STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235228	A. BUILDING _____ B. WING _____	05/20/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CHERRY HILL FOR NURSING AND REHABILITATION	38410 CHERRY HILL RD WESTLAND, MI 48185

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F 0684 **Level of harm -** Actual harm **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** This citation pertains to Intake: 7 Based on interview and record review, the facility failed to properly maintain infection control practices during a COVID-19 Infection Control Survey affecting two residents (R901 and R902) of three sampled residents not being consistently assessed and monitored for COVID-19 symptoms and a change in condition, resulting in both residents being hospitalized . Findings include: R901 On [DATE] at 3:16 PM, an interview was completed with Family Member A, who stated that their family member had been hospitalized in the ICU and placed on a ventilator after contracting COVID-19 in the facility. They further expressed concerns that their family member had been suffering for several days with signs and symptoms of [MEDICAL CONDITION], and nothing had been done about it. A review of R901's medical record revealed that they were admitted into the facility on [DATE] and had a readmission date of [DATE]. Admitting [DIAGNOSES REDACTED]. The Minimum Data Set assessment dated for [DATE] revealed that R901 had a moderately impaired cognition, and required extensive assistance for Activities of Daily Living. Further review of R901's medical record revealed the following progress notes: [DATE] 16:55 (4:55 PM). Nursing Note: Resident presents with low grade temperature. No C/O (complaint of) SOB (shortness of breath). Semi-alert. Ate very little today, C/O thirst. Water given by writer x3 (3 times). All medication taken. Resting at present temperature 99.1. [DATE] 17:35 (5:35 PM). Nursing Note: Resident resting in bed, alert and able to make needs known. Resident with low grade temp of 99.5, no cough noted,denies any pain, PRN (as needed) Tylenol given, will cont (continue) to monitor. [DATE] 16:15 (4:15 PM). Nursing Note: Dr (doctor) in to see resident, new orders for cbc, bmp, and hgA1c (blood work). Enter into (Lab) website and requisitioned and order printed. [DATE] 17:04 (5:04 PM). Physician Note: patient not feeling good at no specific complaints. No cough, No sore throat, No fever, and chills, no difficulty in breathing Continue the current medication. I did order the basic metabolic panel, CBC, Hemoglobin, A1c. Patient will be monitored for cough, temperature, and oxygenation. [DATE] 06:37 (6:37 AM). Nursing Note: Resident has been lethargic. Vitals WNL (within normal limits) - BP (Blood Pressure) ,[DATE], P92 (Pulse), 02 96% (Oxygen). Temp was 99.3 at 0330 (3:30 AM). Gave 2 Tylenol rechecked temp at 0400 (4:00 AM) 97.7. [DATE] 08:00 (8:00 AM) Nursing Note: Resident sent out 911 for mental status change and r/o (Rule out) corvin 19 (COVID 19) physician, (family members) notified . Let it be noted that there were no progress notes between [DATE] and [DATE] which addressed R901's temperatures and/or signs and symptoms of COVID-19. A review of R901's hospital records revealed the following, Details of Hospital Stay: Presenting Problems/History of Present Illness: Stupor, [MEDICAL CONDITION] (low oxygen levels), Non-ST elevated [MEDICAL CONDITION] infarction (a type of [MEDICAL CONDITION]), Coronavirus Infection. (R901) with positive past history [MEDICAL CONDITION](stroke) with left-sided residual deficits, dementia, hypertension, presenting to (local hospital) due to progressively worsening altered mental status. Patient is from a nursing home. Patient was intubated and sedated due to hypoxic [MEDICAL CONDITION] secondary to COVID 19 in the ICU and extubated on ,[DATE] to 2 L (liters) nasal