STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235544	A. BUILDING _____ B. WING _____	05/01/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HALLMARK LIVING BENTON HARBOR	1385 E EMPIRE AVE BENTON HARBOR, MI 49022

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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E 0024 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Establish policies and procedures for volunteers.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to MI 640. Based on observation, interview and record review the facility failed to implement the emergency preparedness policy for emergency staffing for a Covid-19 pandemic, resulting in the potential for all residents to be at risk for an outbreak of Covid-19. Findings include: Review of the Policy Emergency Operations Plan- Pandemic Covid-19 & Influenza dated 11/1/17 and updated 3/12/20 revealed the .purpose of this guideline is to provide objectives, responses, and the need for specialized planning in response to an influenza pandemic and .performs services and functions that may be adversely impacted by an influenza pandemic this guideline outlines how the Organization plans to maintain essential functions and services during an Influenza pandemic or other pandemics. The policy revealed, regarding staffing, Absenteeism attributable to personal or family illness and fear of infection may reach 40 percent during the peak weeks of an outbreak and Certain public health measures (closing schools or public gatherings; quarantining household contacts of infected individuals) are likely to increase absenteeism rates. Every person who becomes ill is likely to miss a few days too many weeks of work. The Policy further revealed the facility was to .Maintain essential operations and services if 40% or more if work is absent. During an interview on 4/14/20 at 1:19 P.M. and at 2:24 P.M., Licensed Practical Nurse (LPN) G reported he was the only nurse for the entire building on 4/14/20 and no he had not given residents their morning medications because he was the only licensed nurse in the facility and did not have enough time. During an interview on 4/14/20 at 2:47 P.M., Registered Nurse (RN) H stated she arrived at the facility about an hour ago (indicated at 1:47 PM arrival) and reviewed medication administrations for locked unit residents and stated, in red that would mean they're (residents) medications are late (indicated at this time of review the morning medications had not been given to the residents) and resident medications are overdue. During an interview on 4/15/20 at 11:30 AM, LPN Q stated, we've been challenged with staffing. During an interview on 4/16/20 at 11:30 AM, Certified Nurse Aide (CNA) R stated, we (facility) don't have enough aides and I had 12 residents this morning and 19 residents now because one of the aides went home because she worked all night. During an interview on 4/14/20 at 10:10 AM, Certified Nurse Aide Scheduler (CNAS) E stated, on 4/14/20, there were only 3 aides and there was supposed to be more but the staff just stopped showing up for work. CNAS E stated, we (facility) normally work with 6 staff. CNAS E stated she was working the floor currently and had 15 residents to care for at that time. During an interview on 4/14/20 at 11:28 AM, Nursing Home Administrator (NHA) A stated, on 4/14/20, there were 3 call ins' today, 2 CNA's (certified nurse aides) and 1 nurse. NHA A stated, no agency staff were able to work at the facility on 4/14/20. NHA A stated, normally 6 to 7 staff working in the facility on a daily basis and the lack of staff was less than ideal. During an interview on 4/14/20 at 10:50 A.M., LPN G reported that he was currently the only nurse working for the entire facility. LPN G reported that he was caring for 54 Residents and began his shift on 4/13/20 at 6:00 P.M. LPN G reported he was unsure when a nurse would enter the facility to relieve him of his duty. During an interview on 4/14/20 at 11:06 CNA F reported that the facility was short staffed. CNA F reported that there were 3 CNA's and 1 LPN working in the facility at that time on 4/14/20. During an interview on 4/14/20 at 12:35 P.M., NHA A reported that LPN G was the only licensed nurse in the facility at that time. During an interview and observation on 4/14/20 at 3:58 P.M., there were no nursing staff observed on the Snowbird Unit. The interim NHA A entered the unit at that time and answered room [ROOM NUMBER]'s call light. When asked if there were staff on the unit to assist residents NHA A stated, CNA's (Certified Nursing Assistant) are on the other side of the door I'm thinking. (Indicating nursing staff were on a different unit beyond the closed double doors). At 4:02 P.M. this surveyor exited the double doors to the Main nurses' station and observed 2 CNA's sitting at that desk. CNA RR reported that she and the other CNA at the desk were working both the Covid/Snowbird Unit as well as the Mockingbird Unit. CNA RR reported that the nurse for the Snowbird Unit was also working the Mockingbird Unit and was assisting a resident on the Mockingbird Unit at that time. (Indicating that at the time of the observation there were no facility staff on the Snowbird Unit). During an interview on 04/16/2020 at 10:23 A.M., Hospital/Hospice RN (HHRN) PP stated the facility is severely understaffed with illness. HHRN PP reported that there had been an increase in hospice referrals for the facility. HHRN PP reported that the building is under resource and she has been trying to find ways to get them support. HHRN PP stated, We've had our hospice nurses in there trying to help as much as we can.
F 0678 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to perform immediate Cardiopulmonary Resuscitation (CPR) and contact emergency medical professionals (911) per the standards of practice and facility policy and procedure resulting in an Immediate Jeopardy when on [DATE] at approximately 1:55 am, Resident #101, whose advanced directive indicated she was a full code, was found by facility staff unresponsive and without a heartbeat. CPR was not initiated, and Resident #101 was pronounced dead. Findings include: On [DATE] at 12:40 P.M. the Nursing Home Administrator was verbally notified and received written notification of the Immediate Jeopardy that began on [DATE] and was identified on [DATE] due to the facility's failure to adequately monitor, assess, and perform CPR on Resident #101. A written plan for removal for the immediate jeopardy was received on [DATE] and the following was verified on [DATE]. 1. All residents will be audited for Valid CPR consent/declination. This audit will be completed by VP of clinical services on [DATE]. 2. All residents Code status will be added to (electronic medical record - EMR) profile on [DATE]. 3. A physician order will be verified for appropriate code status and orders will be reviewed with MD (medical doctor) as of [DATE]. 4. Electronic medical record documentation will be reviewed for all patients to identify any potential change in condition. This task will be completed by VP of clinical services on [DATE]. 5. Nurse consultant/designee will audit all new admissions (when resumed) for appropriate documentation for code status within 48 hrs of admission. This audit will continue for 6 months or until 100% compliance is reached beginning [DATE]. 6. All care plans will be updated to reflect current code status. The MDS (Minimum Data Set) consultant will complete this task on [DATE]. 7. All nursing staff will be in serviced on following guidelines for performing CPR, where CPR status is identified. Staff will be educated on completing rounds and assessing residents for change in condition and utilizing the change in condition assessment for communication to the MD. Staff will also be re-trained on walking rounds at least every two hours. Staff will be educated prior to working their next shift. This training will be completed by corporate staff on [DATE]. 8. The SSD (Social Service Director) is responsible for oversight of the advanced directive process. She will complete audits of 5 residents per week to verify code status is accurately communicated and is still appropriate. SSD will complete this audit for 6 months or until 100% compliance is achieved beginning [DATE] 9. Administrator is responsible to verify completion of audits continuing [DATE]. 10. Medical director and facility will hold a QA (Quality Assurance) meeting to review findings and immediate jeopardy removal plan. This will be a

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

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F 0678 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 1) virtual meeting on [DATE]. Although the Immediate Jeopardy was removed on [DATE], the facility remained out of compliance at a scope of isolated and severity of actual harm due the fact that not all facility staff have received education and sustained compliance has not been verified by the State Agency. Review of the facility policy Cardiopulmonary Resuscitation CPR last revised on [DATE] revealed, Guidelines: This facility will provide basic life support, including CPR - Cardiopulmonary Resuscitation, when a resident requires such emergency care, prior to the arrival of emergency medical services, subject to physician order and resident choice indicated in the resident's advance directives. Nurses and other care staff are educated to initiate CPR, as recommended by the American Heart Association (AHA) unless: A valid Do Not Resuscitate order is in place, Attempts to perform CPR would place the rescuer at risk of serious injury or mortal peril, Regardless of full code status if there are obvious clinical signs of irreversible death, including but not limited to the following: a. Pupils fixed and dilated b. Mottled discoloration of the body or rigor mortis is present c. Skin cold to touch d. Absence of reflexes e. Bowel and bladder sphincter control gone. f. Absence of vital signs (pulse and blood pressure) with the presence of other symptoms listed above. Before a decision to not resuscitate is made, two licensed nurses must verify the clinical signs above. The findings shall be documented in the nursing notes. The attending physician will be notified. Review of a Face Sheet revealed Resident #101 was an [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of Resident #101's Physician Order dated [DATE] revealed, Full Code. Resident #101's code status was electronically ordered by Registered Nurse (RN) U on [DATE] and electronically signed by the physician (MD J) on [DATE]. Review of Resident #101's Physician assessment dated [DATE] revealed, She does not have any current pain or symptoms .This patient is in no apparent distress, has normal physique, no emaciation or dehydration .The patient is relaxed and breathes without effort. The patient is not cyanotic and does not use the accessory muscles of respiration .Cardiovascular The rate is normal, the rhythm is regular. Review of Resident #101's Physician assessment dated [DATE] revealed, NO signs and symptoms suggestive of Covid-19, if there are changes noted in the patient contact provider immediately .No fever, cough, SOB (shortness of breath), n/v (nausea and vomiting) .if there are changes noted in the patient contact provider immediately. Indicated Resident #101 was in stable condition. Review of Resident #101's Progress Notes from [DATE] to [DATE] revealed no documentation that Resident #101's health was declining or any other significant change in her physical condition. Review of Resident #101's Progress Note dated [DATE] 03:44 A.M. revealed, The CENA (Certified Nursing Assistant) summoned this nurse (Licensed Practical Nurse LPN G) to (Resident #101's) room and upon entering noted that her chest did not rise and fall, she was not alert nor responsive to voice or touch, and non arousable, modeling (sic) noted to skin, no capillary refill with grey nail beds, no Apical, radial nor coratid (sic) pulse noted,body cold to the touch, she was stiff with rigamortis starting to set in. After apical check She was pronounced at 01:55. Oncall staff, Family and Doctor notified (sic). During an interview on [DATE] at 2:24 P.M. LPN G reported he was the only nurse for the entire building on the night that Resident #101 passed away. LPN G reported that the aide found Resident #101 and she reported her condition to LPN G. LPN G reported that although he knew Resident #101 was a Full Code he was unable to do CPR because she was in rigor mortis and he could not remove her arms from across her chest to begin CPR. LPN G reported no other nurses were in the building to assist with identifying clinical signs of death.
F 0684 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow Center for Disease Control (CDC) and Centers for Medicare and Medicaid Services (CMS) guidance to asses every resident daily for COVID-19 symptoms, notify physician and health department of abnormal symptom assessments, and isolate Persons Under Investigation (PUI) residents for 4 residents out of 42 residents (Resident's #110, #126, #140 and #141) reviewed for quality of care, resulting in an immediate jeopardy when, beginning on 4/7/2020 the facility staff did not perform a comprehensive assessment on a resident and promptly notify the physician of an acute change in their condition/vital signs. This deficient practice placed all residents at risk for serious harm, injury and/or death. Findings include: On 4/23/2020 at 1:28 P.M. the Nursing Home Administrator was verbally notified and received written notification of the immediate jeopardy that began on 4/7/20 and was identified on 4/22/2020 due to the facility's failure to perform a comprehensive assessment on residents' with abnormal vital signs and notify the physician and health department of abnormal assessments. A written plan for removal for the immediate jeopardy was received on 4/28/2020 and the following was verified on 4/29/2020 1. Facility is adding COVID monitoring to MAR for completion by staff nurses as follows: COVID MONITORING: Loss of smell, fatigue (tiredness), GI (gastrointestinal) upset, SOB (shortness of breath), Cough, Decreased appetite. If the answer is YES they create a progress note right from the emar regarding the symptoms and physical assessment including vital signs. See attached COMPLETED 4/23/20. 2. Residents #110, #126, #140, and #141 will have a Respiratory Infection Screener completed and MD (Medical Doctor) notified of any abnormal findings. MD will complete a telehealth visit on 4/24/20. All residents have been screened for symptoms of Covid-19 as of 4/24/20. 3. All change in condition will be notified to MD immediately utilizing the e-interact change in condition SBAR (Situation, Background, Assessment and Recommendation) beginning 4/26/20. 4. Facility will continue to complete temperature screening and pulse oximetry screening for all residents every shift this began in March 2020. Staff nurses are responsible to obtain and this will be reviewed by IDT (Interdisciplinary Team) in morning meeting. DON (Director of Nursing)/designee is responsible for this oversight. In lieu of DON absence the MDS coordinator ICP (Infection Control Preventionist) will monitor. 5. Infection control screener will be scheduled for every positive or PUI (Person Under Investigation) in the building. The Infection preventionist will initiate this process beginning 4/25/20. 6. Telehealth rounds will be performed daily with NP (Nurse Practitioner) and/or MD (Medical Doctor) the rounds will be completed with consistent nurse and begin at 10am with progress notes uploaded within 48 hrs into the medical record. This began on 4/23/20. 7. Infection preventionist/designee will verify initiation of the Infection Control Screener on each resident with new symptoms within 24hrs (hours) beginning 4/25/20. 8. All licensed nurses and C.N.A's (Certified Nursing Assistants) will be in serviced on infection control symptoms to be evaluated and the new respiratory infection screener for positive or active respiratory infections. They will also be in-serviced on basic screening for new symptoms via the MAR (Medication Administration Record) and notifying MD/NP of ALL condition changes immediately with a complete assessment of the patient including VS (Vital Signs) and The Carepath will be provided to all staff and education will be provided on talking points with the MD for all new and symptomatic patients. Education will be provided prior to next scheduled shift beginning 4/25/20. 9. Care path will be provided to all nursing staff at the nurses station to review symptom management guidelines and physician talking points for all new and current Positive and PUI patients beginning 4/26/20. Although the immediate jeopardy was removed on 4/29/2020 the facility remained out of compliance at a scope of pattern and severity of likelihood of actual harm due the fact that not all facility staff have received education and sustained compliance has not been verified by the State Agency. Review of the INFECTION CONTROL-Interim policy addressing healthcare crisis related to Human [MEDICAL CONDITION] dated 3/5/20 revealed, The following information is only intended to be used as guidelines to address health care concern of Human [MEDICAL CONDITION] specifically COVID-19. 3. The resident that is a PUI or confirmed positive will be assessed at least every 4 hours; This assessment should include but is not limited to: Full set of V/S (Vital Signs) - B/P (Blood Pressure) , pulse, temperature, respirations and oxygen saturation % Respiratory Assessment- Lung sounds, presence or absence of cough, sputum production, shortness of breath Physician or Nurse Practitioner should be notified immediately of any change in condition. Dedicated or disposable noncritical resident-care equipment (e.g., blood pressure cuffs, blood glucose monitor equipment) is used, or if not available, then equipment is cleaned and disinfected according to manufacturers' instructions using an EPA-registered disinfectant for healthcare setting prior to use on another resident. 5.Facility HCP (Health Care Professionals) will follow droplet precautions utilizing the following PPE and infection control precautions. Review of Fundamentals of Nursing (Potter and Perry) 9th edition revealed, Axillary .Measurement lags behind core temperature during rapid temperature changes Not recommended for detecting fever .Underestimates core temperature. Potter, Patricia A.; Perry, Anne Griffin; Stockert, Patricia; Hall, Amy. Fundamentals of Nursing - E-Book (Kindle Locations -). Elsevier Health Sciences. Kindle Edition. Review of Fundamentals of Nursing (Potter and Perry) 9th edition revealed, The temperature of older adults is at the lower end of the normal temperature range, 36 to 36.8 C (96.8 to 98.3 ? F) orally and 36.6 to 37.2 C (98 to 99 F) rectally. Therefore temperatures considered within normal range sometimes reflect a fever in an older adult .Older adults are very sensitive to slight changes in environmental temperature because their thermoregulatory systems are not as efficient .Be especially

