STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235480	A. BUILDING _____ B. WING _____	**05/29/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ADVANTAGE LIVING CENTER - HARPER WOODS	**19840 HARPER AVE HARPER WOODS, MI 48225**

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 0684 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Deficient Practice Statement #1 Based on interview and record review, the facility failed to identify a deteriorating medical condition and transport a resident who requested to go to an acute care setting, for one resident (#703) of three reviewed for a change in condition, resulting in Resident #703 becoming increasingly ill, uncomfortable, and expiring within the facility. Findings include: The Immediate Jeopardy (IJ) started on [DATE] and was identified on [DATE]. The Administrator was notified of the Immediate Jeopardy on [DATE] at 3:18 PM and was asked for a plan to remove the immediacy. The IJ was removed on [DATE], based on the facility's implementation of the removal plan as verified onsite on [DATE]. Although the immediacy was removed, the facility's deficient practice was not corrected and remained isolated with actual harm that is not immediate jeopardy. On [DATE] at 11:22AM, a Confidential Resident (D) was interviewed regarding the facility and their method of communication to update current residents in the facility about the [MEDICAL CONDITION]. Confidential Resident D explained that they felt the facility was not notifying the residents of how many positive cases are within the facility. Confidential Resident D also stated that they were upset because they had lost a friend (Resident #703), whom was another resident in the facility, from the Coronavirus. A record review was completed for Resident #703. The electronic medical record (EMR) revealed the resident was admitted to the facility originally on [DATE], was sent out to the hospital on [DATE] for a fever and a decrease in oxygen saturation requiring a new order for oxygen. Resident #703 was readmitted to the facility on [DATE]. A record review of the Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #703 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating an intact cognition. The MDS also revealed that the resident needed extensive assistance from staff for activities of daily living (ADL) and had the [DIAGNOSES REDACTED]. A record review of the Advanced Directives revealed that Resident #703 was a full code and wished to be transferred to the hospital for changes in medical status as of [DATE]. A record review of the facesheet indicated Resident #703 had one emergency contact (daughter) and was listed as self, meaning own responsible party. An attempt to interview the emergency contact via phone was made on [DATE] at 9:00am and 1:00pm with no call back by the end of the survey. A record review of the care plan for Resident #703 revealed the following: Focus-I have altered respiratory status/difficulty breathing OR potential for an alteration in respiratory status r/t (related to) my history of COVID-19, pneumonia, acute respiratory status with [MEDICAL CONDITION] Revised [DATE]. Goal-I will maintain normal breathing pattern as evidenced by normal respirations .and regular respiratory rate/pattern . Interventions-Monitor for s/sx (signs and symptoms) of respiratory distress .increased respirations; Decreased pulse oximetry, increased heart rate ([MEDICAL CONDITION] .Lethargy; Confusion . A record review of the progress notes for Resident #703 revealed the following: [DATE] 23:36 (11:36PM) Admission Note .Resident (#703) readmitted . with Dx (diagnosis) of Covid-19 (+), Pneumonia,[MEDICAL CONDITION](high blood pressure) . O2 (oxygen) on via nasal cannula at 4L (liters)/min (minute), HOB ^(head of bed up). Resident alert and responsive, able to make needs known . [DATE] 13:30 (1:30PM) Respiratory Therapy Note .Resident seen by Skilled RT (respiratory therapy). Resident has been transferred to isolation and is receiving Covid 19 screening daily. Resident has a history of [MEDICAL CONDITION]. RT found resident on room air. Sp02 (pulse ox) 60% (normal is ,[DATE]%). RT placed resident on 4 liters via nasal cannula. Sp02 increased to 96%. HR (heart rate) 112 (normal is ,[DATE]) RR (respiratory rate) 20. Breath sounds are bilateral with coarse rhonchi (rattling respiratory sounds usually caused by secretions in the airways). Respiration are uneven (lungs not expanding at the same time) and slightly labored (normal is even, unlabored). Continued oxygen support is indicated. RT communicated with nurse and notified of resident's Sp02, HR, and RR. Oxygen order 4 liters and pulse ox q (every) 6 (hours) placed in (EMR) by RT. Skilled RT spent approximately 30 minutes with resident. [DATE] 14:40 (2:40PM) Respiratory Therapy Note . Resident seen by Skilled RT. Resident has been transferred to isolation and is receiving Covid 19 screening daily. Resident has a history of [MEDICAL CONDITION]. Sp02 94% on 4 liters via nasal cannula. HR 85 RR 20. Breath sounds are bilateral with scattered rhonchi. Respiration are uneven and slightly labored. Continued oxygen support is indicated. RT communicated with nurse and notified of resident's Sp02, HR, and RR. Oxygen order 4 liters . Skilled RT spent approximately 20 minutes with resident. [DATE] 19:59 (7:59PM) Nurses Note Late Entry .Resident Alert, very lethargic (drowsy) sleeping on and off. BP (blood pressure) ,[DATE] (normal