| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235661 | A. BUILDING _____ B. WING _____ | 04/10/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| STONEGATE HEALTH CAMPUS | 2525 DEMILLE ROAD LAPEER, MI 48446 |

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 0656<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview and record review, the facility failed to develop and implement comprehensive, resident-centered care plans for four residents (Resident #2, Resident #5, Resident #19 and Resident #20) of twenty seven residents reviewed for care planning, resulting in the potential for unmet care needs and decline in overall health and wellbeing. Findings include: Resident #2: A review, of Resident #2 medical record, revealed an admission into the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the Minimum Data Set assessment revealed severe cognitive impairment and the resident needed extensive assistance with transfers, dressing and bathing. A review of Resident #2's medical record revealed the Resident had an elevated temperatures documented on 3/12/20 and 3/12/20 with a document titled, Abnormal Temperature Event, that revealed a description of the event of a temperature of 100.4 with symptoms documented that included, body aches, cough, fatigue, achiness, pale in color, skin warm and clammy, feeling short of breath and lungs sounds of rhonchi and wheezes. A review of Resident #2's medical record included the following progress notes: -Dated 3/12/20, physician progress notes [REDACTED]. (Online physician service) notified and ordered Rapid flu, CBC, BMP, Respiratory treatments, [MEDICATION NAME] and CXR. Awaiting the results. Resident presents with a temp of 99.4 this morning . -Dated 3/12/20 at 11:03 AM, Nursing Progress Note: XR (x-ray) tech here to do CXR (chest x-ray) at this time. Resident continues with low grade fever of 99.6. Resident remains on 2L (liters) O2 (oxygen) NC (nasal cannula) . Resident continues to pull NC off of face at times and staff continue to replace NC. Resident O2 saturation 89% RA (room air) and 92% with 2L O2 applied. Family notified of resident condition multiple times throughout shift. Resident denies any pain at this time. -Dated 3/13/20 6:03 PM, Nursing Progress Note: Resident alert and oriented to person and situation. Resident received [MEDICATION NAME] syrup for cough. Nebulizers given as ordered. Temps were normal earlier but is 100.1 . -Dated 3/14/20 3:16 PM, Nursing Progress Note: Resident has cough congestion and c/o not feeling well. Had temp last night but has been afebrile today. Lungs have wheezes throughout and some ronchi in left lower lobe. Has nonproductive cough and is SOB. Is on O2 at 2L and O2 is 95%. Ate a few bites of breakfast and lunch and is taking fluids well. Has had 240 mls this shift. States she feels terrible. Had blood work done yesterday and chest x-ray. Blood work was unremarkable and x-ray did not address pneumonia. Spoke with (online physician services) and they ordered 2 view x-ray and cbc with diff stat. Stat blood work done and awaiting x-ray. Will continue to monitor. -Dated 3/14/20 at 3:45 PM, Nursing Progress Note: Flu test done yesterday and was negative per (Assistant Director of Nursing/Infection Control Nurse). -Dated 3/20/20 at 8:36 AM, Nursing Progress Note: Resident continues to have productive cough/congestion. Afebrile at this time . -Dated 3/29/20 at 2:41 PM, Nursing Progress Note: Resident continues to be in isolation d/t (due to) cough and congestion. Breathing tx's (treatments) given as needed. Vitals WNL (within normal limits) . -Dated 3/30/20 10:40 AM, Nursing Progress Note: Continues on droplet isolation at this time for moist cong (congested) cough. Afebrile. Noted SOB (shortness of breath) following coughing episode. No secretions expelled with cough. Encouraged deep breathing. Continues with O2. -Dated 3/30/20 at 1:42 PM, physician progress notes [REDACTED]. She feels her cough has improved and states she is feeling better. Denies further concern at this time. -Dated 3/31/20 at 12:17 PM, Nursing Progress Note: Resident sitting upright in w/c (wheelchair), moist productive cough. Small amt clear thick secretions expelled with cough. BLS rhonchi throughout. Visibly SOB. PRN (as needed) neb tx (breathing treatment) given. Rhonchi, cough and SOB without improvement following neb tx. Deep breathing exercises completed with resident. Afebrile. O2 via NC to maintain oxygen saturation. Sharon, NP aware of above notation and ordered 2 view CXR STAT . -Dated 4/2/20 at 4:30 PM, Nursing Progress Note: Notified NP (nurse practitioner) of chest x-ray result take on 3/31/2020, no new orders at this time. -Dated 4/2/20 at 6:00 PM, Nursing Progress Note, author Director of Nursing: . Resident denies having cough, denies shortness of breath or difficulty breathing. Resident lively and no s/s (signs or symptoms) of respiratory distress. Lungs CTA (clear to auscultation) all through at this time. No wheezing or crackles . Interviewed staff, states, did not hear resident coughing since beginning of shift today until at this time. CXR result on 3/31/20, Impression: No acute cardiopulmonary pathology seen . A review, of Resident #2's care plan, revealed a problem start date on 4/1/20, category: Safety, (Resident #2) is on droplet precautions, with a goal of Resident will maintain droplet precautions with no adverse reactions, and an approach of Follow droplet precautions per policy and guidelines. The care plan lacked a respiratory care plan for directive during the resident's respiratory illness. On 4/3/20 at 12:14 PM, an interview with the Assistant Director of Nursing/Infection Control Nurse (ADON) A was conducted regarding Resident #2's respiratory care plan. The ADON was queried regarding when care plans were to be updated on a Resident's respiratory illness. The ADON reported that the care plans were to be updated the same day or the next working day. A review of Resident #2's care plan was conducted with the ADON and revealed the care plan revealed a care plan with a category of safety and that the Resident was on droplet precautions with the problem start date on 4/1/20. The ADON reported the MDS Nurse usually updates the care plans. Resident #5: A review, of Resident #5's medical record, revealed an admission into the facility on [DATE]. The Resident had been admitted with [DIAGNOSES REDACTED]. Further review of the medical record revealed, on 2/15/20, the Resident had a cough and upper