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F 0684 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) attentive to subtle temperature changes and other manifestations of fever in this population such as tachypnea, anorexia, falls, [MEDICAL CONDITION], and overall functional decline. Older adults without teeth or with poor muscle control may be unable to close their mouths tightly to obtain accurate oral temperature readings. Potter, Patricia A.; Perry, Anne Griffin; Stockert, Patricia; Hall, Amy. Fundamentals of Nursing - E-Book (Kindle Locations -). Elsevier Health Sciences. Kindle Edition. Review of Fundamentals of Nursing (Potter and Perry) 9th edition revealed, Before measuring a pulse, review the patient's baseline rate for comparison .[MEDICAL CONDITION]. [MEDICAL CONDITION] an abnormally elevated HR, above 100 beats/ min in adults.Potter, Patricia A.; Perry, Anne Griffin; Stockert, Patricia; Hall, Amy. Fundamentals of Nursing - E-Book (Kindle Locations -). Elsevier Health Sciences. Kindle Edition. Review of Fundamentals of Nursing (Potter and Perry) 8th edition revealed, [MEDICAL CONDITION] is present when the systolic BP falls to 90 mmHg or below .for most people low blood pressure is an abnormal finding associated with illness .record any signs of BP alteration in nurses notes. Report abnormal findings to nurse in charge or health care provider. Potter, P. A., Perry, A. G., Stockert, P. A., & Hall, A. (2014). Fundamentals of Nursing (8th ed.). St. Louis: Mosby. p. 461 and 465. Resident #110: Review of the Face Sheet revealed Resident #110 was [AGE] year-old male admitted to the facility on [DATE] and diagnosed with [REDACTED]. Review of the MDS dated [DATE] revealed Resident #110 had a BIMS score of 0 out of 15 which indicated he had severely impaired cognition. Review of Resident # 110's Weights and Vitals Summary revealed that on 4/15/2020 at 10:42 A.M., Resident #110's temperature was 99.9 F Axilla (Heart rate and respirations were not assessed). There was no Progress Note written to indicate that the Physician and the Health Department were notified of the elevated temperature or whether Resident #110 was placed in isolation. Review of Resident # 110's Weights and Vitals Summary revealed that on 4/22/2020 at 02:27 A.M., Resident #110's temperature was 100.7 F Tympanic (Heart rate and respirations were not assessed). There was no Progress Note written to indicate that the Physician and the Health Department were notified of the elevated temperature or whether Resident #110 was placed in isolation. Review of Resident # 110's Weights and Vitals Summary revealed that on 04/22/2020 at 9:07 P.M., Resident #110's temperature was 99.2 F (Tympanic) High of 99.0 exceeded (Heart rate and respirations were not assessed). There was no Progress Note written to indicate that the Physician and the Health Department were notified of the elevated temperature or whether Resident #110 was placed in isolation. Review of Resident #110's Infection Charting dated 4/24/20 at 10:00 A.M. revealed, INFECTION TYPE: 13. PUI/COVID .1b. Pneumonia .Vital Signs .Most Recent Temperature .100 Tympanic .O2 90% .RESPIRATORY INFECTION: 2. Wheezing .Non-productive cough. During an interview on 4/22/2020 at 2:50 P.M., NHA A was notified that Resident #110 had a fever documented but was not in isolation or on the Covid-19 designated unit. Review of the Line Listing dated 4/22/20 revealed that Resident #110 was not placed on the line listing (document tracing resident with infections) and the health department was not notified of elevated temperature. During an observation on 4/23/2020 at 9:15am Resident #110 was not in an isolation room or on the Covid-19 designated unit. Review of Resident #110's Social Service Note dated 4/24/2020 3:16 P.M. revealed, Resident (#110) moved to Covid hallway for time being (Indicating he was moved to the isolation unit). During an interview on 4/23/20 at 12:40 PM, Medical Director (MD) J stated he was not contacted about low grade fever or any elevated temperatures for Resident #110 and stated the resident should have been tested for covid-19 and yes should have been in isolation. Review of the Progress Notes (Nurses notes) dated 4/2020 revealed no documented assessment or documented contact with the physician or nurse practitioner for infectious disease follow up. Resident #126: Review of the Face Sheet revealed Resident #126 was a [AGE] year-old female admitted to the facility on [DATE] and diagnosed with [REDACTED]. Review of the MDS dated [DATE] revealed Resident #126 had a BIMS score of 0 out of 15 which indicated she had severely impaired cognition. Review of Resident #126's Weights and Vitals Summary revealed that on 4/16/2020 at 1:59 P.M. Resident #126's temperature was 99.7 F Tympanic (Heart rate, respirations, oxygen level, and blood pressure were not assessed.) There was no Progress Note written to indicate that the Physician and the Health Department were notified of the elevated temperature or whether Resident #126 was placed in isolation. Review of Resident #126's Weights and Vitals Summary revealed that on 4/16/2020 at 08:25 A.M. Resident #126's temperature was 99.7 F Tympanic (Heart rate, respirations, oxygen level, and blood pressure were not assessed.) There was no Progress Note written to indicate that the Physician and the Health Department were notified of the elevated temperature or whether Resident #126 was placed in isolation. Review of Resident #126's Weights and Vitals Summary revealed that on 4/17/2020 at 1:59 P.M. Resident #126's temperature was 99.6 F Tympanic (Heart rate, respirations, oxygen level, and blood pressure were not assessed.) There was no Progress Note written to indicate that the Physician and the Health Department were notified of the elevated temperature or whether Resident #126 was placed in isolation. Review of Resident #126's Weights and Vitals Summary revealed that on 4/20/2020 at 1:59 P.M. Resident #126's temperature was 99.1 F Tympanic, Oxygen level 90% Room air (Heart rate, respirations, and blood pressure were not assessed.) Review of Resident #126's Infection Charting dated 4/22/20 at 12:00 A.M. revealed, patient no showing any S&S (signs or symptoms) of covid, stating (sic) at 93% on RA, lungs clear, no fever 97.4, will continue to monitor. Review of the Line Listing dated 4/22/20 revealed that Resident #126 was not placed on the line listing and the health department was not notified of elevated temperature. During an observation on 4/23/2020 at 9:15am Resident #126 was not in an isolation room or on the Covid-19 designated unit. Review of Resident #126's Progress Note dated 4/24/2020 at 06:21 A.M. revealed, called HCP to notify of HCP of o2 sat of 84%-87%. Order given for o2 for 2-4L to maintain o2 sat of 90% or greater. (name omitted) applied nasal cannula at 3L of 02, bringing 02 sat to 92% at 3 minute increment, 96% after 10 minutes and was able to maintain 96% at 3L. Diminished lung sounds in both fields fields. (sic) Placed in droplet precautions. HCP to examine today resident remains stable at 96% o2 (Indicating Resident #126 had not been in isolation or on the Covid-19 designated unit prior to this progress note). Review of the Progress Notes (Nurses notes) dated 4/2020 revealed no documented assessment or documented contact with the physician or nurse practitioner for infectious disease follow up. Resident #140: Review of the Face Sheet revealed Resident #140 was a [AGE] year-old female admitted to the facility on [DATE] and diagnosed with [REDACTED].#140 had a BIMS score of 10 out of 15 which indicated she had moderately impaired cognition. Review of Resident #140's Weights and Vitals Summary revealed that on 4/7/2020 at 2:07 P.M. Resident #140's temperature was 99.6 F Oral. (Heart rate, respirations, oxygen level, and blood pressure were not assessed.) There was no Progress Note written to indicate that the Physician and the Health Department were notified of the elevated temperature or whether Resident #140 was placed in isolation. Review of Resident #140's Weights and Vitals Summary revealed that on 4/22/2020 at 09:26 A.M. Resident #140's blood pressure was 85 / 56 mmHg. Resident #140's blood pressure was not reassessed until 4/22/20 at 5:45 P.M. and the physician was not notified of an abnormally low blood pressure. Additionally, Resident #140's heart rate, respirations, or oxygen saturation were not assessed at the time of the abnormally low blood pressure). Review of the Line Listing dated 4/22/20 revealed that Resident #140 was not placed on the line listing and the health department was not notified of elevated temperature. During an observation on 4/23/2020 at 9:15 A.M. Resident #140 was not in an isolation room or on the Covid-19 designated unit. Review of Resident #140's Progress Note dated 4/24/2020 at 12:07 A.M. revealed, (name omitted) called HCP to notify of HCP of o2 sat of 84%-87%. Order given for o2 for 2-4L to maintain o2 sat of 90% or greater. (name omitted) applied nasal cannula at 4L of 02, bringing 02 sat to 91 at 3 minute increment, 96% after 10 minutes and was able to maintain. Diminished crackle in right lower lobe and normal breath sounds in left fields. Placed in droplet precautions. HCP to examine today resident remains stable at 96% o2. (Indicating Resident #140 had not been in isolation or on the Covid-19 designated unit prior to this progress note). Review of the Progress Notes (Nurses notes) dated 4/2020 revealed no documented assessment or documented contact with the physician or nurse practitioner for infectious disease follow up. Resident #141: Review of the Face Sheet revealed Resident #141 was a [AGE] year-old male admitted to the facility on [DATE] and diagnosed with [REDACTED]. Review of the MDS dated [DATE] revealed Resident #141 had a BIMS score of 0 out of 15 which indicated he had severely impaired cognition. Review of Resident #141's Weights and Vitals Summary revealed that on 4/7/2020 at 9:28 P.M. Resident #141's temperature was 99.3 F Oral (Heart rate, respirations, oxygen level, and blood pressure were not assessed.) There was no Progress Note written to indicate that the Physician and the Health Department were notified of the elevated temperature or whether Resident #141 was placed in isolation. Review of Resident #141's Weights and Vitals Summary revealed that on 4/7/2020 2:28 P.M. Resident #141's temperature was 99.3 F Axilla (Heart rate, respirations, oxygen level, and blood pressure were not assessed.) There was no Progress Note written to indicate that the Physician and the Health Department were notified of the elevated temperature or whether Resident #141 was placed in isolation. Review of Resident #141's Weights and Vitals Summary revealed that from 2/4/2020 to 4/5/2020 Resident #141's heart rate was in the 60's for beats per minute (bpm). On 4/11/2020 Resident #141's heart rate was to 97 bpm, 4/12/20 95 bpm, 4/14/20 95 bpm, 4/16/20 95 bpm, 4/17/20 93 bpm, 4/18/20 92 bpm, 4/20/20 92 bpm, and on 4/24/20 111 bpm (Indicating Resident #141 had a change in their baseline for heart rate). There was no progress note indicating the physician was notified of the change in Resident #141's baseline heart rate until 4/23/20. Review of the Medication Administration Record [REDACTED]. During an interview on 4/23/20 at 12:40 PM, Medical Director (MD) J stated