is ,[DATE]) MD (Medical Doctor/Dr. B) notified, resident 0.9 sodium chloride ordered to hang at 70cc's (cubic centimeters) x3 1000 bags hypodermoclysis (a method of fluid infusion underneath the skin tissue) location site left side. Site dry intact. BP medications on hold x3 days . An attempt was made to call ([DATE] 10:00AM) the nurse who authored this note, however, the nurse did not return telephone calls by the end of the survey. [DATE] 12:00 (PM) Respiratory Therapy Note .Resident seen by Skilled RT. Resident is receiving Covid 19 screening daily. Sp02 91% on 4 liters via nasal cannula. HR 101 RR 22. Breath sounds are bilateral and diminished (air or fluid build up in or around the lungs). Respiration uneven and labored with dyspnea (difficulty breathing). Continued oxygen support is indicated. RT communicated with nurse and notified of resident's Sp02, HR, and RR. Oxygen order 4 liters .Skilled RT spent approximately 15 minutes with resident. [DATE] 11:23 (AM) Nurses Note .Writer noted that res (resident) had a very small amount of emesis (vomit) W/a (with a) very small amount of blood, VS (vital signs) assessed & recorded BP: ,[DATE], P: 76, T: 97.7, RR: 18, 02SAT 95% via N/C (nasal cannula) infusing @ 5LPM (liters per minute), W/O (without) resp.(respiratory) distress noted, res stated that they wanted to be transferred from facility (to hospital), writer informed assigned MD regarding all stated above, MD prescribed no new orders & denied transfer (to hospital) D/T (due to) res not having an acute reason for hosp.(hospital) transfer, res also C/O (complained of) hypodermaclysis site .writer removed hypodermaclysis .writer will cont (continued) to monitor res. Authored by Licensed Practical Nurse (LPN) A. [DATE] 09:35 (AM) Respiratory Therapy Note .Resident seen by Skilled RT. Resident is receiving Covid 19 screening daily. Sp02 91% on 4 liters via nasal cannula. HR 105 RR 22. Breath sounds are bilateral and diminished. Respiration uneven and labored with dyspnea increased O2 to 5 liters [DATE] 10:00 (AM) Respiratory Therapy Note .Resident seen by Skilled RT. Resident is receiving Covid 19 screening daily. Sp02 94% on 5 liters via nasal cannula. HR 115 RR 22. Breath sounds are bilateral and diminished. Respiration uneven and labored with dyspnea. Continued oxygen support is indicated. RT communicated with nurse and notified of resident' s Sp02, HR, and RR. RT notified nurse of resident lethargic state and 'twitching' with upper body. Nurse assessed and called NPA (Nurse Practitioner), who arrived to room. Oxygen order 5 liters .Skilled RT spent approximately 25 minutes with resident. An attempt was made to call the above mentioned RT on [DATE] at 11:00am, the RT was on bereavement leave and unavailable per the Nursing Home Administrator (NHA). A record review of the COVID-19 Monitoring Assessment for Resident #703 revealed the following: [DATE]-Res (resident) A&O (alert and oriented) C/O pain whenever repositioned .res produces a very small amount of emesis W/a (with a) very small amount of blood noted this A.M. res. request to be transferred to (local hospital) assigned MD notified regarding findings with no new orders prescribed & denied res request .meals intake adequate, need to assist at

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 0684 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) times. [DATE]-Pulse 106, loss of appetite checked. Narrative note stated, Resident A&Ox,[DATE] with come (sic) confusion, able to make needs known .Patient c/o n/v (nausea and vomiting). [MEDICATION NAME] (an anti-nausea medication) given. [DATE] 09:00 (AM) NURSE PRACTIONER (NP C) .Progress Note .altered mental status .This is a [AGE] year old .with a past medical history including and not limited to heart failure, diabetes, hypertension, [MEDICAL CONDITION]([MEDICAL CONDITION]/stroke) .required transfer to acute care facility on ,[DATE] when .found in .room with lethargy, elevated temperature of 103 and hypoxemia (low oxygen saturation) at 79% on 15 liters mask .treated for [REDACTED].was noted with restlessness and c/o worsening muscle weakness .alert and responds to verbal stimuli .no apparent distress, seen sitting up in bed in .room .does require assistance with meals due to weakness since returning from the hospital .denies pain overall .Appears somewhat more confused than baseline. ASSESSMENT/PLAN: - Altered mental status; accucheck 107 (blood glucose levels), VSS (vital signs stable); no noted hypoxemia. Will obtain STAT (Urgent) CBC (complete blood count) and BMP (basic metabolic panel), UA (urinalysis) to r/o (rule out) underlying metabolic cause. - COVID 19; s/p (status [REDACTED].Debility .Patient is stable to remain in the facility at this time, will require close monitoring over the next 24 hours to ensure ongoing improvement, any further changes in condition .may require transfer to acute care facility for further evaluation. Attending was updated and agreeable to plan of care. [DATE] 20:04 (8:04PM) Nurse Note .At 9:50 a.m. noted to be twitching from left side of .body down to .foot. NP notified STAT labs and STAT urine ordered. Refused to let nurse straight catheter .unit manager and DON (Director of Nursing) notified, awaiting labs to be drawn. VS ,[DATE] 115 (pulse) 98.2 ax (temperature-normal is between ,[DATE]) .O2 sat 93% O2 @ 5L/min. Authored by Licensed Practical Nurse A. [DATE] 20:26 (8:26PM) Nurses Note . Lab arrived around 2:20 