cannula. On [DATE] at 10:49 AM, an interview was completed with Nurse B. They were asked to explain R901's physical and mental health status at the time of their transfer to the hospital. Nurse B stated, Everything about R901 was different, they were not their usual self. R901 wasn't talking clearly, had a temperature, and looked pale. I hate to say it but R901 looked like they were on death's door. Nurse B further explained that R901 had a temperature and hadn't been out of the bed in a couple of days which is not like them. Nurse B also explained that R901's lungs weren't clear and were congested. A review of R901's Medication Administration Record [REDACTED]. -D/C (discharge) Date: [DATE] 2122 (9:22 PM). Further review revealed that R901 had a temperature of 99.0 or higher on ,[DATE], ,[DATE], ,[DATE], ,[DATE] and ,[DATE]. Morning vitals on the date of [DATE] were not completed. On [DATE] at 9:54 AM, the labs that were ordered by the physician on [DATE] were requested from the facility. On [DATE] at 10:44 AM, an email was received from the facility indicating the request for labs that were ordered for R901 on [DATE], At the time this lab was ordered, our lab (Lab name and contact information), stated that they were short staffed due to covid 19 and that some labs would have to (be) rescheduled. The lab was ordered but was not taken on regular lab day which was on Monday [DATE]th. Physician gave orders to send (R901) out on [DATE]. On [DATE] at 1:05 PM, interviews were completed with the Administrator, DON and Infection Control Preventionist (ICP). They were asked if COVID testing is completed in the facility. They explained that they have not had the capability to test the residents in the facility, and that they have to be sent to the hospital for tests. They were asked how residents are being monitored for signs and symptoms of COVID-19. The DON explained that starting on [DATE]th, vital signs are taken on each shift and that they are assessing for cough, respiratory, o2 stats and temperature. They were asked if there were any other assessments completed, and the ICP indicated that they follow CDC guidelines and are currently integrating the other symptoms of COVID-19 such as loss of taste and gastrointestinal issues. The DON was asked what signs and symptoms they are expecting for nursing staff to observe when determining when a COVID-19 test should be completed, and they explained that they should be completing thorough assessments and notifying the physician of temperatures of 99.0 or higher. The physician will then have to give the order to have the resident sent out. The DON was further asked about R901, specifically the lack of documentation for monitoring symptoms of R901 between [DATE] and [DATE] especially to the point that R901 was placed in ICU and intubated. The DON explained that R901 did have COVID-19 but that they also had a stroke which is why they were placed in the ICU. It was further explained that R901 was still getting out of bed, had no cough and no fever. The ICP stated that R901 had a Rapid onset. The DON was asked why R901 wasn't sent to the hospital to have their labs drawn, and explained that at [MEDICAL CONDITION]'s peak, if they would have called EMS (Emergency Medical Services), they would have refused to take the resident because they were not showing signs and symptoms of COVID-19. 