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F 0684 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 3) Tylenol when given to a resident would .lower the resident's temperature. MD J stated he did not remember being called regarding Resident #141 but should have been called for the low grade fever and Resident #141 should have been in isolation. During an interview on 4/15/20 at 3:22 P.M. this surveyor notified NHA A of the concerns observed with Resident #141's vital signs and his exposure to Covid-19 from his roommate. NHA A reported she would follow up. During an interview on 4/22/20 at 2:50 P.M., this surveyor notified NHA A that Resident #141 was still not on the line listing with continued irregularities with his vital signs. Review of the Line Listing dated 4/22/20 revealed that Resident #141 was not placed on the line listing and the health department was not notified of elevated temperature. Review of the Progress Notes (Nurses notes) dated 4/2020 revealed no documented assessment or documented contact with the physician or nurse practitioner for infectious disease follow up for Resident #141. Review of Resident #141's Progress Note dated 4/27/2020 at 03:10 A.M. revealed, General medicine on call physician informed of residents change in condition (labored resp, heart rate 114,and large amount of phlegm (sic) suction from mouth) Orders received for ER (emergency room) to eval (evaluate) and treat. Emergency contact called and informed of (omitted) change in condition and orders for transfer to ER. Report given to ER Nurse. (Emergency Medical Service) arrived and resident left building per stretcher with assistance x2 at 0250 am. During an interview on 4/16/20 at 1:25 P.M. with the Local Health Department Epidemiologist (HDE) OO and NHA A. HDE OO reported that it would be beneficial to test a resident with symptoms if they did not reside on the Covid-19 designated unit to ensure Covid-19 had not spread to a clean unit. During an interview on 4/14/20 at 1:43 P.M., NHA A reported that Corporate Nurse (CN) NN is responsible for monitoring symptoms and/or vital signs in the Electronic Health Record to ensure no other residents residing in the facility are displaying symptoms and is responsible for following up with abnormal results. CN NN is reviewing these documents at an offsite out of state location. During an interview on 4/15/20 at 12:43 P.M., Licensed Practical Nurse (LPN) Q reported that staff assess the temperatures and oxygen levels of all residents residing in the facility and the beginning and the end of their shift and monitor for signs and symptoms of a respiratory infection. LPN Q reported that if a resident has a temperature of greater than 100 orally, they are a person of interest. LPN Q reported that if a resident has a cough or a change in condition, they are considered a person of interest. During an interview on 4/15/20 at 2:17 P.M., LPN Q reported that if a Resident has an axillary temperature of 99.0 F, further monitoring would be required to rule them out as a person of interest. LPN Q reported that all vital signs and assessments are documented into the Electronic Health Record in order for CN NN to review the vital signs and assessments from an offsite location. During an interview on 4/15/20 at 11:50 AM, LPN Q stated for [MEDICAL CONDITION] (covid-19 virus) monitoring we monitor temperatures and oxygen saturations 3 times a day for the residents. LPN Q stated it had been difficult to keep up with resident monitoring. During an interview on 4/15/20 at 1:08 PM, LPN Q stated nurse aide staff (certified nurse aide, CNA) were to notify the nurse on duty of any temperature greater than 99 (degrees Fahrenheit) axillary and 100 degrees oral temperature. During an interview on 4/23/20 at 12:40 PM, MD J stated signs and symptoms of covid-19 virus were fever, shortness of breath and low oxygenation levels (O2 saturation). MD J stated [MEDICATION NAME] (Tylenol) would usually lower a residents temperature and if a resident had a low grade fever of 99 degrees then he would want .to have them (residents) tested for covid-19. During an interview on 4/24/20 at 12:05 PM, NHA A stated, yes staff were to input vital signs and nursing assessments into the electronic medical record. NHA A stated there was off site review of vital signs and email correspondence by corporate nursing staff and was asked for validation of said statement. NHA A stated there was no email correspondence between nursing staff offsite and review of the electronic medical record (indicated no vital sign or review of assessments took place by nursing staff off site).
F 0698 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Past noncompliance - remedy proposed** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to MI 911. Based on interview and record review, the facility failed to ensure Resident #138 was transported to [MEDICAL TREATMENT] on 4/18/20 and 4/21/20 resulting in an Immediate Jeopardy when on 4/23/20, Resident #138 was transported and assessed at the [MEDICAL TREATMENT] clinic and had to be immediately transferred to the hospital. Resident #138 was found to have [MEDICAL CONDITION] (elevated potassium) with a potassium level of 6.7 mmol/L causing a cardiac response of a heart rate of 44 and other cardiac complications. Findings include: On 4/24/2020 P.M. the Nursing Home Administrator was verbally notified and received written notification of the Immediate Jeopardy that began on 4/18/20 and was identified on 4/23/20 due to the facility's failure to transport Resident #138 to [MEDICAL TREATMENT] per physician's orders. A written plan for removal for the immediate jeopardy was received on 4/29/20 and the following was verified on 4/29/20. 1. All residents receiving [MEDICAL TREATMENT] have had their transportation confirmed for the next week beginning 4/23/20. 2. Back up transport company with outstanding balance from prior owners has been paid and the company will be available as a back up transportation company for [MEDICAL TREATMENT] beginning 4/23/20. 3. Facility will create a list of available transport companies should a transport company cancel beginning on 4/29/20. 4. All nurses will be trained on [MEDICAL TREATMENT] schedules and provided a list of available transport companies should a transport company cancel. This notice will be at the nurses station posted and was placed there on 4/29/20 5. All nurses will be trained on change in condition, signs and symptoms of renal compromise to evaluate in the event of refusal or transportation failure or emergency. The training for staff began on 4/24/20. 6. All nurses will be trained on e-interact change in condition form to be used for ALL change in condition. Nurses will be trained to notify DON/designee and MD of refusal or failure of a patient to keep scheduled [MEDICAL TREATMENT] appointment. All nurses will be trained prior to next shift beginning on 4/25/20. Although the Immediate Jeopardy was removed on 4/29/20, the facility remained out of compliance at a scope of isolated and severity of actual harm due the fact that not all facility staff have received education and sustained compliance has not been verified by the State Agency. Review of Fundamentals of Nursing (Potter and Perry) 9th edition revealed, [MEDICAL CONDITION] is abnormally high potassium ion concentration in the blood .[MEDICAL CONDITION] can cause muscle weakness, potentially life-threatening cardiac [MEDICAL CONDITION], and [MEDICAL CONDITION]. Potter, Patricia A.; Perry, Anne Griffin; Stockert, Patricia; Hall, Amy. Fundamentals of Nursing - E-Book (Kindle Locations -). Elsevier Health Sciences. Kindle Edition. Review of a Face Sheet revealed Resident #138 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. During an interview on 4/22/20 at 9:06 A.M., [MEDICAL TREATMENT] Nurse (DN) FF reported that Resident #138 had not received [MEDICAL TREATMENT] since 4/16/2020 and that she had notified the facility that he would need [MEDICAL TREATMENT] in the designated Covid-19 [MEDICAL TREATMENT] unit due to his exposure in the facility. DN FF reported that it is the responsibility of the facility to ensure residents are transported to their [MEDICAL TREATMENT] appointments. During an interview 4/22/20 at 9:15 A.M. [MEDICAL TREATMENT] Nurse Practitioner (DNP) GG reported that Resident #138 had not been to [MEDICAL TREATMENT] in a week and he was highly concerned that Resident #138 would become critically ill without intervention. DNP GG reported that he had set up an appointment for Resident #138 at the local emergency department to have [MEDICAL TREATMENT] completed but the facility staff would not transfer him to the hospital for treatment. DNP GG stated this is inexcusable and they are not getting him life saving treatment. DNP GG reported he was concerned that Resident #138's laboratory results would be at a critical level without immediate intervention. DNP GG reported that Resident #138 had not received [MEDICAL TREATMENT] since 4/16/2020 and he typically does not miss his treatments. DNP GG reported that he was notified that the facility staff did not have a way to transport him to [MEDICAL TREATMENT] which was why DNP GG set up for transfer to the local emergency department. DNP GG reported that he made multiple attempts to reach out to the facility staff with little to no response. During an interview on 04/22/2020 at 12:40 P.M., Licensed Practical Nurse (LPN) Q reported that the [MEDICAL TREATMENT] unit notified her on 4/17/2020 that Resident #138 would need to go to the designated Covid-19 [MEDICAL TREATMENT] unit for treatment because of his exposure to Covid-19 in the facility. LPN Q reported she was unable to set up transport for 4/18/20 because of the short notice and Transportation Company (TC) LL could not accommodate the transfer. LPN Q reported that she was unable to set up transportation on Monday 4/21/2020 through TC LL and reported she was told it was short notice again. LPN Q reported she attempted to contact TC MM and was told that it was short notice. LPN Q reported that MD J was notified and directed staff to monitor him for symptoms such as fluid overload. LPN Q reported that the nursing progress notes should reflect that Resident #138 did not have symptoms of fluid overload. LPN Q reported that she did not pursue testing for potassium levels to ensure safe levels. LPN Q reported that he would be transported to [MEDICAL TREATMENT] on 4/23/20. Review of Resident #138's General Progress Note written by LPN Q and dated 04/18/2020 at 05:30 A.M. revealed, Received a call from [MEDICAL TREATMENT] (name omitted), stating that since resident has been exposed to COVID-19, he must attend [MEDICAL TREATMENT] in (name omitted) for isolation patients. This writer called for transport via (TC LL) and they are unable to transport d/t (due to) chair time being 7:20 am. This writer called [MEDICAL TREATMENT] and notified nurse that resident

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	235544	A. BUILDING _____ B. WING _____	05/01/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HALLMARK LIVING BENTON HARBOR	1385 E EMPIRE AVE BENTON HARBOR, MI 49022

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F 0698 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 4) had no transport for [MEDICAL TREATMENT] and was instructed to monitor for signs of fluid overload. MD also notified and instructed to monitor for overload. Resident was made aware of the changes. Review of Resident #138's General Progress Note revealed, Late Entry. Effective date 4/19/2020. Created Date 4/22/2020 patient (Resident #138) has missed [MEDICAL TREATMENT] multiple times because his original [MEDICAL TREATMENT] place is not taking covid or PUIs (person under investigation), the [MEDICAL TREATMENT] place has set up for patient to go to (name omitted) [MEDICAL TREATMENT]. Due to the covid crisis (TC LL) could not transport patient on Tuesday for his [MEDICAL TREATMENT]. Doctor was notified and management were notified. At this time (MD J) does not believe the patient needs to go to the hospital at this time. Per the conversations writer has had with management. The patient will be going to [MEDICAL TREATMENT] on Thursday 4/23/20. During an interview on 4/22/2020 at 2:00 P.M. Medical Doctor (MD) J reported that he was notified that Resident #138 had not been going to [MEDICAL TREATMENT] because the resident was refusing to go. MD J reported that he was not notified of it being a transportation issue. MD J reported that he was not notified that DNP GG had requested and set up [MEDICAL TREATMENT] for Resident #138 in the emergency department on 4/22/2020. There were no physician's orders in the medical record to draw any laboratory specimens to monitor Resident #138's electrolyte levels due to no [MEDICAL TREATMENT] being performed. Review of Resident #138's General Progress Note Dated 4/22/20 at 7:52 A.M. revealed, Late Entry: Spoke with (MD J) re: (regarding) resident not attending [MEDICAL TREATMENT] due to no transportation. This writer asked Dr, if he wanted the resident (sic) to go to the ER for [MEDICAL TREATMENT], (MD J) declined, stating it would be more harmful for him to go to the er, because of COVID. Resident denied feelings of fluid overload, he states I feel fine. Resident is scheduled for [MEDICAL TREATMENT] Thursday chair time 7:20am. Resident aware of conversation with (MD J). During an interview on 4/22/20 at 1:57 P.M., Registered Nurse (RN) U stated, Yes, he (Resident #138) goes to [MEDICAL TREATMENT]. RN U stated she had not heard of Resident #138 refusing to go to [MEDICAL TREATMENT]. During an interview on 4/22/20 at 2:00 P.M., LPN W stated, for the most part he (Resident #138) was willing to go to [MEDICAL TREATMENT]. LPN W stated Resident #138 had not missed a [MEDICAL TREATMENT] appointment due to refusal since I've been working here. During an interview on 4/22/2020 at 2:04 P.M. Certified Nursing Assistant (CNA) HH reported that Resident #138 has never refused care or [MEDICAL TREATMENT]. During an interview on 4/22/2020 at 4:20 P.M., RN U reported that she spoke with DNP GG that morning but was unable to identify why Resident #138 was not sent to [MEDICAL TREATMENT]. RN U reported that she notified LPN Q so she could follow up. During an interview on 04/23/2020 at 9:50 A.M., Social Services Director (SSD) I reported that she had received a phone call from Hospital Case Manager (HCM) EE on 4/21/2020 regarding transportation and she forwarded the call to Main (nursing station) for follow up. SSD I reported that she is not in charge of transportation for resident appointments. Review of Resident #138's Social Service Note dated 4/21/2020 at 10:45 A.M. revealed, (Hospital name omitted) called regarding transportation for resident, passed call to main. During an interview on 04/23/2020at 9:57 A.M., Hospital Case Manager (HCM) EE reported that on 4/21/2020 she reached out to SSD I regarding transportation to [MEDICAL TREATMENT] for Resident #138. HCM EE stated, (Hospital name omitted) felt that if we could help, we didn't want the patient to miss [MEDICAL TREATMENT]. When I called (SSD I) back she said the bills had paid and they could get transportation. They said they didn't need me to facilitate it. HCM EE stated, The hospital was thinking if he didn't go to [MEDICAL TREATMENT], he would wind up here, that's why we wanted to intervene. During an interview on 04/23/2020 at 11:07 A.M., TC LL's Dispatcher (D) JJ reported that she was called close to 5:00 P.M. on 4/17/2020 to set up transportation for Resident #138 for 4/18/2020 at 6:30 A.M. D JJ reported that that accommodation could not be made in short notice. D JJ reported that she reported to LPN Q that additional drivers would need to be scheduled for those days and I advised them to call Monday morning to set up an arrangement. D JJ stated, They (facility staff) never called back to see if we could do it (transport Resident #138) or not. During an interview on 4/23/2020 at 12:12 P.M. LPN Q reported she was never made aware that HCM EE had set up transportation for Resident #138 on 4/21/2020. LPN Q reported that she was notified on 4/17/2020 by DN FF that because Resident #138 was exposed to Covid-19 he would have to go to the designated Covid-19 [MEDICAL TREATMENT] unit. TC LL could not transport because of the short notice and TC MM would not transfer because they (facility management/owners) had not paid their bills. LPN Q reported that Resident #138 was not sent on the 18th or the 21st because she could not get a ride for him. LPN Q was not aware of SSD I's conversation with HCM EE regarding transportation on the 21st or she would have accepted their offer. During an interview on 04/29/2020 at 11:24 A.M., TC MM Dispatcher KK reported that there is no contract between the facility and TC MM. Dispatcher KK stated, A couple weeks ago they called us frantic because there was a patient that had been several days without [MEDICAL TREATMENT]. Dispatcher KK stated, Last week they said they could get us paid but that's not the point. They don't know who they have a contract with. During an interview on 04/23/2020 at 12:33 P.M., DN FF reported that upon arrival to the Covid-19 [MEDICAL TREATMENT] unit he was immediately sent to the emergency room because he was not mentally at his baseline and his blood pressure was low and his heart rate was 43. Review of Resident #138's hospital record dated 4/23/2020 revealed, This is a 64 YO (year old) male with h/o (history of) [MEDICAL CONDITION] (end stage [MEDICAL CONDITION]) on HD ([MEDICAL TREATMENT]) .presenting to the ED (Emergency Department) for evaluation of generalized weakness, fever, cough. Patient is lethargic and somnolent (drowsy), able to open eyes when called, follows some commands but unable to answer questions in an appropriate manner. Majority of the hx (history) obtained via chart review. Patient is a (long term care facility) resident. Patient apparently developed cough and fever and EMS (emergency medical services) was called. Per EMS the patient was hypotensive (low blood pressure) at the scene though this improved. Of note, patient has not been receiving HD for the past 1.5 weeks. Upon arrival to the ED, patient was febrile at 100.6F (Fahrenheit), bradycardic (low heart rate) in the 40-50s, maintaining adequate saturation (oxygen level) on 4L O2 via NC (4 liters of oxygen through a nasal canula). Lab work significant for Cr (Creatinine) 9.6, K (potassium) 6.7 (Creatinine level indicates kidney function. Normal range is 0.7 to 1.2. Potassium level normal range is 3.5-5.1) .Central line placed for IV (intravenous) access. Patient will be given 2 g (grams) of calcium [MEDICATION NAME] as I'm high suspicion for [MEDICAL CONDITION] causing his [MEDICAL CONDITION] .Significantly increased creatinine and pain when from baseline. Elevated potassium of 6.7 with a decreased CO2 of 14. Patient will be given insulin, [MEDICATION NAME] and lokelma (medications used to lower potassium levels). EKG (measures the electrical activity of the heart) shows widened QRS at 144 ms. (Name omitted), nephrology, will consult and call in [MEDICAL TREATMENT] team emergently. Hospitalist will admit. [DIAGNOSES REDACTED]. Review of Resident #138's Nephrology Consult dated 4/23/2020 revealed, (Resident #138) is a [AGE] year old male with [MEDICAL CONDITION] on HD who presented to the ED with EMS after missing 1.5 weeks of HD from (facility). Per data review, patient was febrile (had a fever), bradycardic with a cough. Pt had emergent HD ([MEDICAL TREATMENT]) on admission.
F 0725 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to MI 640. Based on observation, interview, and record review the facility failed to ensure systems were in place to provide sufficient staffing to meet resident needs (Cardiopulmonary Resuscitation CPR and Medication Administration) for 19 out of 42 residents reviewed for staffing which resulted in: 1.) an Immediate Jeopardy when, beginning on [DATE], the facility staff did not perform Cardiopulmonary Resuscitation for Resident #101 who was a full code, which resulted in her death; 2.) on [DATE] the facility staff did not administer prescribed medications for Resident's #102, #103, #104, #105, #106, #107, #108, #109, #110, #111, #112, #113, #114, #115, #116, and #117, and 3.) on [DATE] Residents # 123 and #124 did not receive care in a timely manner. This deficient practice resulted in actual harm for Resident #101, the likelihood for actual harm for Resident's #102, #103, #104, #105, #106, #107, #108, #109, #110, #111, #112, #113, #114, #115, #116, #117, #123, and #124, and placed all residents residing in the facility at risk for serious harm, injury, and/or death. Findings include: On [DATE] at 12:40 P.M. the Nursing Home Administrator was verbally notified and received written notification of the immediate jeopardy that began on [DATE] and was identified on [DATE] due to the facility's failure to provide sufficient staffing to meet resident needs. A written plan for removal for the immediate jeopardy was received on [DATE] and the following was verified on [DATE]. 1. Staffing for the next 14 days was reviewed by VP of Clinical services, open positions verified. All shifts are covered. The facility will implement the emergency staffing policy, including mandated OT (overtime) if a number of employees call in/or are no call no show beginning [DATE]. 2. Incentive wages and bonuses for coming into work provided to reduce call offs. This was completed by operations staff at corporate level beginning [DATE]. 3. Travel staff acquired to cover open positions. 1 fulltime RN (Registered Nurse), 2 fulltime C.N.A (Certified Nursing Assistant), 1 prn (as needed) LPN (Licensed Practical Nurse). The

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HALLMARK LIVING BENTON HARBOR	1385 E EMPIRE AVE BENTON HARBOR, MI 49022