p.m. drew blood, around ten minutes later therapy went in to do therapy and (Resident #703) was unresponsive. Code called, unable to obtain VS, staff performed CPR (cardiopulmonary resuscitation) until 911 services arrived .Emergency responders performed two epi ([MEDICATION NAME]) series and @ 15:11 (3:11) p.m .pronounced (Resident #703) decease .At 5:40 p.m .Funeral Home signed for the remains. On [DATE] at 11:12AM, the NHA was asked the expectations of staff for a resident (#703)that is not improving medically, a full code, with an intact BIMS, and had asked to go to the hospital and stated, We would pull the IDT (interdisciplinary team) together and call the Doctor and discuss. He (Doctor) was not seeing a change in condition and with the COVID pandemic we were trying to follow CDC (Centers for Disease Control) guidelines and not send (Resident #703) to the hospital if we didn't have to. The NHA was asked if knowing the outcome (Resident #703 expiring in the facility on [DATE]) if he would have sent Resident #703 to the hospital and stated, Well yeah, hindsight is always different. Usually it is the opposite, the Doctor wants them (residents) to go to the hospital and they don't want to go, we have to respect their wishes. The NHA was asked if a resident's wishes are to go to the hospital, is that their right, and stated, (Resident #703) was delusional. When asked if Resident #703 was normally delusional, the NHA stated, Usually, no, they came back to us that way from the hospital. The NHA was asked if Resident #703 was at baseline ever when returned to the facility and stated, No, (Resident #703) wasn't. On [DATE] at 11:32AM, NP C was interviewed in regard to the choice to not send Resident #703 to the hospital with a deteriorating condition and a direct request to be sent out and stated, Initially when (Resident #703) returned they did not want to have to go back to the hospital. When asked if that was in writing, the NP stated, I did not say that, I said initially they did not want to go back. At the time, the vital signs were stable and the [MEDICAL CONDITION] had resolved. On [DATE] at 11:47AM, LPN A was interviewed regarding the condition of Resident #703 on [DATE] and stated, They were twitching. LPN A was asked if it was [MEDICAL CONDITION] activity and stated, No. When asked what NP C did about the situation, LPN A stated, Labs and a UA were ordered. On [DATE] at 12:05PM, LPN A was interviewed per telephone and stated, I asked for (Resident #703) to go to the hospital and I grabbed (NP C), and had her look at them. She ordered labs and called the Doctor (Dr. B) to discuss with him what was going on and he said to not send (Resident #703) to the hospital. LPN A was asked what they did next and stated that she attempted to get the UA but the resident refused. LPN A was asked if they felt that Resident #703 needed to go to the hospital and explained that she felt that the resident should have been sent to the hospital. On [DATE] at 12:40PM Dr. B was interviewed via phone and was asked for the reason why Resident #703 was not transported to the hospital upon their request and with a change in condition and stated, I can't recall if I seen them but the vital signs were stable and did not show decomposation. We need to see them and then decide if it is and emergency of if we can treat them in the facility. She was medically stable. The Dr. was asked if he was aware of the RT charting of several days of unlabored breathing and stated, Their lung sounds were clear to auscultation when I seen them. On [DATE] at 1:14PM, the DON was interviewed in regard to Resident #703 requesting to be hospitalized and declining in their overall health condition and stated, We wouldn't deny anybody to go to the hospital. They were seen by our NP and the Doctor. They probably felt like (Resident #703) could be treated here. The DON was asked if she was aware of the resident's condition and stated, Yes, I knew them well, they were one of my favorites. (Resident #703) called my personal cell phone and asked me to bring them hot tea and honey. I brought some tea up there at 10 at night and sat with them and we prayed (for their health) together .(Resident #703) had aches and pain and was on [MEDICATION NAME] (a pain reliever) and would refuse anything stronger. (NP C) did order some'labs. The DON was asked if the nurses are allowed to make a judgement call and send a full code resident that is medically declining to the hospital if they request and stated, We have an NP in the building, they can always ask her or the Doctor. I am not sure why the Doctor did not send (Resident #703), that is a NP or Doctor question. A review of the facility policy titled, Acute Change in Condition (undated) revealed the following: An acute change in condition (ACOC) is a sudden, clinically important deviation from a resident's baseline in physical, cognitive, behavioral, or functional domains. Clinically important means a deviation that without intervention, may result in complications or death. Guidelines-#2. Residents are assessed upon admission to establish 'Baseline Data'. Interact ACOC Warning Signs-Blood Pressure .any significant decrease may trigger an ACOC (e.g.,systolic (top number of BP) BP < (less than) 100 .decline in BP accompanied by other symptoms such as dizziness, decline in systolic BP<15mm (millimeter) in systolic BP, combination of pulse >100 beats . Pulse-Sustained change from normal range .Pulse> (greater than)100 bpm (beats per minute) accompanied with other symptoms (e.g., .dyspnea). Weight/Eating Patterns .A change in eating/drinking patterns. Level of Consciousness-Level of consciousness is the degree of awakeness, i.e. alert, drowsy/lethargic . Weakness-New onset of weakness .Significant variation from baseline .Significant change in ADL ability. Cognitive Symptoms-abrupt onset of, or increase in, confusion. Onset of hallucinations, delusions, or paranoia. Bleeding-Appearance of frank blood in stool, urine, or vomit. A review of the facility policy titled, Advanced Directives Policy(not dated) revealed the following: Policy-The Facility will honor valid advanced directives or treatment preferences made by the resident or healthcare legal decision maker for the resident. Decision-Making Authority-No one can make medical decisions for a resident with capacity, except the resident. A review of the facility policy titled, Resident Rights (undated) revealed the following: 3. Planning and Implementing Care .e. The right to request, refuse, and/or discontinue treatment . IJ Abatement Plan - F684 1. Resident #703 is no longer in the facility. 2. All 102 residents have the potential to be affected. - Residents with Change of condition will be identified immediately, changes will be communicated to the physician/IDT. Physician recommendations will be followed in agreement with the residents or responsible party wishes. Family will be notified of changes. Care plan will be implemented and updated as required. - Adhoc QAPI (Quality Assurance Process Improvement) completed with Medical Director, Administrator, DON, Unit Manager to discuss change in condition; identification and plan of care. 3. 45 Licensed Nursing staff will be re-educated on Policy and Procedure on Acute Change in Condition, including immediate physician notification and updating plan of care as needed. Licensed nursed (sic) will be required to be educated prior to the start of the next shift. All Licensed nursing out on leave will have education sent via certified mail. 4. Changes (symptoms) in a resident's condition are communicated by any staff member to nurses via (see warning signs): a. Stop and Watch/Interact b. Clinical Rounds findings c. Verbal reports d. Huddle reports Nursing rounds will be completed daily and any change in conditions identified will be communicated to the IDT and physicians to implement/update plan of care. DON and/or Designee will ensure immediate compliance by auditing 102 residents residing in the facility. Daily audits will be completed x1 week, weekly x4 and monthly x 4. Report findings to QAPI Committee for further instruction. 5. Compliance date: [DATE] This citation pertains to intake MI 863. Deficient Practice Statement Two: Based on interview and record review, the facility failed to enact policies and procedures to ensure timely and comprehensive assessment and monitoring and failed to notify family representative of a change in condition related to Covid-19 infection for one (#707) of three Residents reviewed for Covid-19 and change in condition, resulting in inconsistent and no assessment documentation in the days preceding the Residents decline in condition, transfer to the hospital, and ultimate death. Findings include: Record review revealed Resident #707 was originally admitted to the facility on [DATE] and readmitted on [DATE] for short term rehabilitation with [DIAGNOSES REDACTED]. Review of the Resident's admission assessment, dated [DATE], revealed the Resident was alert and orientated to person, place and time. The admission assessment further revealed the Resident

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F 0684 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 2) required set up to one-person assistance to perform Activities of Daily Living. Resident #707 was transferred from the facility, to the Emergency Department, on [DATE]. A detailed review of Resident #707's medical record revealed no nursing and/or health care provider note documentation from [DATE] until [DATE] and on [DATE]. The following clinical progress note documentation was contained in the Resident's medical record: -[DATE] at 8:15 PM: physician progress notes [REDACTED]. had fever and mild dyspnea (difficulty breathing) . Blood Pressure: ,[DATE] (at) [DATE] 6:23 (AM) Temperature: 98.5 (on) [DATE] (at) 3:42 PM . O2 sats: 97.0 % (on) [DATE] (at) 3:42 PM . [MEDICAL CONDITION] with dyspnea. CXR (chest X-Ray) with [MEDICAL CONDITION] congestion. empirically treat after testing for Covid 19 monitor closely for symptoms . -[DATE] at 8:02 PM: Nurses Note . Resident noted to be disoriented, without co-ordination; unable to feed self . C/O (complain of) pain in chest on inspiration; gurgling noted on inspiration. C/o difficulty breathing, using accessory muscles to breathe, skin color pale; Oxygen saturation 79% on 2L (liters) via n/c (nasal cannula); began to mouth breath. Mask applied and oxygen increased but O2 sat only increased to ,[DATE]%. Skin clammy to touch; Attempted to face time with physician, but physician's phone unable to connect to face time. 911 initiated and resident was transferred . Resident's family . informed. V/s (Vital Signs) (Blood Pressure) ,[DATE]- (Temperature) 100.2 (elevated) -(Pulse) 77 - (Respiratory Rate) 28 (normal rate ,[DATE]) . Resident #707's medical record further revealed an order to start [MEDICATION NAME] ([MEDICATION NAME]- used