902 A review of R902's medical record revealed, R902 had a readmission date of [DATE] with [DIAGNOSES REDACTED]. The Minimum Data Set assessment dated for [DATE] revealed, that R902 had a moderately impaired cognition, and required assistance for Activities of Daily Living. Further review of R902's medical record review revealed, the following progress notes and vitals: [DATE] 15:12 (3:12 PM) Nursing Note Text: pt (patient) not swallowing well is lethargic not eating well (Physician) ordered to hold (R902) [MEDICATION NAME] and Chorizmine ([MEDICATION NAME]). [DATE] NP (Nurse Practitioner) CC (chief complaint): follow up lethargy and cough. HISTORY OF PRESENT ILLNESS: Nursing staff has reported (R902) was lethargic and [MEDICATION NAME] and Chorizmine. Today (R902) is awake and able to follow simple commands. Lungs with scattered rhonchi, will continue nebulizers, currently satting at 98% on room air. Afebrile 97.8. No cough, no abdominal pain, no nausea . Vitals [DATE] at 01:30, (temperature) 97.7 , at 17:24 (5:24 PM) 100.5. [DATE] 17:23 (5:23 PM) eMar (electronic medication administration record) - Medication Administration Note Text: Tylenol Tablet 325 MG, Give 2 tablet by mouth every 6 hours as needed for pain. [DATE] 02:45 eMar - Medication Administration Note Text: Tylenol Tablet 325 MG Give 2 tablet by mouth every 6 hours as needed for pain PRN (as needed) Administration was: Effective. Follow-up Pain Scale

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

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F 0684 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 1) was: 1. [DATE] 22:45 (10:45 PM) eMar - Medication Administration Note Text: Tylenol Tablet 325 MG Give 2 tablet by mouth every 6 hours as needed for pain. [DATE] 22:42 (10:42 PM) eMar - Medication Administration Note Text: Tylenol Tablet 325 MG Give 2 tablet by mouth every 6 hours as needed for pain PRN Administration was: Effective. Follow-up Pain Scale was: 0. [DATE] at 02:43 temperature 98.7, at 22:48 (10:48 PM) temperature 97.9. [DATE] 03:10 Nursing Note Text: Resident alert and verbally responsive Spo2 (Oxygen saturation) 88% room air at 0200, oxygen applied @ (at) 2L (Liters)/NC (nasal cannula) Spo2 now 94%. Bed in lowest position and call light within (R902) reach. Will continue to monitor. -Bc (because) the O2 (Oxygen) (R902) went up to 95%. [DATE] 02:45 eMar Medication Administration Text: Geri-[MEDICATION NAME] Syrup Give 1 dose by mouth every 6 hours as needed for Cough. [DATE] 03:10 Nursing Note Text: Resident alert and verbally responsive Spo2 88% room air at 0200, oxygen applied @ 2L/NC Spo2 now 94%. Bed in lowest position and call light within (R902) reach. Will continue to monitor. [DATE] 05:39 eMar Medication Administration Note Text: Geri-[MEDICATION NAME] Syrup Give 1 dose by mouth every 6 hours as needed for Cough PRN (as needed) Administration was: Effective. [DATE] 06:39 Nursing Note Text: Resident slept in intervals during the night shift. Alert but slow to respond. All scheduled meds (medication) received as ordered including 02 via face mask 02 sat 95% receiving ,[DATE] liters. No s/s (signs or symptoms) of respiratory distress. Hydration encouraged. Extensive assist provided with ADL (activities of daily living) care by staff. Safety measures in place to ensure no injuries occur. Call light and H20 (water) within reach. Denies any discomfort. Will inform oncoming nurse for follow up care. Vitals: [DATE] at 02:42 temperature 98.1, at 14:30 (2:30 PM) temperature 104.2. [DATE] 14:45 (2:45 PM) Nursing Note Text: At 820am resident with labored breathing and a temp of 104.2, (Physician Assistant notified order to send to ER (emergency room) pt (family) notified at 8:40 pt (patient) transported to (local) hospital via 911 ambulance . [DATE] 14:27 (2:47 PM) eINTERACT SBAR (Situation, Background, Assessment, Recommendation) Summary for Providers Situation: The Change In Condition/s reported on this CIC (Change in condition) Evaluation are/were: Abnormal vital signs (low/high BP, heart rate, respiratory rate, weight change) Fever Functional decline (worsening function and/or mobility) Other change in condition Tired, Weak, Confused, or Drowsy At the time of evaluation resident/patient vital signs, weight and blood sugar were: - Blood Pressure: BP ,[DATE] - [DATE] 14:29 (2:29 