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F 0725 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 5) travel nurses arrived on ,[DATE] and ,[DATE] and began working on those days. The travel C.N.A's will arrive for the weekend ([DATE] and [DATE]). 1 R.N. will arrive on Sunday ([DATE]) and begin working on Monday ([DATE]) beginning [DATE]. Initiated and final R.N. will arrive on ,[DATE]. Staffing ration guidelines and minimum staffing guidelines reviewed and staffing coordinator educated on [DATE]. Required staff Nurses: Dayshift 3 nurses Evening shift 2 nurses Night shift 2 nurses Required C.N.A's Dayshift 5 aides Evening shift 5 aides (can work with 4) Nightshift 4 aides (can work with 3) Corporate staff and ancillary department managers will continue to assist with tasks that do not require a licensed staff member. Any licensed consultant will provide hands on care when necessary and will be present to monitor the abatement plan and ongoing infection control program. Licensed Consultants include, MDS/Reimbursement and Nurse Consultants. Ancillary Department Managers include Housekeeping, Maintenance. There is no designated ancillary person for the covid hall. The Ancillary Department Managers can go in the covid room and not in contact with resident beginning [DATE]. 4. VP of clinical services will call all staff to verify they understand the incentives and get a commitment of working their scheduled shifts. Any vacancies or resignations will be identified and will be addressed. The calls started on [DATE]. All licensed nurses have been called and 3 remain off for COVID positive (diagnosis) with target for one (nurse) to return [DATE], the other two (nurses) remain symptomatic. Nurse aide calls will be completed today beginning [DATE]. 5. All nursing staff will be in serviced on following guidelines for performing CPR, where CPR status is identified. Staff will be educated on completing rounds and assessing residents for change in condition and utilizing the change in condition assessment for communication to the MD. Staff will also be re-trained on walking rounds at least every two hours. The staff will be educated on emergency staffing policy. Staff will be educated prior to working their next shift. If training is not completed staff will be unable to work. This training will be completed by (name omitted) corporate staff; (Name Omitted) and R.N. (Name Omitted). Training was initiated on [DATE] evening and night shift. Staff will not be allowed to work until they have been trained. The training is in person and video, handouts and return demo review. Approximately 54 employees have been in-serviced beginning [DATE]. 6. Staff will be provided with corporate compliance hotline to notify of any staffing crisis or concerns. Corporate compliance officer will verify presence of posters. Will be posted in breakroom and at entrances. This is a 24hr service and (Name Omitted) is the compliance officer who responds to these calls. Interim Administrator and/or VP of Clinical Services will be notified and will report to the building to assist staff and obtain staff. (Name Omitted) Corporate staff will be directed to the building should the need arise beginning [DATE]. 7. Administrator and nursing leadership numbers will be posted to communicate calls offs if unable to fill. The administrator will post these numbers. These will be posted beginning [DATE]. 8. Emergency Staffing and Mandating Policy will be reviewed and revised to prohibit longer than 16 hr shifts without a 6 hour break between shifts. A VP of (Company Name Omitted) will revise policy. This will be shared with nursing staff at education sessions. The policy was revised on [DATE]. 9. Nursing on call rotation will be developed to manage/cover call offs by VP of Clinical Services beginning [DATE]. 10. Director of Nursing is responsible for oversight of this deficient practice. In lieu of DON illness. (Name Omitted) nursing leadership will be responsible beginning [DATE]. Although the immediate jeopardy was removed on [DATE], the facility remained out of compliance at a scope of pattern and severity of actual harm due the fact that not all facility staff have received education and sustained compliance has not been verified by the State Agency. Review of the Facility assessment dated ,[DATE] through ,[DATE] revealed, FACILITY ASSESSMENT TOOL .Staffing plan 3.2. (not completed) (Indicating the staffing required to meet the residents' highest practicable physical, mental, and psychosocial well-being was not assessed). Resident #101: Review of a Face Sheet revealed Resident #101 was an [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of Resident #101's Physician order [REDACTED]. Resident #101's code status was electronically ordered by Registered Nurse (RN) U on [DATE] and electronically signed by the physician (MD J) on [DATE]. During an interview on [DATE] at 1:52 P.M. Registered Nurse (RN) U reported that a verbal or written order would have been received in order to make a change in a resident's code status. RN U reported that if she made a change to a resident's code status, she would have ensured an order was received to make the change in the electronic medical record. Once an order is placed in the computer the physician signs off on the new order. Review of Resident #101's Physician assessment dated [DATE] revealed, She does not have any current pain or symptoms .This patient is in no apparent distress, has normal physique, no emaciation or dehydration .The patient is relaxed and breathes without effort. The patient is not cyanotic and does not use the accessory muscles of respiration .Cardiovascular The rate is normal, the rhythm is regular. Review of Resident #101's Physician assessment dated [DATE] revealed, NO signs and symptoms suggestive of Covid-19, if there are changes noted in the patient contact provider immediately .No fever, cough, SOB (shortness of breath), n/v (nausea and vomiting) .if there are changes noted in the patient contact provider immediately. (Indicating Resident #101 was in stable condition). Review of Resident #101's Progress Notes from [DATE] to [DATE] revealed no documentation that Resident #101's health was declining or any other significant change in her physical condition. Review of Resident #101's Progress Note dated [DATE] 03:44 A.M. revealed, The CENA (Certified Nursing Assistant) summoned this nurse (Licensed Practical Nurse; LPN) G to (Resident #101's) room and upon entering noted that her chest did not rise and fall, she was not alert nor responsive to voice or touch, and non arousable, modeling noted to skin, no capillary refill with grey nail beds, no Apical, radial nor coratid pulse noted,body cold to the touch, she was stiff with rigamortis starting to set in. After apical check She was pronounced at 01:55. Oncall staff, Family and Doctor notified (sic). During an interview on [DATE] at 2:24 P.M. LPN G reported that on the night of Resident #101's death he was the only nurse for the entire building with a census of 60. LPN G reported that the aide found Resident #101 and she reported her condition to LPN G. LPN G reported that although he knew Resident #101 was a Full Code he was unable to do CPR because she was in rigor mortis and he could not remove her arms from across her chest to begin CPR. LPN G reported no other nurses were in the building to assist with identifying clinical signs of death (Per the facility policy and procedure). Review of the Facility Staffing Sheet dated [DATE] to [DATE] from 10:00 P.M. to 6:00 A.M. revealed there was 1 CNA available to assist residents from room [ROOM NUMBER] to room [ROOM NUMBER]. Resident #102: Review of the Face Sheet revealed Resident #102 was an [AGE] year old male admitted to the facility on [DATE] and diagnosed with [REDACTED]. Review of the Minimum Data Set ((MDS) dated [DATE] revealed Resident #102 had a brief interview for mental status (BIMS) score of 0 out of 15 which indicated he had severely impaired cognition. Review of the Electronic Medical Record (EMR) dated ,[DATE] reviewed on [DATE] at 3:05 PM revealed no documentation Resident #102 had been given his ordered morning medications. Review of the EMR dated ,[DATE] reviewed on [DATE] at 9:40 am revealed documentation Resident #102 had been given his morning medications by Registered Nurse (RN) H. Resident #103: Review of the Face Sheet revealed Resident #103 was [AGE] year old male admitted to the facility on [DATE] and diagnosed with [REDACTED]. Review of the MDS dated [DATE] revealed Resident #103 had a BIMS score of 0 out of 15 which indicated he had severely impaired cognition. Review of the EMR dated ,[DATE] reviewed on [DATE] at 3:05 PM, revealed no documentation Resident #103 had been given his ordered morning medications. Resident #104: Review of the Face Sheet revealed Resident #104 was [AGE] year old female admitted to the facility on [DATE] and diagnosed with [REDACTED]. Review of the MDS dated [DATE] revealed Resident #104 had a BIMS score of 2 out of 15 which indicated she had severely impaired cognition. Review of the EMR dated ,[DATE] reviewed on [DATE] at 3:05 PM, revealed no documentation Resident #104 had been given her ordered morning medications. Resident #105: Review of the Face Sheet revealed Resident #105 was [AGE] year old male admitted to the facility on [DATE] and diagnosed with [REDACTED]. Review of the MDS dated [DATE] revealed Resident #105 had a BIMS score of 0 out of 15 which indicated he had severely impaired cognition. Review of the EMR dated ,[DATE] reviewed on [DATE] at 3:05 PM, revealed no documentation Resident #105 had been given his ordered morning medications. Resident #106: Review of the Face Sheet revealed Resident #106 was [AGE] year old male admitted to the facility on [DATE] and diagnosed with [REDACTED]. Review of the MDS dated [DATE] revealed Resident #106 had a BIMS score of 0 out of 15 which indicated he had severely impaired cognition. Review of the EMR dated ,[DATE] reviewed on [DATE] at 3:05 PM, revealed no documentation Resident #106 had been given his ordered morning medications. Resident #107: Review of the Face Sheet revealed Resident #107 was [AGE] year old male admitted to the facility on [DATE] and diagnosed with [REDACTED]. Review of the MDS dated [DATE] revealed Resident #107 had a BIMS score of 6 out of 15 which indicated he had severely impaired cognition. Review of the EMR dated ,[DATE] reviewed on [DATE] at 3:05 PM, revealed no documentation Resident #107 had been given his ordered morning medications. Resident #108: Review of the Face Sheet revealed Resident #108 was [AGE] year old male admitted to the facility on [DATE] and diagnosed with [REDACTED]. Review of the MDS dated [DATE] revealed Resident #108 had a BIMS score of 0 out of 15 which indicated he had severely impaired cognition. Review of the EMR dated ,[DATE] reviewed on [DATE] at 3:05 PM, revealed no documentation Resident #108 had been given his ordered morning

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	235544	A. BUILDING _____ B. WING _____	05/01/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HALLMARK LIVING BENTON HARBOR	1385 E EMPIRE AVE BENTON HARBOR, MI 49022

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 0725 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 6) medications. Resident #109: Review of the Face Sheet revealed Resident #109 was [AGE] year old male admitted to the facility on [DATE] and diagnosed with [REDACTED]. Review of the MDS dated [DATE] revealed Resident #109 had a BIMS score of 0 out of 15 which indicated he had severely impaired cognition. Review of the EMR dated ,[DATE] reviewed on [DATE] at 3:05 PM, revealed no documentation Resident #109 had been given his ordered morning medications. Resident #110: Review of the Face Sheet revealed Resident #110 was [AGE] year old male admitted to the facility on [DATE] and diagnosed with [REDACTED]. Review of the MDS dated [DATE] revealed Resident #110 had a BIMS score of 0 out of 15 which indicated he had severely impaired cognition. Review of the EMR dated ,[DATE] reviewed on [DATE] at 3:05 PM, revealed no documentation Resident #110 had been given his ordered morning medications. Resident #111: Review of the Face Sheet revealed Resident #111 was [AGE] year old male admitted to the facility on [DATE] and diagnosed with [REDACTED]. Review of the MDS dated [DATE] revealed Resident #111 had a BIMS score of 0 out of 15 which indicated he had severely impaired cognition. Review of the EMR dated ,[DATE] reviewed on [DATE] at 3:05 PM, revealed no documentation Resident #111 had been given his ordered morning medications. Resident #112: Review of the Face Sheet revealed Resident #112 was [AGE] year old male admitted to the facility on [DATE] and diagnosed with [REDACTED]. Review of the MDS dated [DATE] revealed Resident #112 had a BIMS score of 0 out of 15 which indicated he had severely impaired cognition. Review of the EMR dated ,[DATE] reviewed on [DATE] at 3:05 PM, revealed no documentation Resident #112 had been given his ordered morning medications. Resident #113: Review of the Face Sheet revealed Resident #113 was [AGE] year old female admitted to the facility on [DATE] and diagnosed with [REDACTED]. Review of the MDS dated [DATE] revealed Resident #113 had a BIMS score of 0 out of 15 which indicated she had severely impaired cognition. Review of the EMR dated ,[DATE] reviewed on [DATE] at 3:05 PM, revealed no documentation Resident #113 had been given her ordered morning medications. Resident #114: Review of the Face Sheet revealed Resident #114 was [AGE] year old male admitted to the facility on [DATE] and diagnosed with [REDACTED]. Review of the MDS dated [DATE] revealed Resident #114 had a BIMS score of 0 out of 15 which indicated he had severely impaired cognition. Review of the EMR dated ,[DATE] reviewed on [DATE] at 3:05 PM, revealed no documentation Resident #114 had been given his ordered morning medications. Resident #115: Review of the Face Sheet revealed Resident #115 was [AGE] year old male admitted to the facility on [DATE] and diagnosed with [REDACTED]. Review of the MDS dated [DATE] revealed Resident #115 had a BIMS score of 0 out of 15 which indicated he had severely impaired cognition. Review of the EMR dated ,[DATE] reviewed on [DATE] at 3:05 PM, revealed no documentation Resident #115 had been given his ordered morning medications. Resident #116: Review of the Face Sheet revealed Resident #116 was a [AGE] year old female admitted to the facility on [DATE] and diagnosed with [REDACTED]. Review of the MDS dated [DATE] revealed Resident #116 had a BIMS score of 0 out of 15 which indicated she had severely impaired cognition. Review of the EMR dated ,[DATE] reviewed on [DATE] at 3:05 PM revealed no documentation Resident #116 had been given her ordered morning medications. Resident #117: Review of the Face Sheet revealed Resident #117 was a [AGE] year old female admitted to the facility on [DATE] and diagnosed with [REDACTED]. Review of the MDS dated [DATE] revealed Resident #117 had a BIMS score of 0 out of 15 which indicated she had severely impaired cognition. Review of the EMR dated ,[DATE] reviewed on [DATE] at 3:05 PM revealed no documentation Resident #117 had received her ordered morning medications. During an interview on [DATE] at 1:19 PM, Licensed Practical Nurse (LPN) G stated, on [DATE], no he had not given residents (#102, #116 and #117) their morning medications because he was the only licensed nurse in the facility and did not have enough time. During an interview on [DATE] at 2:47 PM, RN H stated she arrived at the facility about an hour ago (indicated at 1:47 PM arrival). RN H reviewed the EMR for Resident #102, Resident #116 and Resident #117. RN H stated Resident #102, Resident #116 and Resident #117 medication administrations are in red that would mean they're (residents) medications are late (indicated at this time of review the morning medications had not been given to the above residents) and resident medications are overdue. During an interview on [DATE] at 9:31 am, RN H stated she did initial the morning medications as given to Resident #102, Resident #116 and Resident #117 but I did not give them (medications) in the morning as ordered because she was not in the facility. During an interview on [DATE] at 12:51 PM, Medical Director (MD) J stated, on [DATE], I can't remember a phone call to indicate medications being given late. Resident #123: Review of the Face Sheet revealed Resident #124 was a [AGE] year old female admitted to the facility on [DATE] and diagnosed with [REDACTED]. Review of the Minimum Data Set ((MDS) dated [DATE] revealed Resident #123 had a brief interview for mental status (BIMS) score of 11 out of 15 which indicated she had moderately impaired cognition. In an observation on [DATE] at 10:43 AM, Resident #123 was noted to be in bed and was visibly tearful. During an interview on [DATE] at 10:43 AM, Resident #123 stated, it's not right they (facility) have no aides working today. Resident #124: Review of the Face Sheet revealed Resident #124 was a [AGE] year old male admitted to the facility on [DATE] and diagnosed with [REDACTED]. Review of the MDS dated [DATE] revealed Resident #124 had a BIMS score of 13 out of 15 which indicated he was cognitively intact. During an interview on [DATE] at 10:04 AM, Resident #124 stated, nobody's here (indicated no staff available to assist), I usually put my light (call light) on and they (staff) come after about an hour .there ain't (sic) no aides working. During an interview on [DATE] at 11:30 AM, LPN Q stated, we've been challenged with staffing. During an interview on [DATE] at 11:30 AM, CNA R stated, we (facility) don't have enough aides and I had 12 residents this morning and 19 residents now because one of the aides went home because she worked all night. During an interview on [DATE] at 10:10 AM, Certified Nurse Aide Scheduler (CNAS) E stated, on [DATE], there were only 3 aides and there was supposed to be more but the staff just stopped showing up for work. CNAS E stated, we (facility) normally work with 6 staff. CNAS E stated she was working the floor currently and had 15 residents to care for at that time. The resident census was 54 that day. During an interview on [DATE] at 11:28 AM, Nursing Home Administrator (NHA) A stated, on [DATE], there were 3 call ins' today, 2 CNA's (certified nurse aides) and 1 nurse. NHA A stated, no agency staff were able to work at the facility on [DATE]. NHA A stated, normally 6 to 7 staff working in the facility on a daily basis and the lack of staff was less than ideal. During an interview on [DATE] at 10:50 A.M., LPN G reported that he was currently the only nurse working for the entire facility. LPN G reported that he was caring for 54 Residents and began his shift on [DATE] at 6:00 P.M. LPN G reported he was unsure when a nurse would enter the facility to relieve him of his duty. During an interview on [DATE] at 11:06 CNA F reported that the facility was short staffed. CNA F reported that there were 3 CNA's and 1 LPN were working in the facility at that time. During an interview on [DATE] at 12:35 P.M., NHA A reported that LPN G was the only licensed nurse in the facility at that time. During an interview on [DATE] at 2:52 P.M., LPN G reported that he was currently the only nurse working in the facility and there had not been a nurse who could relieve him of his duty. LPN G had been working since 6:00 PM on [DATE] and had been working almost 21 hours straight. During an interview and observation on [DATE] at 3:58 P.M., there were no nursing staff observed on the Snowbird Unit. The interim NHA A entered the unit at that time and answered room [ROOM NUMBER]'s call light. When asked if there were staff on the unit to assist residents NHA A stated, CNA's (Certified Nursing Assistant) are on the other side of the door I'm thinking. (Indicating nursing staff were on a different unit beyond the closed double doors). At 4:02 P.M. this surveyor exited the double doors to the Main nurses' station and observed 2 CNA's sitting at that desk. CNA RR reported that she and the other CNA at the desk were working both the Covid/Snowbird Unit as well as the Mockingbird Unit. CNA RR reported that the nurse for the Snowbird Unit was also working the Mockingbird Unit and was assisting a resident on the Mockingbird Unit at that time. (Indicating that at the time of the observation there were no facility staff on the Snowbird Unit). During an interview on [DATE] at 10:23 A.M., Hospital/Hospice RN (HHRN) PP stated the facility is severely understaffed with illness. HHRN PP reported that there had been an increase in hospice referrals for the facility. HHRN PP reported that the building is under resourced and she has been trying to find ways to get them support. HHRN PP stated, We've had our hospice nurses in there trying to help as much as we can.
F 0727 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.** This citation pertains to MI 640. Based on interview and record review the facility failed to have a registered nurse (RN) for 8 (eight) consecutive hours, 7 (seven) days a week resulting in the potential for inaccurate and incomplete resident assessment and supervision of all residents. Findings include: Review of the Line Listing for the facility revealed the Director of Nursing (DON) B was off work (at home) due to covid illness on 4/6/20. Several attempts were made by this surveyor and the facility to facilitate an interview with the DON. By end of survey, the surveyor or facility were unable to speak to the DON. Review of the facility daily staffing assignment sheets dated 4/10/20 revealed no documented RN on duty for any of the nursing shifts for the 24 hour period. In an interview on 4/24/20 at 9:25 am, Licensed Practical Nurse