respiratory congestion, a chest x-ray revealed right pneumonia. Hospice services was started on 2/20/20 and the Resident passed away on 2/25/20. A review, of Resident #5's care plan did not reveal a respiratory care plan for pneumonia or for coordination of care with Hospice services. Resident #19: A review, of Resident #19's medical record, revealed an admission into the facility on [DATE] and discharged home on[DATE] with Hospice services. The Resident had been admitted into the facility with [DIAGNOSES REDACTED]. A review, of Resident #19's documented temperatures, revealed a temperature on 3/17/20 at 4:00 PM of 100.4 degrees Fahrenheit. A review, of Resident #19's medical record of Progress Notes, revealed the following: -Dated 3/17/20 at 8:07 PM, Nursing Progress Note, Resident had an unwitnessed fall self transferring from the bathroom .After checking vitals resident was found to have a fever. Lungs sounds auscultated, crackles heard . -Dated 3/20/20 at 11:45 AM, physician progress notes [REDACTED]. -Dated 3/23/20 at 2:18 PM, physician progress notes [REDACTED]. A review, of Resident #19's orders, revealed an order, dated 3/19/20, for isolation droplet precautions and for Resident to stay in room entire shift with no roommate. All therapy, meals, activities and services were provided in the room. A review, of Resident #19's care plan, revealed a lack of a care plan with the directive for the droplet isolation precautions and for the Resident to stay in room entire shift with no roommate, therapy, meals, activities and services provided in the Resident's room. Resident #20: A review, of Resident #20's medical record revealed an admission into the facility on [DATE] with [DIAGNOSES REDACTED]. Further review, of Resident #20's medical record, revealed the following: -Dated 3/17/20, Temperature of 100.8 degrees Fahrenheit. -Dated 3/17/20 at 7:36 PM, Nursing Progress note, Resident having increased congestion this shift. Seen by NP (Nurse Practitioner) and a new order for [MEDICATION NAME] breathing treatments given TID (three times a day) x (times) 7 days. Resident's vitals taken in the afternoon, resident had a low grad fever of 100.8. (Online physician services) contacted. A 2 view |

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235661 | A. BUILDING _____ B. WING _____ | 04/10/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| STONEGATE HEALTH CAMPUS | 2525 DEMILLE ROAD LAPEER, MI 48446 |

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 0656<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | (continued... from page 1)<br>chest x ray ordered, influenza swab ordered, and a respiratory panel. Influenza swab was negative. Respiratory panel expected to take at least a week for results . Rhonchi heard upon auscultation. Resident has increased congestion and a new order for [MEDICATION NAME] was given . A review, of Resident #20's orders revealed an order, dated 3/19/20, for isolation droplet precautions and for Resident to stay in room entire shift with no roommate. All therapy, meals, activities and services were provided in the room. A review, of Resident #20's care plan revealed a lack of directive for respiratory illness, isolation droplet precautions and for Resident to stay in room entire shift with no roommate, therapy, meals, activities and services to be provided in the room. A review, of facility policy entitled, Comprehensive Care Plan Guideline, revised date 5/22/2018, . b. Care plan interventions should be reflective of risk area (s) or disease processes that impact the individual resident. c. Should new identified areas of concern arise during the resident's stay, they should be addressed on the care plan . |
| F 0684<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Provide appropriate treatment and care according to orders, resident's preferences and goals.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview and record review, the facility failed to properly assess/monitor respiratory condition after a change in respiratory status was documented of signs and symptoms that included elevated temperature, cough and congestion, and obtain STAT (immediate) chest x-ray results timely for one resident (Resident #2) of twenty-seven residents reviewed for a change in respiratory status, resulting in the potential of complications related to respiratory illness to go unrecognized and untreated and the potential of a spread of infection to residents and staff. Findings include: Resident #2: A review, of Resident #2 medical record, revealed an admission into the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the Minimum Data Set assessment revealed severe cognitive impairment and the resident needed extensive assistance with transfers, dressing and bathing. A review of Resident #2's medical record included the following progress notes: -Dated 3/12/20, physician progress notes [REDACTED]. (Online physician service) notified and ordered Rapid flu, CBC, BMP, Respiratory treatments, [MEDICATION NAME] and CXR. Awaiting the results. Resident presents with a temp of 99.4 this morning . -Dated 3/12/20 at 11:03 AM, Nursing Progress Note: XR (x-ray) tech here to do CXR (chest x-ray) at this time. Resident continues with low grade fever of 99.6. Resident remains on 2L (liters) O2 (oxygen) NC (nasal cannula) . Resident continues to pull NC off of face at times and staff continue to replace NC. Resident O2 saturation 89% RA (room air) and 92% with 2L O2 applied. Family notified of resident condition multiple times throughout shift. Resident denies any pain at this time. -Dated 3/13/20 6:03 PM, Nursing Progress Note: Resident alert and oriented to person and situation. Resident received [MEDICATION NAME] syrup for cough. Nebulizers given as ordered. Temps were normal earlier but is 100.1 . -Dated 3/14/20 3:16 PM, Nursing Progress Note: Resident has cough congestion and c/o not feeling well. Had temp last night but has been afebrile today. Lungs have wheezes throughout and some ronchi in left lower lobe. Has nonproductive cough and is SOB. Is on O2 at 2L and O2 is 95%. Ate a few bites of breakfast and lunch and is taking fluids well. Has had 240 mls this shift. States she feels terrible. Had blood work done yesterday and chest x-ray. Blood work was unremarkable and x-ray did not address pneumonia. Spoke with (online physician services) and they ordered 2 view x-ray and cbc with diff stat. Stat blood work done and awaiting x-ray. Will continue to monitor. -Dated 