as an off label treatment for [REDACTED]. Review of Resident #707's vital sign documentation in the medical record revealed the Resident's temperature had been obtained on [DATE] at 8:16 PM, [DATE] at 2:36 PM, [DATE] at 3:42 PM, [DATE] at 8:28 PM, and [DATE] at 2:14 PM. On [DATE] at 2:14 PM, Resident #707's temperature was 100.2 degrees Fahrenheit. An interview was conducted with Resident #707's family member, Confidential Witness S on [DATE] at 5:10 PM. When queried regarding Resident #707, Witness S stated, (Resident #707) passed away on [DATE]. Witness S revealed the Resident died from Covid-19 infection and stated, (Resident #707) didn't have it (Covid-19) when they went to the facility. When queried regarding Resident #707's care within the facility including communication regarding the Resident's medical status, Confidential Witness S stated, They didn't get in touch with us other than when (Resident #707) fell and then when they (facility) transferred (Resident #707) to (the Emergency Department) because they were having trouble breathing. Confidential Witness S was then asked when Resident #707's condition declined and replied, They never told us (Resident #707) had Covid. Witness S further revealed they were not made aware by the facility that Resident #707 was started on medications to treat Covid-19. Review of Resident #707's medical record revealed no documentation of facility notification related to Covid-19 [DIAGNOSES REDACTED]. An interview was conducted with the Director of Nursing (DON) on [DATE] at 11:20 AM. When queried regarding the frequency of vital signs, including temperature, monitoring and documentation for Residents per policy/procedure, the DON replied, Twice a day. When queried regarding Resident #707's transfer to the hospital and lack of consistent and twice daily nursing documentation prior to transfer due to a decline in condition, the DON reviewed the Resident's medical record and stated, I'm not sure when cooperate changed the policy. I'll have to find out. When queried regarding the Physician note dated [DATE] which indicated the Resident had a temperature and dyspnea but no nurses documentation, the DON reviewed the Resident's medical record and stated, I don't see any nurses notes either. When queried if there should have been nursing documentation, the DON stated, They could have documented inside the Covid assessment. When asked if there was Covid Assessment documentation, the DON reviewed the Resident's medical record and stated, No, they don't (have documentation). The DON further stated, They should have made a note. When queried how staff were assessing and responding to a change in condition without vital sign and assessment documentation, the DON replied, Should have been documented. When queried regarding facility policy/procedure pertaining to notification of family, the DON revealed family should be notified of all changes. When queried regarding Resident #707 being started on medications for treatment of [REDACTED].#707's medical record and stated, Nope, I don't see it. Lord have mercy. No further explanation was provided. A review of the facility policy entitled, Acute Change in Condition (undated) revealed, An Acute Change in Condition (ACOC) is a sudden, clinically important deviation from a resident's baseline in physical, cognitive, behavioral, or functional domains. 'Clinically important' means a deviation that without intervention, may result in complications or death .Level of Consciousness-Level of consciousness is the degree of awakeness, i.e. alert, drowsy/lethargic . Weakness-New onset of weakness .Significant variation from baseline .Significant change in ADL ability .Cognitive Symptoms-abrupt onset of, or increase in, confusion. Onset of hallucinations, delusions, or paranoia . Review of facility policy/procedure entitled, COVID-19 INTERIM PANDEMIC GUIDELINES (Updated [DATE]) revealed, All residents should have a daily narrative nursing note. The note includes: Vital signs, assessment of reason for Medicare coverage, skilled nursing intervention provided, and response to treatment . If the resident is being admitted under COVID positive or surveillance, the following should be documented in the narrative area of the COVID assessment . Narrative note to include: Review of vital signs - if temp, response to Tylenol, if Pulse is abnormal, interventions taken. If respirations abnormal - fast or slow, are accessory muscles being used (if yes, take action because the breathing is labored unless this is baseline such as someone with chronic [MEDICAL CONDITION]). Description and nature of symptoms (ie cough - dry or productive, headache - dull or pounding etc.). Lung sounds - clear, wheezing, congested, absent (perhaps in a lower lobe). Description of breathing and SPo2 level - if low, intervention provided and effect. Use of oxygen - how many liters, is the resident keeping it on? Skin color particularly around the mouth and nail beds. Pink, pale, bluish in color (take action if blue in color). Skin turgor . Appetite and fluid intake. Interventions currently provided (example IV fluids, Tylenol, respiratory treatment, medications). Response to treatments provided - follow up from previous shift . The policy further revealed, Steps to Having Care Planning Discussions . 4. Document discussion and treatment choice: a. Document in medical record . c. Communicate with family, resident wishes, if family not present .