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F 0727 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 7) (LPN) Q reviewed the daily staffing assignment sheets dated 4/10/20 and stated there was not a registered nurse on that day. LPN Q stated she knew this information because I worked that day and there was not an RN on duty for the day (24 hour period). Review of the facility daily staffing assignment sheet dated 4/13/20 revealed no documented RN on duty for any of the nursing shifts for the 24 hours period. In an interview on 4/24/20 at 9:25 am, LPN Q stated, there was no RN on duty during the 24 hour period on 4/13/20. In an interview on 4/14/20 at 4:04 PM, Certified Nurse Aide (CNA) I stated, LPN G was here since yesterday (indicated only an LPN on duty in the facility since 4/13/20). In an interview on 4/17/20 at 1:57 PM, Director of Social Services (DSS) I stated the Director of Nursing (DON) B last worked at least 2 weeks ago. DSS I stated, on 4/10/20, there was only 1 nurse in the building and there was not an RN in the building. In an interview on 4/14/20 at 11:28 AM, Nursing Home Administrator (NHA) A stated, I don't think there was an RN in the building at that time.
F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure medication error rates are not 5 percent or greater.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to maintain a medication error rate less than 5% for 4 of 4 residents (Resident #102, #103, #106 and #110) reviewed for medication administration, resulting in a medication error rate of 100%. Findings include: Review of the Policy Medication Administration Times dated 5/1/10 revealed, Facility should commence medication administration within 60 (sixty) minutes before the designated times of administration and should be completed 60 (sixty) minutes after the designated times of administration. Resident #102: Review of the Face Sheet revealed Resident #102 was an [AGE] year old male admitted to the facility on [DATE] and diagnosed with [REDACTED]. Review of the Minimum Data Set ((MDS) dated [DATE] revealed Resident #102 had a brief interview for mental status (BIMS) score of 0 out of 15 which indicated he had severely impaired cognition. Review of Medication Administration Record [REDACTED].M. revealed no documentation that Resident #102's [MEDICATION NAME] tablet (medication for [MEDICAL CONDITION]) due at 07:00 A.M., [MEDICATION NAME] Sprinkles Capsule (medication for [MEDICAL CONDITION] II disorder) due at 06:00 A.M., Pantoprazole tablet (medication for acid reflux) due at 06:00 A.M., Polyethylene [MEDICATION NAME] powder (medication for gastric motility) due at 07:00 A.M., Potassium ER tablet (medication for potassium replacement) due at 07:00 A.M., and [MEDICATION NAME] Tablet (medication used for swelling) due at 08:00 A.M. were administered. Resident #103: Review of the Face Sheet revealed Resident #103 was a [AGE] year old male admitted to the facility on [DATE] and diagnosed with [REDACTED]. Review of the MDS dated [DATE] revealed Resident #103 had a BIMS score of 0 out of 15 which indicated he had severely impaired cognition. Review of MAR indicated [REDACTED].M., Levetiracetam tablet (medication for [MEDICAL CONDITION] disorder) due at 07:00 A.M., [MEDICATION NAME] tablet (medication for high blood pressure) due at 07:00 A.M., [MEDICATION NAME] Tablet (medication for arthritis pain) due at 07:00 A.M., and [MEDICATION NAME] Tablet (used for mood disorder) due at 5:00 P.M. were administered. Resident #106: Review of the Face Sheet revealed Resident #106 was [AGE] year old male admitted to the facility on [DATE] and diagnosed with [REDACTED]. Review of the MDS dated [DATE] revealed Resident #106 had a BIMS score of 0 out of 15 which indicated he had severely impaired cognition. Review of Medication Administration Record [REDACTED].M., [MEDICATION NAME] Tablet (medication for high blood pressure) due at 07:00 A.M., NAME] Tablet (medication for acid reflux) due at 06:00 A.M., [MEDICATION NAME] Tablet (medication for delusions) due at 08:00 A.M., [MEDICATION NAME] HCl 25 mg Tablet (medication for anxiety disorder) due at 08:00 A.M., [MEDICATION NAME] HCl Tablet 50MG due at 08:00 A.M., [MEDICATION NAME] XL Tablet (medication for high blood pressure) due at 07:00 A.M., Apixaban Tablet (used for [MEDICAL CONDITION]) due at 12:00 A.M. and 5:00 P.M., [MEDICATION NAME] Tablet (medication used for [MEDICAL CONDITION]) due at 07:00 A.M. and 04:00 P.M., Senna-Plus Tablet (medication for gastric motility) due at 07:00 A.M., and Tylenol Tablet (medication used for general discomfort) due at 07:00 A.M. were administered. Resident #110: Review of the Face Sheet revealed Resident #110 was [AGE] year-old male admitted to the facility on [DATE] and diagnosed with [REDACTED]. Review of the MDS dated [DATE] revealed Resident #110 had a BIMS score of 0 out of 15 which indicated he had severely impaired cognition. Review of Medication Administration Record [REDACTED].M., Aspirin Tablet 1 tablet by mouth one time a day [MEDICAL CONDITION](stroke) at 07:00 A.M., [MEDICATION NAME] (medication for high blood pressure) Tablet at 08:00 A.M., [MEDICATION NAME] .one time a day for Hypertension at 07:00 A.M., POLYETHYLENE [MEDICATION NAME] (for gastrointestinal motility) at 07:00 A.M., TAMSULOSIN (medication for [MEDICAL CONDITION]- enlarged prostate) at 07:00 A.M., [MEDICATION NAME]-S (for gastrointestinal motility) at 07:00 A.M., [MEDICATION NAME] Sodium (medication for mood disorder with manic features) at 06:00 A.M. and 01:00 P.M., Tylenol Extra Strength Tablet ([MEDICATION NAME]/medication for pain) at 08:00 A.M. and 12:00 P.M., [MEDICATION NAME] ([MEDICATION NAME]- [MEDICATION NAME] inhaler for difficulty breathing) at 08:00 A.M., 12:00 P.M., and 5:00 P.M. were administered. In an interview on 4/14/20 at 1:19 PM, Licensed Practical Nurse (LPN) G stated, on 4/14/20, no he had not given residents (#102, #103 #106 and #110) their medications because he was the only licensed nurse in the facility and did not have enough time. In an interview on 4/14/20 at 2:47 PM, RN H stated she arrived at the facility about an hour ago (indicated at 1:47 PM arrival). RN H reviewed the MAR for Resident #102, #103, #106 and Resident #110 and stated all the medications are late (indicated at this time of review the morning medications had not been given to the above residents) and resident medications are overdue. In an interview on 4/17/20 at 12:51 PM, Medical Director (MD) J stated, on 4/14/20, I can't remember receiving a phone call to give medications late to Resident #102, Resident #103, Resident #106 and Resident #110.
F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to keep residents free from significant medication errors in 4 of 4 residents (Resident #102, #102, #106 and #110) reviewed for medication administration resulting in the potential for medication adverse effects and complications. Findings include: Review of the Policy Medication Administration Times dated 5/1/10 revealed, Facility should commence medication administration within 60 (sixty) minutes before the designated times of administration and should be completed 60 (sixty) minutes after the designated times of administration. Resident #102: Review of the Face Sheet revealed Resident #102 was an [AGE] year old male admitted to the facility on [DATE] and diagnosed with [REDACTED]. Review of the Minimum Data Set ((MDS) dated [DATE] revealed Resident #102 had a brief interview for mental status (BIMS) score of 0 out of 15 which indicated he had severely impaired cognition. Review of Medication Administration Record [REDACTED].M. revealed no documentation that Resident #102's [MEDICATION NAME] Tablet (medication used for swelling) due at 08:00 A.M. was administered. Resident #103 Review of the Face Sheet revealed Resident #103 was a [AGE] year old male admitted to the facility on [DATE] and diagnosed with [REDACTED]. Review of the MDS dated [DATE] revealed Resident #103 had a BIMS score of 0 out of 15 which indicated he had severely impaired cognition. Review of Medication Administration Record [REDACTED].M. was administered. Resident #106 Review of the Face Sheet revealed Resident #106 was [AGE] year old male admitted to the facility on [DATE] and diagnosed with [REDACTED]. Review of the MDS dated [DATE] revealed Resident #106 had a BIMS score of 0 out of 15 which indicated he had severely impaired cognition. Review of Medication Administration Record [REDACTED].M. was administered. Resident #110 Review of the Face Sheet revealed Resident #110 was [AGE] year-old male admitted to the facility on [DATE] and diagnosed with [REDACTED]. Review of the MDS dated [DATE] revealed Resident #110 had a BIMS score of 0 out of 15 which indicated he had severely impaired cognition. Review of Medication Administration Record [REDACTED].M. and [MEDICATION NAME] (medication for high blood pressure) 20mg Tablet at 08:00 A.M. was administered. In an interview on 4/14/20 at 1:19 PM, Licensed Practical Nurse (LPN) G stated, on 4/14/20, no he had not given residents (#102, #103 #106 and #110) their medications because he was the only licensed nurse in the facility and did not have enough time. In an interview on 4/17/20 at 12:51 PM, Medical Director (MD) J stated, on 4/14/20, I can't remember receiving a phone call to give medications late to Resident #102, Resident #103, Resident #106 and Resident #110.