PM) Position: Lying l/arm - Pulse: P 104 - [DATE] 14:29 (2:29 PM) Pulse Type: Regular - RR: R 16.0 - [DATE] 12:02 - Temp: T 104.2 - [DATE] 14:30 (2:30 PM) Route: Tympanic - Weight: W 203.5 lb - [DATE] 09:31 Scale: Wheelchair - Pulse Oximetry: O2 91 % - [DATE] 14:31 (2:31 PM) Method: Oxygen via Nasal Cannula - Blood Glucose: BS 132.0 - [DATE] 07:58 . Resident/Patient had the following medications changes in the past week: placed on 02 . Outcomes of Physical Assessment: Positive findings reported on the resident/patient evaluation for this change in condition were: - Mental Status Evaluation: Altered level of consciousness (hyperalert, drowsy but easily aroused, difficult to arouse) Increased confusion(e.g. disorientation) Other - Functional Status Evaluation: Needs more assistance with ADLs Decreased mobility - Behavioral Status Evaluation: Other behavioral symptoms - Respiratory Status Evaluation: Labored or rapid breathing Inability to eat or sleep due to SOB (shortness of breathe) Cough Abnormal lung sounds(rales, rhonchi, wheezing) Other respiratory changes - Cardiovascular Status Evaluation: Resting pulse greater than 100 or less than 50 Nursing observations, evaluation, and recommendations are:may have aspirated food not able to swallow well Primary Care Provider Feedback: Primary Care Provider responded with the following feedback: A. Recommendations: send to ER . A review of the facility's line listing for COVID-19 noted, R902, Lowest Temp: 91, Highest Temp: 104.2, Shortness of Breath: Labored Resp. (Respiratory), Date tested : [DATE], Results: Positive, Other notes: Acute [MEDICAL CONDITIONS], Resident return date: Expired [DATE]. On [DATE] at 1:03 PM, during a interview via phone, the Director of Nursing (DON) was asked about R902's change in condition on [DATE], the DON stated, [DATE] was the first day of symptoms. (R902) was having problems swallowing, we reached out to speech and talked to the family. The DON was asked, what happened after the NP saw (R902) on [DATE], the DON stated, We assumed that it was (R902's) [MEDICAL CONDITION]'s disease. (R902) was the first person to test positive. We got labs on [DATE]. The DON was asked if COVID-19 was considered with R902's symptoms. The DON stated, (R902) didn't have symptoms of COVID at that time. The DON was asked about the NP's note dated [DATE], for the change in condition for R902 on [DATE], that noted R902 being seen regarding the complaint of a cough. The DON stated, When (R902) was trying to eat (they) would cough, (R902) could not swallow. The DON was asked for documentation regarding R902's cough and the reason. The DON stated, We gave two doses of cough medication on ,[DATE]. I don't have a note on why (R902) was coughing. The DON was asked at anytime was R902 put into isolation away from R902's roommate or the general population. The DON stated, No. We did not think (R902) had COVID. (R902) was not considered positive, (R902) was positive at the hospital. The DON was asked about R902's temperatures greater than 100 and if there was a follow up temperature after the Tylenol was given. The DON stated, We chart by exception. We kept monitoring (R902) and stayed in contact of NP, nothing was out of range. The facility's Change in a Resident's Condition or Status policy was reviewed and outlined the following, Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.). 1. The nurse will notify the resident's Attending Physician or physician on call when there has been a(an): a. accident or incident involving the resident; b. discovery of injuries of an unknown source; c. adverse reaction to medication; d. significant change in the resident's physical/emotional/mental condition; e. need to alter the resident's medical treatment significantly; f. refusal of treatment or medications two (2) or more consecutive times); g. need to transfer .