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation Pertains to Intake MI 079. Deficient Practice Statement One: Based on observation, interview and record review, the facility failed to implement, operationalize, and maintain a comprehensive infection prevention and control program, including surveillance, identification, monitoring, and investigation of infectious processes comprised of documentation, collection and analysis of surveillance data to identify and track trends and patterns of infection for one (#708) of six Residents reviewed as well as all 103 Residents currently residing in the facility from January 2020, resulting in lack of data collection, infection analysis and the likelihood of undocumented infections, unidentified transmission, and delayed recognition of infectious processes including Covid-19. Findings include: During a tour of the facility beginning on 11:10 AM on 5/27/20, a sign indicating, See nurse before entering and an over-door hanging Personal Protective Equipment (PPE) [MEDICATION NAME] was noted on Resident #708's door. The PPE [MEDICATION NAME] contained gloves and one disposable gown. An interview was conducted with Nursing Assistant I on 5/27/20 at 11:20 AM. When queried regarding the PPE [MEDICATION NAME] and sign on Resident #708's door, Nursing Assistant I stated, (Resident #708) has shingles. When asked what PPE is required when providing care to the Resident, Nursing Assistant I replied, Mask and gloves. On 5/27/20 at 11:25 AM, an interview was completed with Licensed Practical Nurse (LPN) J. LPN J was noted to be wearing an N-95 mask (respirator mask that is worn snuggly to the face to filter 95% of 0.3 microns sized airborne particles). When asked why they were wearing an N-95 mask when other staff were wearing droplet/procedural masks, LPN J stated, I got it from the Administrator and revealed they felt more comfortable wearing an N-95 mask while working. When queried regarding Resident #708's [DIAGNOSES REDACTED]. LPN J was asked if they change their mask after providing care to Resident #708 and stated, No. When asked if any other Residents in the unit which they are assigned to care for are on isolation precautions, LPN J revealed no other Residents were on precautions. An interview was conducted with Nursing Assistant K on 5/27/20 at 11:40 AM. When queried regarding PPE required when providing care to Resident #708, Nursing Assistant K stated, I didn't wear anything when I was in there this morning. With further inquiry, Nursing Assistant K revealed they had been in the Resident's room earlier during their shift and had not worn any PPE because they were not aware any Residents outside of the designated Covid Unit of the facility were on isolation precautions. With further inquiry regarding Nursing Assistant I and LPN J stating the Resident had shingles and PPE required for shingles, per facility policy/procedure, Nursing Assistant K indicated they would need to wear gown, gloves, and mask. An interview was completed with the Director of Nursing (DON) on 5/27/20 at 12:00 PM. When queried regarding facility policy/procedure pertaining to PPE for Resident #708 related to shingles, the DON stated, (Resident #708) is on contact precautions for contact [MEDICAL CONDITION]. When asked why facility nursing staff caring for the Resident stated the Resident had shingles, the DON stated, They probably assumed. When queried what PPE is required for Residents on contact precautions, the DON replied, Glove, gown, and sanitizer. When queried regarding the location of hand sanitizer to perform hand hygiene as dispensers were not observed in the hall, the DON stated, It the (Resident) room. When queried regarding mask use, the DON indicated masks were not required. Review of

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	235480	A. BUILDING _____ B. WING _____	05/29/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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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 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 3) facility provided documentation provided in response to requested information revealed documentation pertaining only to Covid-19 infection within the facility. Review of facility provided information revealed a combined list of Residents and staff Covid-19 related illness. The first date of illness was 3/19/20 with a testing date of 3/18/20 for a Resident. The facility provided document further revealed the total number of Covid-19 related illnesses in the facility included 22 staff members and 54 Residents. Comprehensive facility infection Prevention and Control Program Policies and Procedures including the Surveillance Plan were requested from the facility Administrator on 5/27/20 at 11:00 AM, 5/28/20 at 10:59 AM, 5/28/20 at 1:52 PM, and on 5/29/20 at 8:08 AM. Record review of Resident #708's medical record revealed the Resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was moderately cognitively impaired and required supervision to limited assistance to perform Activities of Daily Living (ADLs). Resident #708's medical record revealed the following progress note documentation: -5/26/20: Nurse Practitioner Notes Late Entry . Chief complaint: f/u (follow up) [MEDICAL CONDITION] and pruritis . Patient was seen today per staff concern due to worsening rash to LUE (Left Upper Extremity), increased pruritis and isolation follow up . Assessment/Plan: [MEDICAL CONDITION]; high suspicion for contact . Scabies . remain in isolation; repeat permethecin topical cream (cream used to treat scabies) as ordered second dose; d/w (dealt with) staff; plan for dermatology appt (appointment) when office reopens due to current covid 19 regulations for confirmation . -5/18/20: Nurse Practitioner Notes . evaluated today . noted with a new rash to ble (bilateral lower extremities), left upper arm and low back which (Resident #708) states developed and has worsened over the past few days . c/o (complain of) itching and burning to the rash sites . Assessment/Plan: [MEDICAL CONDITION]; contact vs vasculitis vs possible scabies; pt (patient) to isolation; begin permethecin topical cream; apply to entire body and leave for 12 hours and then shower; repeat in one week . Covid 19 exposure . Review of Resident #708's Medication Administration Record [REDACTED]. On 5/28/20 at 10:40 AM, an interview was conducted with LPN A. When queried regarding Resident #708, LPN A stated, (Resident #708) has shingles now. The Doctor was just in and they told me to transfer them to the hospital. When queried why the Resident was being transferred, LPN A replied, Not sure. The Doctor was just in and told me. They haven't put no notes in yet. With further inquiry regarding the Resident's condition