F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** Based on interview and record review the facility failed to store drugs and biological's with proper authorized personnel in 1 of 4 medication storage carts reviewed for medication storage resulting in the potential for diversion of narcotic medications and misappropriation of resident medications. Findings include: Review of the Policy Medication Storage dated 10/1/15 revealed the Facility should ensure that only authorized Facility staff, as defined by Facility, should have

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F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 8) possession of the keys, access cards, electronic codes, or combinations which open medication storage areas. Authorized staff may include nursing supervisors, charge nurses, licensed nurses, and other personnel authorized to administer medications in compliance with Applicable Law. In an interview on 4/14/20 at 1:14 PM, Licensed Practical Nurse (LPN) G stated this morning I gave her (Nursing Home Administrator (NHA) A) the keys (to the locked unit medication cart) and report. LPN G stated, I had to get back to my people in the other units. In an interview on 4/14/20 at 1:38 PM, NHA A stated this morning He (LPN G) had given me the keys to the locked unit medication cart. NHA A stated, yes I had the keys to the medication cart and I am not a licensed nurse. NHA A stated, No, I was not supposed to have access (keys) to the medication carts and medications.
F 0838 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete a facility wide assessment to determine the level of staffing required to meet the needs of all residents residing in the facility, resulting in insufficient staffing to meet the needs of the residents, inadequate knowledge of the facility population and inadequate resources to care for residents and unmet care needs for all facility residents. Findings include: Review of the Facility assessment dated ,[DATE] to ,[DATE] received via email from Nursing Home Administrator (NHA) A. Review of the Facility assessment dated ,[DATE] through ,[DATE] revealed, FACILITY ASSESSMENT TOOL- Facility Name: (Name Omitted) Persons (names/ titles) involved in completing assessment Administrator: (Blank, no documentation) Director of Nursing: (Blank, no documentation) Governing Body Rep: (Blank, no documentation) Medical Director: (Blank, no documentation) Other: (Blank, no documentation) Date(s) of assessment or update (Blank, no documentation) Date(s) assessment reviewed with QAA/QAPI committee (Blank, no documentation) . Staffing plan 3.2. (not completed) (Indicating the staffing required to meet the residents' highest practicable physical, mental, and psychosocial well-being was not assessed). During an email interview on [DATE] at 10:03 AM, Vice President of Compliance and Risk Management (VPCRM) Y stated, Updated facility assessment attached (Indicating the Facility Assessment was complete, accurate, and current). Review of the Facility assessment dated ,[DATE] through ,[DATE] (indicated date change from previous facility assessment) revealed, FACILITY ASSESSMENT TOOL- Facility Name: (Name Omitted) Persons (names/ titles) involved in completing assessment Administrator: (Blank, no documentation) Director of Nursing: (Blank, no documentation) Governing Body Rep: (Blank, no documentation) Medical Director: (Blank, no documentation) Other: (Blank, no documentation) Date(s) of assessment or update (Blank, no documentation) Date(s) assessment reviewed with QAA/QAPI committee (Blank, no documentation) . Staffing plan 3.2. (not completed) (Indicating the staffing required to meet the residents' highest practicable physical, mental, and psychosocial well-being was not assessed). Review of the Facility assessment dated ,[DATE] through ,[DATE] revealed, FACILITY ASSESSMENT TOOL .Staffing plan 3.2. (not completed) (Indicating the staffing required to meet the residents' highest practicable physical, mental, and psychosocial well-being was not assessed). Resident #101: Review of a Face Sheet revealed Resident #101 was an [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of Resident #101's Physician order [REDACTED]. Resident #101's code status was electronically ordered by Registered Nurse (RN) U on [DATE] and electronically signed by the physician (MD J) on [DATE]. During an interview on [DATE] at 1:52 P.M. Registered Nurse (RN) U reported that a verbal or written order would have been received in order to make a change in a resident's code status. RN U reported that if she made a change to a resident's code status, she would have ensured an order was received to make the change in the electronic medical record. Once an order is placed in the computer the physician signs off on the new order. Review of Resident #101's Physician assessment dated [DATE] revealed, She does not have any current pain or symptoms .This patient is in no apparent distress, has normal physique, no emaciation or dehydration .The patient is relaxed and breathes without effort. The patient is not cyanotic and does not use the accessory muscles of respiration .Cardiovascular The rate is normal, the rhythm is regular. Review of Resident #101's Physician assessment dated [DATE] revealed, NO signs and symptoms suggestive of Covid-19, if there are changes noted in the patient contact provider immediately .No fever, cough, SOB (shortness of breath), n/v (nausea and vomiting) .if there are changes noted in the patient contact provider immediately. (Indicating Resident #101 was in stable condition). Review of Resident #101's Progress Notes from [DATE] to [DATE] revealed no documentation that Resident #101's health was declining or any other significant change in her physical condition. Review of Resident #101's Progress Note dated [DATE] 03:44 A.M. revealed, The CENA (Certified Nursing Assistant) summoned this nurse (Licensed Practical Nurse; LPN) G to (Resident #101's) room and upon entering noted that her chest did not rise and fall, she was not alert nor responsive to voice or touch, and non arousable, modeling noted to skin, no capillary refill with grey nail beds, no Apical, radial nor coratid pulse noted,body cold to the touch, she was stiff with rigamortis starting to set in. After apical check She was pronounced at 01:55. Oncall staff, Family and Doctor notified (sic). During an interview on [DATE] at 2:24 P.M. LPN G reported that on the night of Resident #101's death he was the only nurse for the entire building with a census of 60. LPN G reported that the aide found Resident #101 and she reported her condition to LPN G. LPN G reported that although he knew Resident #101 was a Full Code he was unable to do CPR because she was in rigor mortis and he could not remove her arms from across her chest to begin CPR. LPN G reported no other nurses were in the building to assist with identifying clinical signs of death (Per the facility policy and procedure). Review of the Facility Staffing Sheet dated [DATE] to [DATE] from 10:00 P.M. to 6:00 A.M. revealed there was 1 CNA available to assist residents from room [ROOM NUMBER] to room [ROOM NUMBER]. Resident #102: Review of the Face Sheet revealed Resident #102 was an [AGE] year old male admitted to the facility on [DATE] and diagnosed with [REDACTED]. Review of the Minimum Data Set ((MDS) dated [DATE] revealed Resident #102 had a brief interview for mental status (BIMS) score of 0 out of 15 which indicated he had severely impaired cognition. Review of the Electronic Medical Record (EMR) dated ,[DATE] reviewed on [DATE] at 3:05 PM revealed no documentation Resident #102 had been given his ordered morning medications. Review of the EMR dated ,[DATE] reviewed on [DATE] at 9:40 am revealed documentation Resident #102 had been given his morning medications by Registered Nurse (RN) H. Resident #103: Review of the Face Sheet revealed Resident #103 was [AGE] year old male admitted to the facility on [DATE] and diagnosed with [REDACTED]. Review of the MDS dated [DATE] revealed Resident #103 had a BIMS score of 0 out of 15 which indicated he had severely impaired cognition. Review of the EMR dated ,[DATE] reviewed on [DATE] at 3:05 PM, revealed no documentation Resident #103 had been given his ordered morning medications. Resident #104: Review of the Face Sheet revealed Resident #104 was [AGE] year old female admitted to the facility on [DATE] and diagnosed with [REDACTED]. Review of the MDS dated [DATE] revealed Resident #104 had a BIMS score of 2 out of 15 which indicated she had severely impaired cognition. Review of the EMR dated ,[DATE] reviewed on [DATE] at 3:05 PM, revealed no documentation Resident #104 had been given her ordered morning medications. Resident #105: Review of the Face Sheet revealed Resident #105 was [AGE] year old male admitted to the facility on [DATE] and diagnosed with [REDACTED]. Review of the MDS dated [DATE] revealed Resident #105 had a BIMS score of 0 out of 15 which indicated he had severely impaired cognition. Review of the EMR dated ,[DATE] reviewed on [DATE] at 3:05 PM, revealed no documentation Resident #105 had been given his ordered morning medications. Resident #106: Review of the Face Sheet revealed Resident #106 was [AGE] year old male admitted to the facility on [DATE] and diagnosed with [REDACTED]. Review of the MDS dated [DATE] revealed Resident #106 had a BIMS score of 0 out of 15 which indicated he had severely impaired cognition. Review of the EMR dated ,[DATE] reviewed on [DATE] at 3:05 PM, revealed no documentation Resident #106 had been given his ordered morning medications. Resident #107: Review of the Face Sheet revealed Resident #107 was [AGE] year old male admitted to the facility on [DATE] and diagnosed with [REDACTED]. Review of the MDS dated [DATE] revealed Resident #107 had a BIMS score of 6 out of 15 which indicated he had severely impaired cognition. Review of the EMR dated ,[DATE] reviewed on [DATE] at 3:05 PM, revealed no documentation Resident #107 had been given his ordered morning medications. Resident #108: Review of the Face Sheet revealed Resident #108 was [AGE] year old male admitted to the facility on [DATE] and diagnosed with [REDACTED]. Review of the MDS dated [DATE] revealed Resident #108 had a BIMS score of 0 out of 15 which indicated he had severely impaired cognition. Review of the EMR dated ,[DATE] reviewed on [DATE] at 3:05 PM, revealed no documentation Resident #108 had been given his ordered morning medications. Resident #109: Review of the Face Sheet revealed Resident #109 was [AGE] year old male admitted to the facility on [DATE] and diagnosed with [REDACTED]. Review of the MDS dated [DATE] revealed Resident #109 had a BIMS score of 0 out of 15 which indicated he had severely impaired cognition. Review of the EMR dated ,[DATE] reviewed on [DATE]

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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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0838 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 9) at 3:05 PM, revealed no documentation Resident #109 had been given his ordered morning medications. Resident #110: Review of the Face Sheet revealed Resident #110 was [AGE] year old male admitted to the facility on [DATE] and diagnosed with [REDACTED]. Review of the MDS dated [DATE] revealed Resident #110 had a BIMS score of 0 out of 15 which indicated he had severely impaired cognition. Review of the EMR dated ,[DATE] reviewed on [DATE] at 3:05 PM, revealed no documentation Resident #110 had been given his ordered morning medications. Resident #111: Review of the Face Sheet revealed Resident #111 was [AGE] year old male admitted to the facility on [DATE] and diagnosed with [REDACTED]. Review of the MDS dated [DATE] revealed Resident #111 had a BIMS score of 0 out of 15 which indicated he had severely impaired cognition. Review of the EMR dated ,[DATE] reviewed on [DATE] at 3:05 PM, revealed no documentation Resident #111 had been given his ordered morning medications. Resident #112: Review of the Face Sheet revealed Resident #112 was [AGE] year old male admitted to the facility on [DATE] and diagnosed with [REDACTED]. Review of the MDS dated [DATE] revealed Resident #112 had a BIMS score of 0 out of 15 which indicated he had severely impaired cognition. Review of the EMR dated ,[DATE] reviewed on [DATE] at 3:05 PM, revealed no documentation Resident #112 had been given his ordered morning medications. Resident #113: Review of the Face Sheet revealed Resident #113 was [AGE] year old female admitted to the facility on [DATE] and diagnosed with [REDACTED]. Review of the MDS dated [DATE] revealed Resident #113 had a BIMS score of 0 out of 15 which indicated she had severely impaired cognition. Review of the EMR dated ,[DATE] reviewed on [DATE] at 3:05 PM, revealed no documentation Resident #113 had been given her ordered morning medications. Resident #114: Review of the Face Sheet revealed Resident #114 was [AGE] year old male admitted to the facility on [DATE] and diagnosed with [REDACTED]. Review of the MDS dated [DATE] revealed Resident #114 had a BIMS score of 0 out of 15 which indicated he had severely impaired cognition. Review of the EMR dated ,[DATE] reviewed on [DATE] at 3:05 PM, revealed no documentation Resident #114 had been given his ordered morning medications. Resident #115: Review of the Face Sheet revealed Resident #115 was [AGE] year old male admitted to the facility on [DATE] and diagnosed with [REDACTED]. Review of the MDS dated [DATE] revealed Resident #115 had a BIMS score of 0 out of 15 which indicated he had severely impaired cognition. Review of the EMR dated ,[DATE] reviewed on [DATE] at 3:05 PM, revealed no documentation Resident #115 had been given his ordered morning medications. Resident #116: Review of the Face Sheet revealed Resident #116 was a [AGE] year old female admitted to the facility on [DATE] and diagnosed with [REDACTED]. Review of the MDS dated [DATE] revealed Resident #116 had a BIMS score of 0 out of 15 which indicated she had severely impaired cognition. Review of the EMR dated ,[DATE] reviewed on [DATE] at 3:05 PM revealed no documentation Resident #116 had been given her ordered morning medications. Resident #117: Review of the Face Sheet revealed Resident #117 was a [AGE] year old female admitted to the facility on [DATE] and diagnosed with [REDACTED]. Review of the MDS dated [DATE] revealed Resident #117 had a BIMS score of 0 out of 15 which indicated she had severely impaired cognition. Review of the EMR dated ,[DATE] reviewed on [DATE] at 3:05 PM revealed no documentation Resident #117 had received her ordered morning medications. During an interview on [DATE] at 1:19 PM, Licensed Practical Nurse (LPN) G stated, on [DATE], no he had not given residents (#102, #116 and #117) their morning medications because he was the only licensed nurse in the facility and did not have enough time. During an interview on [DATE] at 2:47 PM, RN H stated she arrived at the facility about an hour ago (indicated at 1:47 PM arrival). RN H reviewed the EMR for Resident #102, Resident #116 and Resident #117. RN H stated Resident #102, Resident #116 and Resident #117 medication administrations are in red that would mean they're (residents) medications are late (indicated at this time of review the morning medications had not been given to the above residents) and resident medications are overdue. During an interview on [DATE] at 9:31 am, RN H stated she did initial the morning medications as given to Resident #102, Resident #116 and Resident #117 but I did not give them (medications) in the morning as ordered because she was not in the facility. During an interview on [DATE] at 12:51 PM, Medical Director (MD) J stated, on [DATE], I can't remember a phone call to indicate medications being given late. Resident #123: Review of the Face Sheet revealed Resident #124 was a [AGE] year old female admitted to the facility on [DATE] and diagnosed with [REDACTED]. Review of the Minimum Data Set ((MDS) dated [DATE] revealed Resident #123 had a brief interview for mental status (BIMS) score of 11 out of 15 which indicated she had moderately impaired cognition. In an observation on [DATE] at 10:43 AM, Resident #123 was noted to be in bed and was visibly tearful. During an interview on [DATE] at 10:43 AM, Resident #123 stated, it's not right they (facility) have no aides working today. Resident #124: Review of the Face Sheet revealed Resident #124 was a [AGE] year old male admitted to the facility on [DATE] and diagnosed with [REDACTED]. Review of the MDS dated [DATE] revealed Resident #124 had a BIMS score of 13 out of 15 which indicated he was cognitively intact. During an interview on [DATE] at 10:04 AM, Resident #124 stated, nobody's here (indicated no staff available to assist), I usually put my light (call light) on and they (staff) come after about an hour .there ain't (sic) no aides working. During an interview on [DATE] at 11:30 AM, LPN Q stated, we've been challenged with staffing. During an interview on [DATE] at 11:30 AM, CNA R stated, we (facility) don't have enough aides and I had 12 residents this morning and 19 residents now because one of the aides went home because she worked all night. During an interview on [DATE] at 10:10 AM, Certified Nurse Aide Scheduler (CNAS) E stated, on [DATE], there were only 3 aides and there was supposed to be more but the staff just stopped showing up for work. CNAS E stated, we (facility) normally work with 6 staff. CNAS E stated she was working the floor currently and had 15 residents to care for at that time. The resident census was 54 that day. During an interview on [DATE] at 11:28 AM, Nursing Home Administrator (NHA) A stated, on [DATE], there were 3 call ins' today, 2 CNA's (certified nurse aides) and 1 nurse. NHA A stated, no agency staff were able to work at the facility on [DATE]. NHA A stated, normally 6 to 7 staff working in the facility on a daily basis and the lack of staff was less than ideal. During an interview on [DATE] at 10:50 A.M., LPN G reported that he was currently the only nurse working for the entire facility. LPN G reported that he was caring for 54 Residents and began his shift on [DATE] at 6:00 P.M. LPN G reported he was unsure when a nurse would enter the facility to relieve him of his duty. During an interview on [DATE] at 11:06 CNA F reported that the facility was short staffed. CNA F reported that there were 3 CNA's and 1 LPN were working in the facility at that time. During an interview on [DATE] at 12:35 P.M., NHA A reported that LPN G was the only licensed nurse in the facility at that time. During an interview on [DATE] at 2:52 P.M., LPN G reported that he was currently the only nurse working in the facility and there had not been a nurse who could relieve him of his duty. LPN G had been working since 6:00 PM on [DATE] and had been working almost 21 hours straight. During an interview and observation on [DATE] at 3:58 P.M., there were no nursing staff observed on the Snowbird Unit. The interim NHA A entered the unit at that time and answered room [ROOM NUMBER]'s call light. When asked if there were staff on the unit to assist residents NHA A stated, CNA's (Certified Nursing Assistant) are on the other side of the door I'm thinking. (Indicating nursing staff were on a different unit beyond the closed double doors). At 4:02 P.M. this surveyor exited the double doors to the Main nurses' station and observed 2 CNA's sitting at that desk. CNA RR reported that she and the other CNA at the desk were working both the Covid/Snowbird Unit as well as the Mockingbird Unit. CNA RR reported that the nurse for the Snowbird Unit was also working the Mockingbird Unit and was assisting a resident on the Mockingbird Unit at that time. (Indicating that at the time of the observation there were no facility staff on the Snowbird Unit).
F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to maintain complete and accurately documented medical records for 3 of 4 residents (Resident #102, Resident #116 and Resident #117) reviewed for complete medical records resulting in documentation of resident medication administered inaccurately and a lack of accurate resident representation of condition. Findings include: Review of the Policy Documentation-Electronic Health Record dated 11/2/18 revealed, Documentation Guidelines for the .electronic health record shall be .Timely, Accurate, Relevant and complete. Resident #102: Review of the Face Sheet revealed Resident #102 was an [AGE] year old male admitted to the facility on [DATE] and diagnosed with [REDACTED]. Review of the Minimum Data Set ((MDS) dated [DATE] revealed Resident #102 had a brief interview for mental status (BIMS) score of 0 out of 15 which indicated he had severely impaired cognition. Review of the Electronic Medical Record (EMR) dated 4/2020 reviewed on 4/14/20 at 3:05 PM revealed no documentation Resident #102 had been given his ordered morning medications. Review of the EMR dated 4/2020 reviewed on 4/16/20 at 9:40 am revealed documentation Resident #102 had been given his morning medications by Registered Nurse (RN) H. Resident #116: Review of the Face Sheet revealed Resident #116 was a [AGE] year old female admitted to the facility on [DATE] and diagnosed with [REDACTED]. Review of the MDS dated [DATE] revealed Resident #116 had a BIMS score of 0 out of 15 which indicated she had severely impaired cognition. Review of the EMR dated 4/2020 reviewed on 4/14/20 at 3:05 PM revealed no documentation Resident #116 had been given her

