [DATE] (taken twice on this day) 10:44 am- T (temperature)- 97.9 F (Fahrenheit), O2 sat (the level of oxygen in the blood)- 94% on RA (room air) and 22:32 (10:32 pm) - T- 97.4, O2 Sat- 96% on RA On [DATE] (taken twice on this day) 11:48 am- T- 97.6, O2 sat- 97% and 21:47 (9:47 pm) - T- 97.3, O2 sat- 97% On [DATE] (taken twice- temperatures were taken less than an hour apart)- O2 sat (10:52 am)- 96%, 13:52 (1:52 pm)- T- 97.6 and 14:50 (2:50 pm) - T- 97.9, O2 sat- 96% On [DATE] (taken twice on this day) 11:51- T- 98.2, O2 sat- 95% and 21:22 (9:22 pm) - T- 98.2, O2 sat- 95% On [DATE] (taken once on this day) 22:41 (10:41 pm) - T- 97.5, O2- 97% On [DATE] (taken twice on this day) 11:19 am- T- 98.1, O2 sat- 97% and 21:28 (9:28 pm) -T- 97.5, O2 sat 97% (9:29 pm) On [DATE] (taken once on this day) 1:27 am- T- 97.5, there were no O2 sats documented for [DATE]. R#808's Respiratory Symptom Evaluations were reviewed and revealed the following: [DATE] two evaluations completed, ,[DATE] one completed, ,[DATE] one completed, ,[DATE] one completed, ,[DATE] two completed, ,[DATE] one completed, ,[DATE] two completed, ,[DATE] two completed and there were no documented Respiratory Symptom Evaluation(s) for [DATE], ,[DATE], and ,[DATE]. The facility failed to consistently assess the resident on [DATE], who at 7:56 pm was found unresponsive and their death was pronounced shortly after. On [DATE] at 9:24 am, the DON and Corporate Infection Control Nurse (CICN) C was queried regarding the facility's lack of assessments and vital monitoring of residents with COVID and acknowledged the facilities deficient practice and the Infection Control Nurse stated in part . We would follow CDC's current recommendations . The facility policy titled Novel Coronavirus Control Plan (last updated [DATE]) was provided on [DATE] and documented in part, the following . Resident Care: . Daily temperature checks and monitoring for respiratory symptoms are recommended to assess for changes in the residents' condition . The policy revealed outdated guidance. The policy did not reflect CDC's current guidance for COVID in the nursing homes. New Admission Placement (R#810) The Centers for Disease Control (CDC) Guidelines Preparing for COVID-19 in Nursing Homes (updated [DATE]) documents in part, Create a Plan for Managing New Admissions and Readmissions Whose COVID-19 Status is Unknown. Depending on the prevalence of COVID-19 in the community, this might include placing the resident in a single-person room or in a separate observation area so the resident can be monitored for evidence of COVID-19. HCP should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a face shield that covers the front and sides of the face), gloves, and gown when caring for these residents. Residents can be transferred out of the observation area to the main facility if they remain afebrile and without symptoms for 14 days after their admission. Testing at the end of this period can be considered to increase certainty that the resident is not infected . R#810 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. An MDS assessment dated [DATE] documented a BIMS of 7 (indicating severely impaired cognition) and R#810 was dependent on staff for all ADL's. The facility currently has two units dedicated for new and/or readmissions. On these two units, the facility staff are required to apply all recommended COVID-19 PPE while caring for these residents. CDC's guidance for new/readmissions in the nursing home documents in part . Newly admitted or readmitted residents should still be monitored for evidence of COVID-19 for 14 days after admission and cared for using all recommended COVID-19 PPE . New residents could be transferred out of the observation area or from a single to a multi-resident room if they remain afebrile and without symptoms for 14 days after their last exposure (e.g., date of admission) . A Clinical Census report documented R#810 was admitted to a unit that was not designated for new and/or readmissions. A review of the clinical record revealed the following: A review of the physician orders [REDACTED]. A Nursing note dated [DATE] at 11:03 am documented in part b/p (blood pressure) ,[DATE], pulse 113, respiration 20, spo2 with 2-liter N/C 35 (normal levels ,[DATE] %), with 5-liter N/C 97%, patient confused, restless, not eating or drinking, notified son, requested to send him to hospital, notified doctor, son requested to send him to (hospital name redacted), NOTIFIED AMBULANCE . The facility Corporate Infection Control Nurse (CICN) C provided COVID-19 test results for R#810 that documented a positive COVID-19 test dated [DATE]. On [DATE] at 12:51 pm, the DON and DON in training