3/14/20 at 3:45 PM, Nursing Progress Note: Flu test done yesterday and was negative per (Assistant Director of Nursing/Infection Control Nurse). -Dated 3/20/20 at 8:36 AM, Nursing Progress Note: Resident continues to have productive cough/congestion. Afebrile at this time . -Dated 3/29/20 at 2:41 PM, Nursing Progress Note: Resident continues to be in isolation d/t (due to) cough and congestion. Breathing tx's (treatments) given as needed. Vitals WNL (within normal limits) . -Dated 3/30/20 10:40 AM, Nursing Progress Note: Continues on droplet isolation at this time for moist cong (congested) cough. Afebrile. Noted SOB (shortness of breath) following coughing episode. No secretions expelled with cough. Encouraged deep breathing. Continues with O2. -Dated 3/30/20 at 1:42 PM, physician progress notes [REDACTED]. She feels her cough has improved and states she is feeling better. Denies further concern at this time. -Dated 3/31/20 at 12:17 PM, Nursing Progress Note: Resident sitting upright in w/c (wheelchair), moist productive cough. Small amt clear thick secretions expelled with cough. BLS rhonchi throughout. Visibly SOB. PRN (as needed) neb tx (breathing treatment) given. Rhonchi, cough and SOB without improvement following neb tx. Deep breathing exercises completed with resident. Afebrile. O2 via NC to maintain oxygen saturation. Sharon, NP aware of above notation and ordered 2 view CXR STAT . -Dated 4/2/20 at 4:30 PM, Nursing Progress Note: Notified NP (nurse practitioner) of chest x-ray result take on 3/31/2020, no new orders at this time. -Dated 4/2/20 at 6:00 PM, Nursing Progress Note, author Director of Nursing: . Resident denies having cough, denies shortness of breath or difficulty breathing. Resident lively and no s/s (signs or symptoms) of respiratory distress. Lungs CTA (clear to auscultation) all through at this time. No wheezing or crackles . Interviewed staff, states, did not hear resident coughing since beginning of shift today until at this time. CXR result on 3/31/20, Impression: No acute cardiopulmonary pathology seen . A review, of the document titled Potential Respiratory Exposure Observation, with a completed date on 3/26/20, revealed respiratory observation documented as labored/accessory muscles used, shortness of breath with exertion, lung sounds as crackles/rales, rhonchi and wheezes, Character of respirations as shortness of breath with activity and shallow, cough present with a dry cough. A review, of the document titled, Abnormal Temperature Event, dated as completed on 3/12/20 at 7:41 AM, revealed a description of the event of a temperature of 100.4 with symptoms documented that included, body aches, cough, fatigue, achiness, pale in color, skin warm and clammy, feeling short of breath and lungs sounds of rhonchi and wheezes. A review, of Resident #2's Medication Administration History (MAH) for 3/12/20 to 4/3/20, revealed an order for [REDACTED]. The assessment was documented on three of the treatments given from 3/12/20 to 3/21/20, and not documented for 34 treatments given. Another order for [MEDICATION NAME]-[MEDICATION NAME] nebulization for every 6 hours PRN with a start date on 3/21/20 with an open ended date, revealed a treatment given on 3/23/20 and 3/31/20 with the assessment documented. A review of Resident #2's temperature documentation, included the following: -Date 3/12/20 at 2:21 AM, 99.6 degrees Fahrenheit. -Date 3/12/20 at 5:28 am, 100.4 degrees Fahrenheit. -Date 3/12/20 at 10:34 am, 99.4 degrees Fahrenheit. -Date 3/12/20 at 3:56 pm, 100 degrees Fahrenheit. -Date 3/12/20 at 9:09 pm, 99.6 degrees Fahrenheit. -Date 3/13/20 at 9:21 pm, 100.1 degrees Fahrenheit. -Date 3/13/20 at 11:18 pm, 100.5 degrees Fahrenheit. On 4/2/20 at 4:12 pm, an interview was conducted with Nurse O regarding Resident #2's respiratory assessments and STAT chest x-ray that was ordered on [DATE]. When queried what the STAT chest x-ray results were, the Nurse was unsure of the chest x-ray results and upon review of the Resident's medical record was unable to find the results. The Nurse reviewed the x-ray book and indicated a STAT chest x-ray had been completed by the x-ray service. The Nurse indicated she would call the x-ray service and get the results of the chest x-ray. Upon the return phone call to this surveyor, Nurse O reported the x-ray service faxed the results that indicated no acute cardiopulmonary pathology seen and reported she had contacted the Doctor of the results. The Nurse was queried regarding respiratory assessments on the Resident after the last documentation on 3/31/20. After review of the medical record, the nurse was unable to find documentation of the Resident's respiratory status. A review of the lack of consistent documented respiratory assessment was reviewed with the Nurse and was queried what would be included in a respiratory assessment with a resident with signs and symptoms of a respiratory infection. The Nurse reported an assessment would include the temperature, vital signs, SpO2 (oxygen saturation) and lung sounds. When queried regarding documentation, the Nurse reported the assessment would be documented in the progress notes. The Nurse indicated that if a resident was having signs and symptoms, a respiratory assessment would be done as soon as it starts and then every shift or if the resident gets worse. The Nurse was queried when a STAT x-ray results should be obtained and reported a STAT was in 4 hours. The Nurse reported the chest x-ray had been performed on 3/31/20 at 2:17 pm and indicated the results had just been faxed by the x-ray service when she had called to inquire about the results. On 4/2/20 at 5:10 PM, an interview was conducted with the Director of Nursing (DON) regarding Resident #2's lack of respiratory assessments when the Resident had signs and symptoms of elevated, fever, cough and congestion and the follow up of the STAT chest x-ray that had been ordered on [DATE] with the results obtained on 4/2/20. The DON was queried regarding the lack of consistent respiratory assessments when Resident #2 had a cough and elevated temperature on 3/12/20. The DON stated, They (Nurses) should be doing the lung sounds, and reviewed the Resident's medical record. A review of the medical record with the DON revealed the assessment on the Abnormal Temperature Event on 3/12/20 and the progress notes of Nursing staff of a lack of consistent respiratory assessment that included lung sounds. The DON reported the Nurses work a 12-hour shift and assessments should be done every shift and stated, I saw that. I did not see that they did it. A review was conducted with the DON of the STAT Chest X-ray ordered on [DATE] and the results were not available until Nurse O called for the results on 4/2/20. The DON was queried when STAT |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235661 | A. BUILDING _____ B. WING _____ | 04/10/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| STONEGATE HEALTH CAMPUS | 2525 DEMILLE ROAD LAPEER, MI 48446 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |