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F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 10) ordered morning medications. Review of the EMR dated 4/2020 reviewed on 4/16/20 at 9:40 am revealed documentation Resident #116 had received her morning medications by RN H. Resident #117: Review of the Face Sheet revealed Resident #117 was a [AGE] year old female admitted to the facility on [DATE] and diagnosed with [REDACTED]. Review of the MDS dated [DATE] revealed Resident #117 had a BIMS score of 0 out of 15 which indicated she had severely impaired cognition. Review of the EMR dated 4/2020 reviewed on 4/14/20 at 3:05 PM revealed no documentation Resident #116 had received her ordered morning medications. Review of the EMR dated 4/2020 reviewed on 4/16/20 at 9:40 am revealed documentation Resident #116 had received her morning medications by RN H. In an interview on 4/14/20 at 1:19 PM, Licensed Practical Nurse (LPN) G stated, on 4/14/20, no he had not given residents (#102, #116 and #117) their morning medications because he was the only licensed nurse in the facility and did not have enough time. In an interview on 4/17/20 at 12:51 PM, Medical Director (MD) J stated, on 4/14/20, I can't remember receiving a phone call to give medications late to Resident #102, Resident #116 and Resident #117. In an interview on 4/14/20 at 2:47 PM, RN H stated she arrived at the facility about an hour ago (indicated at 1:47 PM arrival). RN H reviewed the EMR for Resident #102, Resident #116 and Resident #117. RN H stated Resident #102, Resident #116 and Resident #117 medication administrations are in red that would mean they're (residents) medications are late (indicated at this time of review the morning medications had not been given to the above residents) and resident medications are overdue. In an interview on 4/23/20 at 9:31 am, RN H stated she did initial the morning medications as given to the residents but I did not give them (medications) in the morning as ordered. RN H stated, no the medical record was not accurate.
F 0880 **Level of harm** - Immediate jeopardy **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 MI 640. Based on observation, interview, and record review the facility failed to follow Center for Disease Control (CDC) and Centers for Medicare and Medicaid Services (CMS) guidance to asses every resident daily for COVID-19 symptoms, ensure a complete and accurate Line Listing, and failed to implement established infection control interventions to provide care for, and prevent the spread of Covid-19 to residents and staff members in the facility for 10 out of 42 residents (Resident #119, #120, #125, #130, #132, #138, #110, #126, #140, and #141) reviewed for infection control, resulting in an immediate jeopardy when, beginning on [DATE], facility staff did not perform surveillance, implement established infection control standard interventions to provide care for, and prevent the spread of Covid-19 to staff members and residents in the facility. This deficient practice placed all residents at risk for serious harm and/or death. On [DATE] at 12:40 pm the Nursing Home Administrator was verbally notified and received written notification of the immediate jeopardy that was identified on [DATE] due to the facility's failure to perform a proper infection control surveillance and implement established infection control interventions. A written plan for removal for the immediate jeopardy was received on [DATE] and the following was verified on [DATE]: 1. All staff will be educated on proper infection control steps: Including: donning and doffing PPE (Personal Protective Equipment) and opportunities to perform hand hygiene. The staff will be re-educated on droplet and contact precaution, when to use PPE and when to remove PPE. Staff will be educated before their next shift. (Registered Nurse Y) and (Licensed Practical Nurse Q) are providing the education. Education provided by discussion, handouts, and video. Nurse Agency training is completed by their employer prior to reporting to the facility. New hires will be educated prior to their assigned first shift. This began [DATE]. 2. Line listing will be re-organized to identify all residents who are PUI and require droplet precautions. Signs will be posted outside rooms where patients require precautions indicating type of precautions. This will be completed by VP of clinical services and maintained and updated daily. The facility will continue to send state the daily line listing beginning [DATE]. 3. (Nursing Home Administrator A), (Corporate Nurse NN), (Licensed Practical Nurse Q) are monitoring temperatures/vital signs/symptoms; documented in (Electronic Medical Record) and/or paper. Staff have been educated on covid symptoms and elevated temperatures/pulse oximetry beginning [DATE]. 4. (Licensed Practical Nurse Q), (Nursing Home Administrator A) or designee will track employee illness & symptoms beginning [DATE]. 5. Employee & Visitor temperature & symptoms will be reviewed by (Licensed Practical Nurse Q), (Nursing Home Administrator A) or designee daily beginning [DATE]. 6. Medical Director has been notified and involved in the infection prevention of covid and care of residents beginning [DATE]. 7. Resident's representatives have (been) notified beginning [DATE]. 8. VP of Clinical Services, MDS and Interim Administrator have thoroughly reviewed all other residents in the building to identify resp/covid symptoms and date this was done beginning [DATE]. 9. PPE stations will be placed strategically in the building with a minimum of two per hall. Re-usable goggles be cleaned and sanitized according to CDC guidelines beginning [DATE]. 10. Administrator/Designee will complete random 10 audits per week on all shifts to ensure proper utilization of PPE without cross contamination. She will complete this audit for 6 months beginning [DATE]. 11. Mapping will be completed on all PUI and infections to ensure that those affected are cohorted or clustered and to identify trends by staff, organism or symptoms. This will be completed by VP of clinical services (infection preventionist) and responded to and verified onsite by facility infection preventionist beginning [DATE]. 12. On [DATE], facility and consultant staff began reeducating facility staff on infection control practices including when and how to use appropriate personal protection equipement. The consultant firm stationed a staff member outside the isolation unit to ensure staff utilized appropriate PPE at entry and upon exit to the isolation unit. Although the immediate jeopardy was removed on [DATE], the facility remained out of compliance at a scope of widespread and severity of actual harm due the fact that not all facility staff have received education and sustained compliance has not been verified by the State Agency. Findings include: Review of the INFECTION CONTROL-Interim policy addressing healthcare crisis related to Human [MEDICAL CONDITION] dated [DATE] revealed, The following information is only intended to be used as guidelines to address health care concern of Human [MEDICAL CONDITION] specifically COVID-19. This policy will address prevention, education, screening, surveillance, investigating and reporting of persons at risk. Due to the nature of the illness and persons served in long term care environment a tool kit is created and available titled COVID-19 tool kit. All forms, education and screening tools are included in the COVID-19 tool kit. As this is a rapidly evolving situation, frequent updates may be made to these guidelines as recommendations are released by CDC .13. All attempts should be made to care for residents with a change in condition in the facility to reduce the risk of exposure in the acute care / hospital setting. Only those emergency situations that are deemed to be medically necessary and/or the services or treatment required cannot be provided at the facility should be sent to the hospital for evaluation. Any resident returning to the facility should be screened as well as quarantine measures and monitoring implemented for 14 days .Resident and Staff Screening: 1. All new admissions will be assessed for respiratory illness and will be asked about travel outside of the US for them and their immediate family. Anyone responding affirmatively will have a laboratory testing algorithm completed to determine if laboratory testing is appropriate and if they should be classified as a person under investigation (PUI). The state and local department of health should be notified immediately for further action steps. 2. Staff will complete a one-time questionnaire regarding respiratory symptoms AND travel outside of the US for them or their immediate family. 3. All residents and staff will have temperature taken every shift and observe for respiratory symptoms. 4. Any resident noted with a fever and/or respiratory symptoms should be addressed with physician and the COVID-19 PUI screen will be done. Local health department will be notified. 5. Any staff with a fever and/or respiratory symptoms will result in the staff being screened for PUI and sent home with local health department being notified as indicated utilizing the PUI algorithm. Refer to Healthcare Provider (HCP) Return to Work Guidelines and Alternate Crisis Strategies to Mitigate Staffing Shortages listed below .Process and Outcome Surveillance Guidelines: 1. Outcome Surveillance: Infection preventionist will track all residents with fever and/or respiratory symptoms and utilize the laboratory testing algorithm to determine if these individuals should be considered a person under investigation. Any trends or patterns identified will be evaluated and addressed as deemed appropriate. 2. The state and local department of health should be notified immediately of anyone meeting the criteria of PUI for further action steps. Utilize the state and local health department algorithm to determine PUI. 3. The facility will complete the CMS COVID-19 Focused Survey Self-Assessment Tool to ensure the facility has implemented proper infection prevention and control practices to prevent the development and transmission of COVID-19 and other communicable diseases and infections. 4. Process Surveillance: Infection Preventionist or designee will frequently monitor staff compliance with hand hygiene and PPE practices on varied shifts. Immediate actions and education will be provided as needed when concerns are noted .Care of Confirmed Positive COVID-19 or Person Under Investigation (PUI): 1. Residents with known or suspected COVID-19 should be cared for in a single-person room OR cohorted with another positive COVID-19 patient (this does not include PUI) with the door closed. The resident should have a dedicated (not shared) bathroom. Cohorting: It might not be possible to distinguish patients who have COVID-19 from patients with other respiratory viruses. As such, patients with different respiratory pathogens will

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 11) likely be housed on the same unit. However, only patients with the same respiratory pathogen may be housed in the same room. For example, a patient with COVID-19 should not be housed in the same room as a patient with an undiagnosed respiratory infection. 2. Where possible, buildings will designate a unit, hall or cluster of rooms dedicated to caring for known or suspected COVID-19 patients. 3. The resident that is a PUI or confirmed positive will be assessed at least every 4 hours; This assessment should include but is not limited to: Full set of V/S - B/P, pulse, temperature, respirations and oxygen saturation % Respiratory Assessment- Lung sounds, presence or absence of cough, sputum production, shortness of breath Physician or Nurse Practitioner should be notified immediately of any change in condition. Dedicated or disposable noncritical resident-care equipment (e.g., blood pressure cuffs, blood glucose monitor equipment) is used, or if not available, then equipment is cleaned and disinfected according to manufacturers' instructions using an EPA-registered disinfectant for healthcare setting prior to use on another resident. 5. Facility HCP will follow droplet precautions utilizing the following PPE and infection control precautions . Personal Protective Equipment Employees should select appropriate PPE and demonstrate knowledge of: when to use PPE what PPE is necessary how to properly don, use, and doff PPE in a manner to prevent self-contamination how to properly dispose of or disinfect and maintain PPE the limitations of PPE. Any reusable PPE must be properly cleaned, decontaminated, and maintained after and between uses. Facilities should have policies and procedures describing a recommended sequence for safely donning and doffing PPE .When COVID-19 is identified in the facility, staff wear all recommended PPE (i.e., gloves, gown, eye protection and respirator or facemask) for the care of all residents on the unit (or facility-wide based on the location of affected residents), regardless of symptoms (based on availability). Review of Fundamentals of Nursing (Potter and Perry) 9th edition revealed, Axillary .Measurement lags behind core temperature during rapid temperature changes Not recommended for detecting fever .Underestimates core temperature. Potter, Patricia A.; Perry, Anne Griffin; Stockert, Patricia; Hall, Amy. Fundamentals of Nursing - E-Book (Kindle Locations ,[DATE]). Elsevier Health Sciences. Kindle Edition. Review of Fundamentals of Nursing (Potter and Perry) 9th edition revealed, The temperature of older adults is at the lower end of the normal temperature range, 36 to 36.8 C (96.8 to 98.3 F) orally and 36.6 to 37.2 C (98 to 99 F) rectally. Therefore temperatures considered within normal range sometimes reflect a fever in an older adult .Older adults are very sensitive to slight changes in environmental temperature because their thermoregulatory systems are not as efficient .Be especially attentive to subtle temperature changes and other manifestations of fever in this population such as tachypnea, anorexia, falls, [MEDICAL CONDITION], and overall functional decline. Older adults without teeth or with poor muscle control may be unable to close their mouths tightly to obtain accurate oral temperature readings. Potter, Patricia A.; Perry, Anne Griffin; Stockert, Patricia; Hall, Amy. Fundamentals of Nursing - E-Book (Kindle Locations ,[DATE]). Elsevier Health Sciences. Kindle Edition. Resident #119 Review of a Face Sheet revealed Resident #119 was an [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of Resident #119's Progress Note dated [DATE] at 2:18 P.M. revealed, Writer engaged in telehealth meeting with Nurse Practitioner today. NP has been made aware of patients c/o (complains of) fatigue and intermitent (sic) fever. New orders have been put in place regarding medication holds and/or changes. Patient will have STAT (immediate) labs drawn today. If cough becomes productive or persistent order STAT chest x ray. Call provider directly for IV orders. Review of the Line Listing (infection tracking spreadsheet for Covid 19) dated [DATE] revealed Resident #119 was not added. During an interview on [DATE] at 2:53 P.M., Nursing Home Administrator (NHA) A reported Resident #119 would be added to the Line Listing and the Health Department would be notified. Resident #120 Review of a Face Sheet revealed Resident #120 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of Resident #120's Weights and Vitals dated [DATE] at 07:51 A.M. revealed Resident #120 had a temperature of 100.9 F Tympanic Review of Resident #120's Weights and Vitals dated [DATE] at 10:25 A.M. revealed Resident #120 had a temperature of 100.4 F Tympanic Review of Resident #120's Weights and Vitals dated [DATE] at 05:47 A.M. revealed Resident #120 had a temperature of 99.8 F Tympanic Review of Resident #120's Weights and Vitals dated [DATE] at 12:35 P.M. revealed Resident #120 had a temperature of 100.5 F Tympanic Review of Resident #120's Weights and Vitals dated [DATE] at 02:26 A.M. revealed Resident #120 had a temperature of 99.9 F Temporal Artery. Review of the line listing on [DATE] at 3:28 P.M. revealed Resident #120 had not been placed on the Line Listing. During an interview on [DATE] 10:31 AM, Health Department Epidemiologist (HDE) OO reported that any resident residing on the Covid-19 Unit that had any symptoms (fever, shortness of breath, cough, sore throat, headache) would be placed on the Line Listing as a Presumptive Positive. Resident #125 Review of a Face Sheet revealed Resident #125 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of Resident #125's Weights and Vitals dated [DATE] at 08:16 A.M. revealed that Resident #125 had a temperature of 100.2 F Tympanic. Review of Resident #125's Progress Note dated [DATE] at 09:12 A.M. revealed, Patient's (guardian) notified of patient's status Temp 100.2 ,SpO2 94 RA (oxygen saturation 94% on room air),no coughing noted, no c/o (complaints of) sore throat voiced, and patient states feeling good, no usual complains at this time. (No indication that the physician and the Health Department were notified of a fever for a resident residing on the Covid-19 unit). Review of the Line Listing received on [DATE] at 12:55 P.M. via email revealed that Resident #125 was not placed on the Line Listing. During an interview on [DATE] at 1:15 P.M., NHA A reported that she did not see Resident #125 on the Line Listing and reported that she was not made aware that he had a fever. NHA A reported that she would notify the Health Department. During an interview on [DATE] at 1:25 P.M. HDE OO and NHA A. HDE OO reported that he had not been notified that Resident #125 was residing on the Covid-19 Unit and had a temperature. HDE OO reported that had he known he would have had him on the line listing for a presumptive positive. Resident #130 Review of a Face Sheet revealed Resident #130 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of the Line Listing dated [DATE] revealed that Resident #130's roommate died on [DATE] and was Covid-19 positive. During an interview on [DATE] at 9:06 A.M., [MEDICAL TREATMENT] Nurse (DN) FF reported that any resident/patient that is exposed to Covid-19 is sent to the designated Covid-19 [MEDICAL TREATMENT] Unit as a way to limit the spread of [MEDICAL CONDITION]. DN FF reported that the facility had not notified the [MEDICAL TREATMENT] Unit that Resident # 130 had been exposed to Covid-19 on [DATE] but that would have been the expectation. DN FF reported that Resident #130 had received [MEDICAL TREATMENT] at the clean [MEDICAL TREATMENT] Unit until [DATE] when DN FF had identified that Resident #130 had been exposed to Covid-19. DN FF reported that had she known Resident #130 was exposed to Covid-19 on [DATE] he (Resident #130) would have been sent there (Covid-19 [MEDICAL TREATMENT] Unit) immediately. During an interview on [DATE] at 12:40 P.M., Licensed Practical Nurse (LPN) Q reported that she was aware that Resident #130's roommate died on [DATE] and was Covid-19 positive but did not notify the [MEDICAL TREATMENT] center. LPN Q reported that the nurse on duty that date should have notified the [MEDICAL TREATMENT] center. During an interview on [DATE] at 1:52 P.M. LPN Q reported that if any [MEDICAL TREATMENT] resident is exposed to Covid-19 the [MEDICAL TREATMENT] center should be notified. During an interview on [DATE] at 2:00 P.M. Medical Doctor (MD) J reported that the facility staff should be notifying the [MEDICAL TREATMENT] center if there is a positive Covid-19 case, presumptive positive case, or an exposure. Resident #132 Review of a Face Sheet revealed Resident #132 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. During an observation on [DATE] at 12:44 P.M. CNA F entered a Covid Positive residents' room (Resident #132) without donning a gown or gloves. CNA F washed Resident #132's tray table, delivered his lunch tray, and exited the room. Resident #138 Review of a Face Sheet revealed Resident #138 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. During an observation on [DATE] at 2:04 P.M., CNA HH walked into a Covid Positive resident' room (Resident #138) with no gown or gloves (wearing only a face mask). CNA HH repositioned Resident #138 using her hands on each of his shoulders to move him over, her nursing scrubs were touching his bed. CNA HH exited the room, performed no hand hygiene, and entered room [ROOM NUMBER]. CNA H exited room [ROOM NUMBER] without performing hand hygiene, reentered Resident #138's room without donning a gown or gloves, took out Resident #138's nasal canula, wiped his nose, and repositioned him. CNA H exited his room and used hand sanitizer. Resident #110: Review of the Face Sheet revealed Resident #110 was [AGE] year-old male admitted to the facility on [DATE] and diagnosed with [REDACTED]. Review of Resident # 110's Weights and Vitals Summary revealed that on [DATE] at 10:42 A.M., Resident #110's temperature was 99.9 F Axilla (Heart rate and respirations were not assessed). There was no Progress Note written to indicate that the Physician and the Health Department were notified of the elevated temperature or that Resident #110 was placed in isolation Review of Resident # 110's Weights and Vitals Summary revealed that on [DATE] at 02:27 A.M., Resident #110's temperature was 100.7 F Tympanic (Heart rate and respirations were not assessed). There was no Progress Note written to indicate that the Physician and the Health Department were notified of the elevated temperature or that Resident #110 was placed in isolation Review of Resident # 110's Weights and Vitals Summary revealed that on [DATE] at 9:07 P.M., Resident #110's temperature was 99.2 F (Tympanic) High of 99.0 exceeded (Heart rate and respirations were not