was queried regarding R#810's initial placement into the facility on admission and staff not utilizing the proper PPE while providing care to the resident and acknowledged the deficient practice. At that time documentation was requested of COVID-19 test results for all other residents that resided on that unit during [DATE] and [DATE], as well as COVID-19 test results for all facility staff that provided care in that hallway during that time period. Delayed test results and inconsistent tracking of staff made it difficult to identify additional residents/staff members affected by this deficient practice. The facility policy titled Novel Coronavirus Control plan (last updated [DATE]) documented in part, . Resident Care: Observe new admission (residents) for development of respiratory symptoms and implement appropriate infection prevention practices for symptomatic residents . The policy revealed outdated guidance. The policy did not reflect CDC's current guidance for COVID in the nursing homes. Observations of both the COVID-19 Unit and the two monitoring units were conducted during the Survey as follows: On [DATE] at approximately 11:00 AM, Certified Nursing Assistant (CNA) N was observed exiting off the COVID-19 unit holding gowns and towels. When queried as to care of the COVID-19 residents, CNA N reported that they needed to leave the unit to obtain a mask for a resident. When queried as to whether masks were available on the COVID-19 unit, the CNA indicated that they may have been locked in the nursing cart, but the nurse was not on the unit. When queried as to the where the nurse was, CNA stated they were not sure. On [DATE] at 12:10 pm, Registered Nurse (RN) E, who was the only nurse assigned to the COVID unit, was observed outside of the COVID unit and sitting at the nurses station which contained all of the residents who resided on the COVID unit charts. RN E was observed on the phone with their face mask under their chin. When queried regarding their face mask, RN E stated they normally would not wear their mask below their chin. Further observation revealed the COVID unit crash cart located outside the contained doors of the COVID unit. RN E was then queried on if they had a resident in distress or unresponsive how would they know the residents code status and/or obtain the crash cart. RN E stated I would have to take off all of my PPE and leave off the COVID unit to get to the charts to check the code status and retrieve the crash cart and then go back on the COVID unit. On [DATE] at 1:37 pm, observations were completed on the two monitoring units. These units were designated by the facility to place new admissions and readmissions, to monitor them for 14 days per CDC's guidance. After entry onto the first monitoring unit, a housekeeping staff was observed coming out of a resident's room to go to their cart. This housekeeping staff was wearing a KN95 mask. At 1:45 pm, Certified Nursing Assistant (CNA) T was the only staff member observed on the unit (since entry at 1:37 pm). CNA T was asked what they would do if they found/observed a resident in respiratory distress. CNA T replied in part . well I would tell the nurse, but she isn't on the floor right now. I would have to take off all of my PPE (Personal Protective

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) Equipment), go off of the unit and find management or a receptionist for them to page the nurse . At 1:52 pm, the second monitoring unit was observed. Four staff members (one nurse, 2 CNA's and one housekeeper) was observed entering and exiting resident rooms with no shield or protective eye equipment on. Licensed Practical Nurse (LPN) U was queried on why they weren't utilizing eye protective equipment when caring for the residents and stated in part . We were told to only use it if we came in contact with bodily fluids . LPN V was observed walking onto the second monitoring unit and after entry was observed donning on all PPE. LPN V was queried on if they are supposed to don on the PPE before or after entering the contained unit and stated in part that was my question . I was asking the same thing . At 2:05 pm, the facility's designated COVID unit was observed, upon entering the unit and walking throughout, there was no staff present on the unit and a resident's call light was blinking on and off. At 2:11 pm, a CNA arrived on the unit. The DON was queried on if this was normal practice for the facility to not have any staff member on the COVID unit, and if so, who would be able to promptly identify a change of condition with a resident as it occurs, The DON acknowledged the concern and stated a staff member should be on the unit at all times.