|---|---|
| F 0684<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | (continued... from page 2)<br>x-ray should be done and reported, two to four hours, and indicated the Nurse should call if the results were not obtained timely. The DON was queried regarding respiratory assessments with breathing treatments given and indicated she would get back with the surveyor regarding assessments with breathing treatments. On 4/3/20 at 12:14 PM, an interview was conducted, with the ADON/Infection Control Nurse A, regarding resident #2's onset of illness signs and symptoms. The ADON reported Resident #2 had an onset of symptoms on 3/12/20 that included elevated fever, cough, congestion and productive cough, was tested for the [MEDICAL CONDITION] on 3/13/20 and was negative. When queried when the isolation had been started, the ADON indicated 3/12/20 but with a review of the medical record revealed an order for [REDACTED]. When queried regarding facility policy the ADON indicated an order was to be obtained for transmission based precautions. The ADON was queried regarding care plans and indicated the care plans were to be updated the same day or the next working day when isolation precautions were started. A review of the care plan revealed isolation precautions were documented in the care plans on 4/1/20. The ADON was queried regarding the lack of respiratory assessments for Resident #2 and reported the Nurse was to document every shift for a resident with a respiratory illness and document the findings in the Nurses Note, Respiratory Observation or with the lung assessment on the breathing treatments. When queried regarding Resident #2's breathing treatment changed to as needed on 3/21/20 the ADON indicated the assessments were to be every shift or at least once a day. On 4/6/20 at 1:16 PM, an interview was conducted with the DON regarding the lack of assessments with breathing treatments given to Resident #2. The DON explained that a respiratory assessment was done with the PRN (as needed) breathing treatments but was not conducted for around the clock treatments and stated, I noticed no consistency of assessment with the breathing treatments. The DON indicated she had done an audit and education of the assessments with the nursing staff. The DON reported that if was a facility standard that the assessments are done for any respiratory illness that included cough, shortness of breath, congestion and fever. A review of the facility policy entitled, Respiratory/Inhalation Treatments, with a revised date on 5/11/2016, revealed, . 5. Prior to beginning, the treatment a lung and heart rate assessment should be completed. 6. Results of the assessment and the time spent with the resident should be documented . 9. Upon completion of the breathing treatment, reassess lung sounds, pulse, respirations and document assessment results and time spent with the resident on Respiratory/Inhalation/Breathing Treatment Assessment form . |
| F 0880<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Many | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview and record review, the facility was placed in Immediate Jeopardy due to the facility's systemic collapse of the Infection Prevention and Control program with failure to follow evidence-based practices for Infection Control, including analysis of surveillance data to identify trends and patterns and implement appropriate interventions, including Transmission Based Precautions and diagnostic testing to prevent the spread of respiratory infections. The failure to maintain infection control practices during a COVID-19 Infection Control Survey resulted in a likelihood for a serious adverse outcome for all residents, including infectious illness and death if appropriate Infection Prevention and Control Standards of Practice were not enacted. Immediate Jeopardy: During a tour of the facility on [DATE] at 10:25 AM, the Director of Nursing (DON) provided a list of 5 residents identified to be in Isolation Precautions (Transmission Based Precautions): Three Residents diagnosed with [REDACTED].#1, #3, (#4 hospitalized [DATE])), one Resident #2 with respiratory signs and symptoms including a cough and one Resident #25 diagnosed with [REDACTED]. While approaching the residents' rooms on the Isolation List, none of the residents had a sign on or near their room door identifying what type of precautions were in place and what type of Personal Protective Equipment (PPE) was to be worn to safely care for the residents to prevent the spread of infection to other residents, staff and visitors. The DON said the residents with Influenza needed Droplet Precautions, the resident with respiratory symptoms needed Droplet Precautions and the resident with [MEDICAL CONDITION] needed Contact Precautions. There was no visible PPE at the entrance to the resident's rooms. The DON said it was hanging behind the resident's door. When the DON was asked how staff would know what precautions to follow, she pointed to a small red magnet, approximately 3 inches by 3inches attached to the doorframe that said Stop see the nurse. There was no indication the resident was in Transmission Based Precautions. The Centers for Disease Control and Prevention- CDC- 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, Last update: [DATE], . Droplet Precautions are intended to prevent transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions . Healthcare personnel wear a mask (a respirator is not necessary) . Patients on Droplet Precautions who must be transported outside of the room should wear a mask . and . Contact Precautions are intended to prevent transmission of infectious agents, including epidemiologically important microorganisms, which are spread by direct or indirect contact with the patient or the patient's environment . Contact Precautions also apply where the presence of . other discharges from the body suggest an increased potential for