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** Based on observation, interview, and record review, the facility failed to follow recommended guidelines for Personal Protective Equipment (PPE) during a COVID-19 Infection Control Focused Survey, potentially affecting all residents in the facility, resulting in lack of or improper use of PPE. Findings include: On 5/19/20 at 11:45 AM, the Assistance Director of Nursing/Infection Control Preventionist (ADON/ICP) was observed to be wearing a cloth gown intended for use as PPE. The gown was observed to be open in the front and loosely tied. On 5/19/20 at 11:48 AM, a resident was heard calling out for water in a room on the 200 unit. Certified Nursing Assistant (CNA) C was observed walking in the hallway wearing a KN95 (particle filtering PPE) on their face but without it covering their nose. CNA C then proceeded to enter the resident's room and was observed exiting the room with the mask still covering their mouth but not their nose. CNA C continued down the hallway and walked into another resident's room with the mask in the same position. On 5/19/20 at 11:50 AM, the Minimum Data Set (MDS) Nurse was observed coming out of their office onto the hallway of the COVID-19 isolation unit with their face mask under their nose and with their gown open and loosely tied. At that time the MDS Nurse was asked if the facility did a fit test for the staff's mask. The MDS Nurse stated, No. On 5/19/20 at 11:56 AM, three residents were observed in the 200 hallway. One resident was ambulating without a mask on, and two other residents were observed sitting in their wheelchairs in the hallway with no mask coverings. One of the residents in the wheelchair had a mask hanging off their ear, and the other resident in the wheelchair had no mask at all. Two unidentified staff members were observed to walk past all three residents without saying anything to them. At this time, the ADON/ICP was present in the hallway where the residents were and was queried if the residents should be wearing masks while in the hall. The ADON/ICP pointed at the resident with the mask hanging on their ear and stated, That one takes (their) mask off. They aren't alert and oriented. But if residents are outside of their room we prefer them to have masks on. The mask was then adjusted and placed back on the resident's face. The ADON/ICP then directed a staff member in the hallway to retrieve and place a mask on the other resident who was sitting in the hall in their wheelchair without a mask. On 5/19/20 at 12:05 PM, an additional unidentified resident was observed sitting in the back corridor by the dish room. The resident was in their wheelchair and did not have a mask covering their nose and mouth. When queried regarding a mask, the resident shrugged their shoulders. On 5/20/20 at 3:45 PM, the Nursing Home Administrator (NHA), Director of Nursing (DON), and ADON/ICP were interviewed. When queried regarding proper use of gowns intended as PPE, the ADON/ICP indicated the staff were wearing the white cloth gown in the general population area (non-COVID-19 units) for additional protection. The ADON/ICP stated, The idea is they should be worn with the tie in the back. When queried regarding the proper use of masks, the ADON/ICP stated the masks are to be worn, Covering the nose, including for the residents. That includes for both employees and residents. Sometimes residents don't have the cognitive ability to remember to keep it above the nose. The DON then stated, Everyone is reminding them (residents) (how to wear the masks). When queried regarding the observations of residents not wearing masks in the hallway and lack of staff acknowledgement of residents not wearing masks, the DON stated, Some residents refuse to wear them. We can redirect them and some of them still refuse. No further information was provided. A review of the facility's policy titled, Coronavirus (Covid-19) Policy, reviewed/revised 4/21/20, revealed the following: Educate and communicate with your staff on Covid-19 along with Infection Prevention practices such as Handwashing- Ensure staff clean their hands according to CDC (Centers for

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) Disease Control and Prevention) Guidelines, including before and after contact with patients, after contact with contaminated surfaces or equipment, and after removing personal protective equipment (PPE), Isolation practices/protocols, Proper PPE and usage, Monitor infection prevention/PPE supplies, Monitor patients for symptoms of respiratory infection and fever upon admission, daily, and/or as needed (Per current CDC guidance) and implement appropriate infection prevention practices as required . A review of CDC Guidance, updated 5/19/20, titled Preparing for COVID-19 in Nursing Homes, revealed: HCP (health care professionals) should wear a facemask at all times while they are in the facility. When available, facemasks are generally preferred over cloth face coverings for HCP as facemasks offer both source control and protection for the wearer against exposure to splashes and sprays of infectious material from others. Guidance on extended use and reuse of facemasks is available. Cloth face coverings should NOT be worn by HCP instead of a respirator or facemask if PPE is required. Residents should wear a cloth face covering or facemask (if tolerated) whenever they leave their room, including for procedures outside the facility. Cloth face coverings should not be placed on anyone who has trouble breathing, or anyone who is unconscious, incapacitated, or otherwise unable to remove the mask without assistance. Reference: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html