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	235544	A. BUILDING _____ B. WING _____	05/01/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HALLMARK LIVING BENTON HARBOR	1385 E EMPIRE AVE BENTON HARBOR, MI 49022

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 -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 12) assessed). There was no Progress Note written to indicate that the Physician and the Health Department were notified of the elevated temperature or that Resident #110 was placed in isolation Review of Resident #110's Infection Charting dated [DATE] at 10:00 A.M. revealed, INFECTION TYPE: 13. PUI/COVID .1b. Pneumonia .Vital Signs .Most Recent Temperature .100 Tympanic .O2 90% .RESPIRATORY INFECTION: 2. Wheezing .Non-productive cough. During an interview on [DATE] at 2:50 P.M., NHA A was notified that Resident #110 had a fever documented but was not in isolation or on the Covid-19 designated unit. Review of the Line Listing dated [DATE] revealed that Resident #110 was not placed on the line listing and the health department was not notified of elevated temperature. During an observation on [DATE] at 9:15am Resident #110 was not in an isolation room or on the Covid-19 designated unit. Review of Resident #110's Social Service Note dated [DATE] 3:16 P.M. revealed, Resident (#110) moved to Covid hallway for time being. (Indicating he was moved to the isolation unit.) Review of the Progress Notes dated ,[DATE] revealed no documented assessment or documented contact with the physician or nurse practitioner for infectious disease follow up. Resident #126: Review of the Face Sheet revealed Resident #126 was a [AGE] year-old female admitted to the facility on [DATE] and diagnosed with [REDACTED]. Review of Resident #126's Weights and Vitals Summary revealed that on [DATE] at 1:59 P.M. Resident #126's temperature was 99.7 F Tympanic (Heart rate, respirations, oxygen level, and blood pressure were not assessed.) There was no Progress Note written to indicate that the Physician and the Health Department were notified of the elevated temperature or that Resident #126 was placed in isolation. Review of Resident #126's Weights and Vitals Summary revealed that on [DATE] at 08:25 A.M. Resident #126's temperature was 99.7 F Tympanic (Heart rate, respirations, oxygen level, and blood pressure were not assessed.) There was no Progress Note written to indicate that the Physician and the Health Department were notified of the elevated temperature or that Resident #126 was placed in isolation. Review of Resident #126's Weights and Vitals Summary revealed that on [DATE] at 1:59 P.M. Resident #126's temperature was 99.6 F Tympanic (Heart rate, respirations, oxygen level, and blood pressure were not assessed.) There was no Progress Note written to indicate that the Physician and the Health Department were notified of the elevated temperature or that Resident #126 was placed in isolation. Review of Resident #126's Weights and Vitals Summary revealed that on [DATE] at 1:59 P.M. Resident #126's temperature was 99.1 F Tympanic, Oxygen level 90% Room air (Heart rate, respirations, and blood pressure were not assessed.) Review of the Line Listing dated [DATE] revealed that Resident #126 was not placed on the line listing and the health department was not notified of elevated temperature. During an observation on [DATE] at 9:15 A.M., Resident #126 was not in an isolation room or on the Covid-19 designated unit. Review of Resident #126's Progress Note dated [DATE] at 06:21 A.M. revealed, called HCP to notify of HCP of o2 sat of 84%-87%. Order given for o2 for ,[DATE]L to maintain o2 sat of 90% or greater. (name omitted) applied nasal cannula at 3L of 02, bringing 02 sat to 92% at 3 minute increment, 96% after 10 minutes and was able to maintain 96% at 3L. Diminished lung sounds in both fields fields. (sic) Placed in droplet precautions. HCP to examine today resident remains stable at 96% o2 (Indicating Resident #126 had not been in isolation or on the Covid-19 designated unit prior to this progress note). Review of the Progress Notes (Nurses notes) dated ,[DATE] revealed no documented assessment or documented contact with the physician or nurse practitioner for infectious disease follow up. Resident #140: Review of the Face Sheet revealed Resident #140 was a [AGE] year-old female admitted to the facility on [DATE] and diagnosed with [REDACTED].#140 had a BIMS score of 10 out of 15 which indicated she had moderately impaired cognition. Review of Resident #140's Weights and Vitals Summary revealed that on [DATE] at 2:07 P.M. Resident #140's temperature was 99.6 F Oral. (Heart rate, respirations, oxygen level, and blood pressure were not assessed.) There was no Progress Note written to indicate that the Physician and the Health Department were notified of the elevated temperature or that Resident #140 was placed in isolation. Review of Resident #140's Weights and Vitals Summary revealed that on [DATE] at 09:26 A.M. Resident #140's blood pressure was 85 / 56 mmHg. Resident #140's blood pressure was not reassessed until [DATE] at 5:45 P.M. and the physician was not notified of an abnormally low blood pressure. Additionally, Resident #140's heart rate, respirations, or oxygen saturation were not assessed at the time of the abnormally low blood pressure. Review of the Line Listing dated [DATE] revealed that Resident #140 was not placed on the line listing and the health department was not notified of elevated temperature. During an observation on [DATE] at 9:15 A.M. Resident #140 was not in an isolation room or on the Covid-19 designated unit. Review of Resident #140's Progress Note dated [DATE] at 12:07 A.M. revealed, (name omitted) called HCP to notify of HCP of o2 sat of 84%-87%. Order given for o2 for ,[DATE]L to maintain o2 sat of 90% or greater. (name omitted) applied nasal cannula at 4L of 02, bringing 02 sat to 91 at 3 minute increment, 96% after 10 minutes and was able to maintain. Diminished crackle in right lower lobe and normal breath sounds in left fields. Placed in droplet precautions. HCP to examine today resident remains stable at 96% o2. (Indicating Resident #140 had not been in isolation or on the Covid-19 designated unit prior to this progress note). Review of the Progress Notes (Nurses notes) dated ,[DATE] revealed no documented assessment or documented contact with the physician or nurse practitioner for infectious disease follow up. Resident #141: Review of the Face Sheet revealed Resident #141 was a [AGE] year-old male admitted to the facility on [DATE] and diagnosed with [REDACTED]. Review of the MDS dated [DATE] revealed Resident #141 had a BIMS score of 0 out of 15 which indicated he had severely impaired cognition. Review of Resident #141's Weights and Vitals Summary revealed that on [DATE] at 9:28 P.M. Resident #141's temperature was 99.3 F Oral (Heart rate, respirations, oxygen level, and blood pressure were not assessed.) There was no Progress Note written to indicate that the Physician and the Health Department were notified of the elevated temperature or that Resident #141 was placed in isolation. Review of Resident #141's Weights and Vitals Summary revealed that on [DATE] 2:28 P.M. Resident #141's temperature was 99.3 F Axilla (Heart rate, respirations, oxygen level, and blood pressure were not assessed.) There was no Progress Note written to indicate that the Physician and the Health Department were notified of the elevated temperature or that Resident #141 was placed in isolation. Review of Resident #141's Weights and Vitals Summary revealed that from [DATE] to [DATE] Resident #141's heart rate was in the 60's for beats per minute (bpm). On [DATE] Resident #141's heart rate was to 97 bpm, [DATE] 95 bpm, [DATE] 95 bpm, [DATE] 95 bpm, [DATE] 93 bpm, [DATE] 92 bpm, [DATE] 92 bpm, and on [DATE] 111 bpm (Indicating Resident #141 had a change in their baseline for heart rate). There was no progress note indicating the physician was notified of the change in Resident #141's baseline heart rate until [DATE]. During an interview on [DATE] at 3:22 P.M. this surveyor notified NHA A of the concerns observed with Resident #141's vital signs and his exposure to Covid-19 from his roommate. NHA A reported she would follow up. During an interview on [DATE] at 2:50 P.M., this surveyor notified NHA A that Resident #141 was still not on the line listing with continued irregularities with his vital signs. Review of the Line Listing dated [DATE] revealed that Resident #141 was not placed on the line listing and the health department was not notified of elevated temperature. Review of the Progress Notes (Nurses notes) dated ,[DATE] revealed no documented assessment or documented contact with the physician or nurse practitioner for infectious disease follow up. Review of Resident #141's Progress Note dated [DATE] at 03:10 A.M. revealed, General medicine on call physician informed of residents change in condition (labored resp, heart rate 114,and large amount of phelgm (sic) suction from mouth) Orders received for ER (emergency room) to eval (evaluate) and treat. Emergency contact called and informed of (omitted) change in condition and orders for transfer to ER. Report given to ER Nurse. (Emergency Medical Service) arrived and resident left building per stretcher with assistance x2 at 0250 am. During an interview on [DATE] at 1:25 P.M. with Health Department Epidemiologist (HDE) OO and NHA A. HDE OO reported that it would be beneficial to test a resident with symptoms if they did not reside on the Covid-19 designated unit to ensure Covid-19 had not spread to a clean unit. During an interview on [DATE] at 1:43 P.M., NHA A reported that Corporate Nurse (CN) NN is responsible for monitoring symptoms and/or vital signs in the Electronic Health Record to ensure no other residents residing in the facility are displaying symptoms and is responsible for following up with abnormal results. CN NN was to be reviewing the documentation at an offsite, out of state location. During an interview on [DATE] at 12:43 P.M., Licensed Practical Nurse (LPN) Q reported that staff assess the temperatures and oxygen levels of all residents residing in the facility and the beginning and the end of their shift and monitor for signs and symptoms of a respiratory infection. LPN Q reported that if a resident has a temperature of greater than 100 orally, they are a person of interest. LPN Q reported that if a resident has a cough or a change in condition, they are considered a person of interest. During an interview on [DATE] at 2:17 P.M., LPN Q reported that if a Resident has an axillary temperature of 99 further monitoring would be required to rule them out as a person of interest. LPN Q reported that all vital signs and assessments are documented into the Electronic Health Record in order for CN NN to review the vital signs and assessments from an offsite location. During an interview on [DATE] at 10:00 A.M., Certified Nursing Assistant (CNA) F reported she was working a split unit (Covid-19 Unit and a Clean Unit.) During an interview on [DATE] at 3:02 P.M., LPN Q reported that facility staff members walk in and out of the Covid Unit when they are working a split unit. LPN Q reported that proper PPE (Personal Protective Equipment) should be donned when entering the Covid Unit and doffed before exiting the Covid Unit. During an observation on [DATE] at 2:27 P.M., CNA RR entered the Covid Unit without donning a gown or gloves, walked down the entire hall of the Covid Unit,

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 13) and exited the Covid Unit to the main lobby area. During an observation on [DATE] at 12:36 PM, CNA Z was noted to be in the covid unit and was not wearing a gown or gloves to deliver cups of water to resident rooms. CNA Z was observed to have exited a resident room in the covid unit, did not sanitize hands and