extensive environmental contamination and risk of transmission . Healthcare personnel caring for patients on Contact Precautions wear a gown and gloves for all interactions that may involve contact with the patient or potentially contaminated areas in the patient's environment. Donning PPE upon entry and discarding before exiting the patient room is done to contain pathogens . A review of the Infection Surveillance Line Listings (The facility only provided Antibiotic Usage Reports for February 2020) for February and [DATE] revealed 19 residents of an approximate Resident Census of 73 residents (26.0 %) were positive for respiratory symptoms including: fever, cough, congestion, sore throat, shortness of breath, decreased oxygen saturation levels, increased confusion, and lethargy. None of the 8 residents (#'s 5, 8, 9, 10, 11, 12, 13, 14) identified with respiratory symptoms in February 2020, were placed on Transmission Based Precautions to prevent the spread of infection. In addition, there was inconsistency in initiating Transmission Based Precautions for those 11 (#'s 2, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24) residents with positive respiratory symptoms, identified in [DATE] (not identified to have Influenza B). The residents with positive respiratory symptoms were not tested for Influenza until [DATE] or Covid-19 (a highly infectious respiratory virus) until Resident #4 was tested in the hospital for Covid-19 on [DATE]. Four additional Residents tested positive for Influenza B from [DATE]-[DATE] (Residents #'s 1, 3, 6, 7). Residents, who exhibited respiratory symptoms and who tested Negative for the Influenza A and B virus, were not consistently place on Transmission Based Precautions. Beginning on [DATE], the facility began collecting data for the residents exhibiting respiratory symptoms of illness but did not analyze the data or present it to the QAPI Committee and the Medical Director. The facility did not notify the Local County Health Department of the 19 residents with signs and symptoms of respiratory illness, that were not positive for Influenza, until [DATE]. The Immediate Jeopardy began on [DATE]. The Immediate Jeopardy was identified on [DATE]. The Administrator was notified on [DATE] of the Immediate Jeopardy that began on [DATE]. The IJ Abatement (Removal) Plan was approved on [DATE] with a Removal Date of [DATE]. Findings Include: On [DATE] at 10:25 AM, during a tour of the facility and review of residents placed in Transmission Based Precautions (without signage designating the necessary precautions or visible PPE), with the Director of Nursing (DON) she was asked where the Infection Control (IC) Nurse was; The DON said (IC Nurse A) was not present at the facility. On [DATE] at 11:25 AM, IC Nurse A called from the facility and said she had just arrived, but she would be working as a Staff Nurse on the 3rd Shift (midnight shift) that night. The IC Nurse said she sometimes had to work as a Staff Nurse instead of in her role as Infection Control Nurse, because of a lack of available nurses in the facility. The IC Nurse was asked for Surveillance data for February and [DATE] and Infection Control Policies and Procedures for review. Arrangements were made for an interview with the DON and IC Nurse on [DATE], due to the IC Nurses work schedule. On [DATE] at 7:05 AM, the DON and IC Nurse were interviewed. The February and [DATE] Infection Surveillance data was reviewed with the IC Nurse. Upon review, there were 8 Residents (#'s 5, 8, 9, 10, 11, 12, 13, 14) with identified respiratory symptoms (on the February 2020 Antibiotic Usage Report) including fever, cough, congestion, sore throat, shortness of breath, decreased oxygen saturation levels, increased confusion, and lethargy in February 2020. The IC Nurse was asked if any diagnostic testing had been performed to aid in identifying a specific infectious organism and she said the facility had not done that. When asked if the facility placed the residents in Transmission Based Precautions to aid in preventing the spread of illness to other residents, the IC Nurse said the residents had not been placed in precautions. IC Nurse A was questioned if data was collected for residents with signs and symptoms of illness who did not receive an antibiotic and said, Not in February. The IC Nurse was asked if an analysis of the February 2020 data had been completed to determine if there were any trends and she said she had reviewed each resident with the physician at the time the illness was noted, but there was no overall analysis that identified multiple residents had similar symptoms or that there was a potential outbreak of illness. The IC Nurse said there was no documented summary data, for the February 2020 Antibiotic Usage Report, reported to the Infection Control Committee. The Association for Professionals in Infection Control and Epidemiology (APIC), [DATE] provided, Surveillance of healthcare-associated infections (HAI) is the cornerstone of an effective infection prevention program. By |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235661 | A. BUILDING _____ B. WING _____ | 04/10/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| STONEGATE HEALTH CAMPUS | 2525 DEMILLE ROAD LAPEER, MI 48446 |

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 0880<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Many | (continued... from page 3)<br>definition, surveillance is a comprehensive method of measuring outcomes and related processes of care, analyzing the data, and providing information to members of the healthcare team to assist improving those outcomes and processes . CDC, Long-Term Care (LTC) Respiratory Surveillance Line List, [DATE], 'The Respiratory Surveillance Line List provides a template for data collection and active monitoring of both residents and staff during a suspected respiratory illness cluster or outbreak . Using this tool will provide facilities with a line listing of all individuals monitored for or meeting the case definition for the outbreak illness . Each row represents an individual resident or staff member who may have been affected . The information . capture data on the case demographics, location in the facility, clinical signs/symptoms, diagnostic testing results and outcomes . ' Information gathered on the worksheet should be used to build a case definition, determine the duration of outbreak illness, support monitoring for and rapid identification of new cases and assist