and if the rash was getting worse, LPN A stated, Yeah. It was just on their legs and now it over their whole body except their face. It's everywhere. When queried regarding the Resident's diagnoses, LPN A stated, Shingles. With further inquiry regarding PPE required to care for the Resident, per facility policy/procedure, LPN A replied, Gown, gloves, mask. LPN A was then asked if they change their mask upon exiting Resident #708's room and replied, No. An interview was conducted with the Nurse Practitioner C on 5/28/20 at 11:35 AM. When queried regarding the reason Resident #708 was being transferred, Nurse Practitioner C replied, Not able to get a dermatology consult. When queried regarding multiple facility staff stating the Resident had shingles, Nurse Practitioner C indicated they never mentioned shingles in their documentation. When asked for clarification regarding the Residents [DIAGNOSES REDACTED]. Nurse Practitioner C then stated, We have been seeing unknown rashes related to Covid as well. When asked if they suspected the Resident had Covid and why the Resident was not placed in the Covid unit if they did, Nurse Practitioner C replied, We treat based on signs and symptoms. (Resident #708) was on isolation precautions. No further explanation was provided. An interview was conducted with the DON on 5/28/20 at 1:27 PM. When queried regarding Resident #708's medical record documentation indicated a [DIAGNOSES REDACTED]. When queried regarding PPE required for scabies infection per facility policy/procedure, the DON replied, Contact. An interview was conducted with the Director of Nursing (DON) on 5/29/20 at 11:20 AM. When queried regarding Covid-19 isolation units within the facility, the DON revealed the facility currently had one isolation unit, Four South Bay. When asked if any other facility units had been utilized as Covid-19 isolation units, the DON stated, Second Bay North was also isolation. The DON was then asked the dates that the Second Bay North (Oak) Unit had been a Covid-19 isolation unit and replied, Not sure. When queried who the Infection Prevention and Control Nurse was for the facility, the DON revealed the Infection Control Nurse was no longer employed at the facility and stated, The Infection Control person left. I guess I am the back up. When asked the length of time since the Infection Control Nurse left employment at the facility, the DON elaborated, They started (employment) in December (2019) and went off (work) twice. Had Covid twice. When asked how long it had been since they worked at the facility, the DON replied, Been gone for about two weeks now. Facility infection control data, including surveillance, data analysis including infection line listings from February 2020 to present were requested to be reviewed with the DON at this time. The DON then retrieved the infection control documentation binder and proceeded to open the binder for review. The Binder was empty and contained no documentation of infection control surveillance, tracking, and/or analysis for 2020. When asked, the DON stated, There is nothing in their (prior Infection Control Nurse) book. The DON then obtained another binder which including facility infection control data and documentation ending in December 2019. When queried regarding the lack of infection control data, surveillance, and analysis from January 2020 to present, the DON stated, There is information and data up until December (2019). I was doing it before then. I did it (infection control) for the annual survey then we hired someone. I thought they were doing it. When asked about facility policy/procedure pertaining to infection control data reporting and if the facility had an infection control committee, the DON stated, We had meetings and QAPI (Quality Assurance and Performance Improvement). When asked if infection control data was reported and where the data come from, if reported, the DON did not provide further explanation. When queried how they were aware of infections within the facility, including potential outbreaks, without surveillance, data, and analysis, the DON replied, I don't know what to say. When queried regarding Covid-19 infection in the facility, the DON indicated they were tracking Covid-19 infection data. When asked how the facility was able to identify Covid-19 infection without a comprehensive Infection Prevention and Control program in place including surveillance, identification, and tracking of infections, the DON indicated they were tracking Covid-19 infections separately from other infections. When asked if infection other than Covid-19 had been tracked since December 2019, the DON replied, No. There is nothing. When asked who the first individual with Covid-19 was in the facility, the DON indicated they thought it was March (2020) but were unable to recall the Resident's name. The DON further revealed the first case of Covid was someone who came from the hospital. When queried regarding staff with Covid-19 infection, the DON revealed multiple staff had became ill. When queried regarding the dates of staff verses Resident illness and if any patterns were identified, the DON replied, It just kind of hit us. When queried regarding the lack of infection control surveillance and data including potential earlier identification of Covid-19 infection with surveillance, the DON stated, Yes, it could have. An interview was conducted with the facility Administrator on 5/29/20 at 12:28 PM. When queried regarding the facility infection control nurse, the Administrator stated, They were here from December to a couple of weeks ago. When asked about the facility not having any infection control data from January 2020 until present, the Administrator was unable to provide an explanation. When queried regarding facility policy/procedure pertaining to reporting of infection data, the Administrator revealed the facility have filed a waiver pertaining to reduction of required reporting meetings and stated, They (infection control) did give a report. At this time, the Administrator revealed they would look into the situation and provide any documentation available. Record review of facility provided documentation at survey exit entitled, Infection Control Report: Clinical Laboratories revealed a document including urinalysis specimen collection results from the laboratory from 1/1/20 to 2/29/29. The facility also provided a Pharmacy Antimicrobial Stewardship Report which did not include any Resident specific information. The documentation did not demonstrate active surveillance and monitoring of Resident infections within the facility. Facility policies/procedures pertaining to infection control policies/procedures were requested, as indicated above, but not received by the conclusion of the