with implementation of infection control measures . During the interview and review of [DATE] Infection surveillance on [DATE] at 7:05 AM, with IC Nurse A and the DON, there were 11 residents (#'s 2, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24) on the line listing with respiratory symptoms similar to the 8 residents in February 2020: including fever, cough, congestion, sore throat, shortness of breath, decreased oxygen saturation levels, increased confusion, and lethargy in February 2020. IC Nurse A said not all of the residents had been placed in Transmission Based Precautions and none of the residents had been tested for Covid 19, until Resident #4 was transferred to the hospital [DATE] and tested [DATE]. IC Nurse A was questioned if an analysis of the February and [DATE] infection surveillance data had been completed to determine if there were any trends and she said she had reviewed each resident with the physician at the time the illness was noted, but there was no overall analysis that identified multiple residents had similar symptoms or that there was a potential outbreak of illness. The IC Nurse said there was no documented summary data, for the February or [DATE] infection line listing indicating 19 residents had similar symptoms of a respiratory illness. Per the CDC, [DATE], Transmission-Based Precautions are the second tier of basic infection control and are to be used in addition to Standard Precautions (Standard Precautions are used for all patient care. They're based on a risk assessment and make use of common sense practices and personal protective equipment use that protect . from infection and prevent the spread of infection from patient to patient.) for patients who may be infected or colonized with certain infectious agents for which additional precautions are needed to prevent infection transmission . Source: Guidelines for Isolation Precautions. On [DATE] at 7:15 AM, during the interview with the DON and IC Nurse A, the IC Nurse said on [DATE] the facility began testing several residents for Influenza. IC Nurse A said Five additional residents (#'s 1, 3, 4, 6, 7) tested positive for Influenza B from [DATE] to [DATE]. The IC Nurse was asked if the residents were placed in Transmission Based Precautions and she said they were placed in Droplet Precautions and received treatment with [MEDICATION NAME]. The IC Nurse was asked if the residents in the facility, including those with signs and symptoms of respiratory illness or Influenza received the FLU and Pneumonia vaccinations and said she would need to check on that. The IC Nurse was asked for the Infection Control Program Plan and Surveillance Plan. CDC, [DATE], Prevention Strategies for Seasonal Influenza in Healthcare Settings . more than 200,000 persons, on average, are hospitalized each year for influenza related complications. Healthcare-associated influenza infections can occur in any healthcare setting and are most common when influenza is also circulating in the community. Therefore, the influenza prevention measures outlined in this guidance should be implemented in all healthcare settings. Supplemental measures may need to be implemented during influenza season if outbreaks of healthcare-associated influenza occur within certain facilities, such as long-term care facilities and hospitals . The core prevention strategies include: administration of influenza vaccine . adherence to infection control precautions for all patient-care activities and aerosol-generating procedures . A record review of the electronic medical record and scanned documents for the 73 residents living in the building, indicated 9 residents (12%) did not have any documented vaccination information for Influenza and Pneumonia. For the remaining 64 residents, 24 had received the Influenza vaccination for the ,[DATE] Influenza Season. Nine residents had documentation that they had received the vaccination prior to admission, but there were no details of where and when to confirm that it actually occurred. There were also many discrepancies between the Preventive Health tab documentation of vaccinations and what was recorded on the Minimum Data Set (MDS) assessments. In addition, of the 5 residents who were infected and tested positive for Influenza B (Residents #'s 1, 3, 4, 6, 7), there was no confirmation in the medical record of when and where they were given an Influenza vaccination. Resident #3 tested positive for Influenza B on [DATE] and was not started on the Anti-[MEDICAL CONDITION]-[MEDICATION NAME] until 4 days later [DATE].<br>Resident #6 tested positive for Influenza B on [DATE] and died on [DATE]. Resident #4 tested positive for Influenza B on [DATE] and was transferred to the Hospital on [DATE]. Per CDC Guidance, Influenza, [DATE] . There are prescription medicines that fight against flu viruses in your body . [MEDICAL CONDITION] treatment works best when started soon after flu illness begins. When treatment is started within two days of becoming sick with flu symptoms, [MEDICAL CONDITION] drugs can lessen fever and flu symptoms . they may also reduce the risk of complications such as . respiratory complications requiring antibiotics and hospitalization in adults. For people at high risk of serious flu complications, early treatment with an [MEDICAL CONDITION] drug can mean having milder illness instead of more severe illness . During the record review for vaccinations, all residents living in the facility were assessed for Pneumococcal (Pneumonia) vaccinations Pneumococcal conjugate vaccine PCV13 and Pneumococcal [MEDICATION NAME] vaccine (PPSV23). Seventeen residents had previously received either one of the vaccinations. There was no documentation that any resident had received both Pneumococcal vaccinations nor was there mention of monitoring to aid in ensuring the residents were offered both vaccinations. Per the CDC, Pneumococcal Vaccination, [DATE], 'Vaccines help prevent pneumococcal disease, which is any type of illness caused by Streptococcus pneumoniae bacteria. There are two kinds of pneumococcal vaccines available in the United States: Pneumococcal conjugate vaccine or PCV13, Pneumococcal [MEDICATION NAME] vaccine or PPSV23 . CDC recommends routine administration of pneumococcal [MEDICATION NAME] vaccine (PPSV23) for all adults [AGE] years or older. In addition, CDC recommends PCV13 based on shared clinical decision- making for adults [AGE] years or older who do not have an immunocompromising condition . and have never received a dose of PCV13. Clinicians should consider discussing PCV13 vaccination with these patients to decide if vaccination might be appropriate .' A record review of the electronic medical record revealed the following for Residents identified with respiratory signs and symptoms of illness on the February 2020 Antibiotic Usage Report: Resident #8: The record review of the Face Sheet indicated Resident #8 was admitted to the facility on [DATE] with Diagnoses: [REDACTED]. The Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of ,[DATE] indicating moderate cognitive impairment and needed assistance with all care. The resident was treated for [REDACTED]. Resident #9: The record review of the Face sheet indicated Resident #9 was admitted to the facility on [DATE] with Diagnoses: [REDACTED]. A progress note dated [DATE] at 10:18 PM on admission revealed, Resident arrived at facility at 7 pm . (temperature) 98.4, sp02 93% on 2 liters (L) NC . (oxygen saturation normal ,[DATE]%). A progress note dated [DATE] at 4:21 AM by Nurse P provided, Resident currently wearing 5 liters NC (nasal cannula oxygen) to maintain 02 saturation in the 90's . The physician's History and Physical dated [DATE] at 2:49 PM by Physician E indicated Pneumonia- onset [DATE]. A progress note written by Nurse Q on [DATE] at 6:38 AM provided, . At 5:30 AM writer went to check on resident and noticed grayish skin tone. Writer checked sp02 81% on 5/L . The resident was sent to ER for respiratory distress. Continued review of the progress notes for Resident #9 revealed the resident was readmitted to the facility on [DATE]. A progress note dated [DATE] at 7:51 PM said the resident had several loose stools that day. A physician E progress note dated [DATE] at 1:33 PM revealed, . CT confirmed bilateral lower lobes infiltrate and pneumonia (diagnosed in the hospital) Treated with IV [MEDICATION NAME] and [MEDICATION NAME], IV steroids . The note said a nasal swab was positive [MEDICAL CONDITION] ([MEDICAL CONDITION]- a Multi-drug resistant organism), but there was no clarification if the resident was colonized [MEDICAL CONDITION] with no infection or if the pneumonia was caused from [MEDICAL CONDITION]. There was no sputum culture. A progress note for Resident #9 dated [DATE] at 12:17 PM, RR (respiratory rate) ,[DATE], pursed lip breathing, labored, using accessory muscles, diaphoretic (sweating), restless, (oxygen saturation) 96% on 4L per minute (oxygen) on left hand, right hand 47%. Resident unable to follow instructions to take deep breaths . resident transferred to ER . A progress note dated [DATE] at 2:37 PM, . Per (hospital nurse) resident admitted to ICU on ventilator with pneumonia which is worse since previous hospital stay. The Antibiotic Usage Report for February 2020 said the resident had low oxygen saturation an increased heart rate and shortness of breath and began on antibiotics [DATE]. The column titled Infection resolved said Dc'd (discharged ) Resident #10 A record review of the Face sheet indicated Resident #10 was admitted to the facility on [DATE] with Diagnoses: [REDACTED]. The most recent MDS assessment indicated the resident had full cognitive abilities and needed assistance with care. A note by Physician E dated [DATE] at 1:27 PM indicated the resident had symptoms of a cough, abnormal lung sounds and a fever. A progress note written by Nurse P dated [DATE] at 7:09AM provided, Resident called staff to room at 0445 am (complained of) sudden onset (shortness of |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235661 | A. BUILDING _____ B. WING _____ | 04/10/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| STONEGATE HEALTH CAMPUS | 2525 DEMILLE ROAD LAPEER, MI 48446 |

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 0880<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Many | (continued... from page 4)<br>breath). Vitals assessed and resident (had high blood pressure, increased heart rate, increased respiratory rate and a fever), vitals in chart. Wheezing noted in all fields posteriorly, and bilateral upper extremities had a noticeable tremor . The resident refused to go to the ER. The February 2020 Antibiotic Usage Report said the resident had positive bilateral infiltrates and shortness of breath 6 days after admitted d [DATE] with antibiotics from [DATE]-[DATE]. A column heading on the report was titled, Clinical signs of Infection present it was marked Yes and the column titled Infection resolved was blank. Resident #14: A record review of the Face sheet indicated Resident #10 was admitted to the facility on [DATE] with Diagnoses: [REDACTED]. The most recent MDS assessment revealed the resident had decreased cognitive abilities and needed assistance with care. A review of a hospital progress note dated [DATE] at 7:23 AM, indicated Resident #14 was admitted to the hospital on [DATE] after being discharged to home from a different facility on the same day. The resident was brought to ER because he developed shortness of breath. The note said, .On their arrival his oxygen was hypoxemic (a low level of oxygen in the blood). Patient was started on oxygen supplement . Patient has been diagnosed with [REDACTED]. A progress note dated [DATE] at 7:15 PM, Resident up in wheelchair for meals . Coughing was minimal . A review of the physician orders [REDACTED]. The Antibiotic Usage Report said the resident had shortness of breath, hypoxemia and [MEDICAL CONDITION]. A review of the physician orders [REDACTED].# 8, 9, 10 and 14 indicated there were no orders or a Care Plan for Transmission Based Precautions to aid in preventing the spread of infection, as each had similar respiratory symptoms of illness. The February 2020 Antibiotic Usage Report had columns titled Date of Culture and Is organism sensitive to antibiotic (each resident was receiving an antibiotic). The Date of Culture column included no information about antimicrobial cultures that would identify the causative infectious agent and whether the antibiotic treatment was appropriate, except for Resident #9'[MEDICAL CONDITION] nasal swab that was not definitive for respiratory infection. The column titled Is organism sensitive to antibiotic said N/A not applicable for each resident including Resident #9. A record review of the electronic medical record revealed the following for Residents identified with respiratory signs and symptoms of illness on the [DATE] Antibiotic Usage Report: Resident #16: A record review of