survey. Deficient Practice Statement #2 Based on interview and record review, the facility failed to properly isolate and implement infection control practices for two residents (R705 and R706) exhibiting signs and symptoms of COVID-19 (symptoms of fever, cough and shortness of breath) in a timely manner from a sample of seven residents reviewed for COVID-19 Infection Control Protocol, resulting in the potential for spread and transmission of COVID-19. Findings include: On 5/27/2020 at 10:35 AM, an initial tour of the facility was conducted. The facility had a COVID-19 unit designated for positive residents on four south. Nurse E was observed wearing an isolation gown and N95 mask while preparing medication at the medication cart. On 5/27/2020 at 10:50 AM, an interview was conducted with Nurse E. Nurse E was queried about the facilities initial implementation of infection control and isolation of symptomatic residents. Nurse E said, Early on (March and April), we were not given much directions. We did not wear PPE (Personal Protective Equipment) until staff and patients became sick. On 5/28/2020 at 9:10 AM, a review of the facility list of residents transferred to hospitals from 3/10/2020-5/10/2020 was conducted. On 5/28/2020 at 9:20 AM, a review of R705's electronic medical record was reviewed. R705 was initially admitted to the facility on [DATE] with the [DIAGNOSES REDACTED]. The Minimum Data Set ((MDS) dated [DATE] noted a BIMS (Brief

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 4) Interview for Mental Status) score of 15 (Intact cognitive response). A review of R705's care plan dated 3/11/2020 noted R705 required extensive assistance with activities of daily living. A review of Physician F order dated 2/19/2020 noted R705 as a Full Code (all resuscitative and aggressive curative treatment are provided). On 5/28/2020 at 11:15 AM, a review of R705's progress notes noted the following: 3/24/2020 at 5:54PM progress note written by Nurse G: Resident appears to be having a mood change. Resident has been refusing meals from facility and from outside sources, not drinking as much as usual, and an extreme delay with taking medication if at all. Resident is not getting out of bed or continent of B&B (bowel and bladder) anymore. Writer spoke to resident regarding these things resident just states I'm ok I'm ok. Psych consult ordered 3/25/2020 at 7:33AM progress note written by Nurse H: Resident had emesis x1 (one time) during the shift, (R705) claimed that she felt a lot better after, (R705) took PM meds (afternoon medication) but it took a lot of convincing before (R705) took them, and this morning (R705) refused (their) 6AM meds . 3/29/2020 at 1:29 AM progress note written by Nurse H: Resident had emesis once fluids slight pale phlegm noted moderate amount she felt weak .temperature . 3/31/2020 at 7:43 AM progress note written by Nurse N: Resident (R705) has some behavior issues during pericare and reports to writer that she does not want to lie back d/t (due to) anxiety and writer did attempt to comply w/some (with some) of resident request. 4/1/2020 at 2:12 AM progress note written by Nurse N: Resident refused care during shift and sat in w/c (wheelchair) all night. 4/1/2020 at 2:21 AM progress note written by Nurse N: Resident appears to make a bolus of spit and then spits saliva into a kleenex, but not swallowing. 4/2/2020 at 7:48AM progress note written by Nurse N: Resident has not been eating or drinking. Lips are chapped and bleeding Writer gave her a few sips of water and (ointment) for the lips. Skin is dry and turger is poor. 4/4/2020 at 7:06 AM progress note written by Nurse N noted: sodium chloride via hypodermoclysis was completed (R705 received subqutaneous (sic) fluids (given in this way to maintain patients who have mild to moderate dehydration). 4/4/2020 at 7:08 PM progress note written by Nurse O: Resident temperature was taken 101.6, heart rate 123 .1000mg tylenol. 4/5/2020 at 2:12 PM progress note written by Nurse M, (R705) had a temperature of 99.7 and a heart rate of 136. R705 was sent to the hospital. No documentation noted to isolate or implementation of infection control practices . R706 On 5/28/2020 at 12:30 PM, a review of R706's electronic medical record was reviewed. R706 was admitted to the facility on [DATE] with the [DIAGNOSES REDACTED]. The Minimum Data Set ((MDS) dated [DATE] noted a BIMS (Brief Interview for Mental Status) with a score of 15 (Intact cognitive response). A review of R706's care plan dated 3/3/2020 noted R706 required total assistance with activities of daily living. On 5/28/2020 at 11:15 AM, a review of R706's progress notes noted the following: 3/27/2020 at 8:06 PM progress note written by Nurse P: Resident returned from [MEDICAL TREATMENT] T (temperature) 99.4. 3/28/2020 at 6:56 PM progress note written by Nurse A: Refused all meds today stated she wasn't feeling well, asked to explain what's wrong, 'I just don't feel like myself' .poor appetite. 4/1/2020 at 1:00 AM progress note written by Nurse Q: Resident (temperature) 99.6, ice packs applied under both arms .resident alert and states, 'I just don't feel right.' 4/1/2020 at 7:52 PM progress note written by Nurse A: Resident alert and oriented able to make needs known per resident is not feeling well and will not go to [MEDICAL TREATMENT]. 4/2/2020 at 2:30 PM progress note written by Nurse Practitioner C: Asked to evaluate patient per staff report c/o (complaint of) cough with thick phlegm and noted with small amount of bright red in (their) tissue . (R706) states wants to be transferred to an acute care hospital for evaluation .speaking full sentences without distress. 4/3/2020 at 4:48 PM progress note written by Nurse Practitioner R: (R706 transferred to hospital. No documentation noted to isolate or implementation of infection control practices. On 5/29/2020 at 11:55 AM, an interview with the Director of Nursing (DON) was conducted. The DON was queried if residents 705 and 706 should be isolated when their temp is over 99.0 degrees, cough, and changes in condition. The DON said, They both were in rooms alone. The DON was queried if residents should be placed in a specific isolation due to possible COVID symptoms. The DON reported the Nurse Practitioner is usually consulted to find out what should be done. The DON then reported, Anyone with symptoms should be put in isolation. A review of the Initiating Isolation policy noted the following: The charge nurse notified the resident's attending physician for appropriate instructions when there is reason to believe that a resident has an infectious or communicable disease. On 5/29/2020 at 8:08 AM, requested the infection control policy from the Administrator, however, policy was not received by the end of the survey.