the Face Sheet indicated Resident #16 was admitted to the facility on [DATE] with Diagnoses: [REDACTED]. The MDS assessment full cognitive abilities on admission. A review of the physician orders [REDACTED]. On [DATE] an order was written to Monitor resident for signs of infection: shortness of breath, shallow respirations, abnormal vitals or change in condition. Notify MD of fever over 100, [DATE] to [DATE]. An Influenza A & B test was ordered [DATE]. Sodium Chloride 0.9% solution: amount 500 ml, injection, Special Instructions: Start IV and infuse 0.9% NS (Normal saline solution) @ 100 ml/hour for 5 hours, Once-one time 3:30 PM. A record review of the progress notes revealed the following for Resident #16: [DATE] at 7:02 PM, . Resident has completed antibiotic therapy . Resident has not been short of breath. No coughing noted . A nurses note dated [DATE] at 3:01 PM . Low grade fever noted . New order to use incentive spirometer and monitor vitals every 4 x 24 hours. A nurse's note [DATE] at 6:00 PM, . Resident has had a low-grade fever this shift . increased respiratory rate, non-productive coughing noted . A nurses note [DATE] at 6:58 PM, . Nonproductive cough observed . A nurses Note [DATE] at 2:50 PM (1 day after the order was written) Influenza A & B test given with negative results. A nurses note dated [DATE] at 5:37 AM, Staff report multiple loose stool during the shift . A nurses note dated [DATE] at 1:48 PM, . Resident is having increased cough and confusion . Resident is alert and oriented x1 . A Care Conference note dated [DATE] . recent change in mental status from baseline. Presents with decreased attention span and concentration . A nurses note [DATE] at 3:46 PM, . currently watching TV in the sitting area . A Nutrition note dated [DATE], (Resident) with noted overall decline in status/increased confusion. Not eating the past couple of days, refusing meals . requires a lot of encouragement . A nurses note [DATE] at 9:26 PM, Resident showed considerable decline. Resident was unable to work with therapy . A nurses note [DATE] at 12:51 AM, Resident has been laying on the couch in front of the nursing area . A nurses note [DATE] at 1:47 PM, Resident went to dining room for restorative dining only staying for a short period . A nurses note [DATE] at 3:46 AM, . Resident has been confused, laying out on sofa with her belongings . A review of the physician orders [REDACTED]. There was no laboratory testing to determine what the resident's respiratory illness was. Resident #18: According to a review of the EMR on [DATE], Resident #18 was an [AGE] year-old female admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A progress note in the EMR reflected that on [DATE] Resident #18 developed confusion, bilateral wheezing in her lungs, bluish color of the lips, and an oxygen saturation of 91%. Resident #18 had also vomited. Resident #18 was sent to the emergency room of the local hospital where she was admitted to the intensive care unit (ICU). The hospital tested for Influenza, and reported that the test was positive for Influenza B and negative for Influenza A. A progress note dated [DATE] at 2:00 AM, stated that the writer had called the hospital and was told that Resident #18 had been admitted to the ICU because she aspirated and has Influenza A. Resident #18 was readmitted to the facility on [DATE] with orders for two more doses of [MEDICATION NAME], 48 hours apart, for upper respiratory. According to the hospital records in the EMR, the emergency room had suspected that Resident #18 has aspirated. The notes from the hospital indicated that Resident #18 had pneumonia. On [DATE] at 3:29 PM, it was documented in a progress note that Resident #18 continued to have a non-productive cough and congestion. Resident #18's oxygens saturation was recorded as 90% on 4 liters of oxygen per minute. A breathing treatment was administered by the nurse. The physician saw resident #18 on [DATE] and noted that she had reported muscle weakness but denied other respiratory symptoms. On [DATE] at 9:46 AM, a progress note provided, Resident was positive of Influenza B per hospital records . Resident admitted from hospital on droplet precautions that gave been discontinued with resident free of (signs and symptoms) for 24 hours . According to the Minimum Data Set Resident Assessment (MDS), dated [DATE], Resident #18 had received the Influenza vaccine outside of the facility for this year's Influenza season. No documentation was located in the EMR that identified when the vaccine was received or where the information was obtained. The MDS revealed that Resident #18's Pneumococcal Vaccination was up to date. The EMR did not provide documentation about which and when the two vaccines, or both, Prevnar 13 or Pneumococcal 23, was received by Resident #18. A review of the facility Antibiotic Usage Report for [DATE] indicated Resident #18 received antibiotic treatment from [DATE] to [DATE] for respiratory symptoms of low oxygen saturation, shortness of breath and chest pain. Per the report, the IC Nurse categorized the infection as CAI a Community Acquired Infection, when the symptoms including wheezing in bilateral lungs, low oxygen saturation 90% and increased confusion began prior to transferring the resident to the hospital on [DATE]. Resident #21: A record review indicated Resident #21 was admitted to the hospital on [DATE] with Diagnoses: [REDACTED]. The resident was discharged back to the hospital on [DATE] due to labored breathing, increased respirations, abnormal lung sounds bilaterally a temperature of 103.0, moaning and diaphoresis. The resident was readmitted on [DATE] with [DIAGNOSES REDACTED]. A record review of the progress notes for Resident #21 revealed the following: [DATE] at 12:22 PM, . Resident on 2 liters 02 NC, (oxygen saturation within normal limits). Resident had period of labored breathing at approximately 1130; resolved after scheduled breathing (treatment given) . [DATE] at 9:53 AM, Resident continues with fever of 99.5 . Rhonchi (abnormal lung sounds) noted to all lung fields, audible congestion noted . [DATE] at 12:05 AM, Chest single view results .No evidence of acute cardiopulmonary disease . [DATE] at 9:38 AM, Resident continues on contact/droplet precautions. (Bilateral upper lung) expiratory wheeze . Moist congested cough . dried thick pale green secretions removed from oral cavity . A review of the physician orders [REDACTED]. Influenza A & B swab ordered [DATE]. There was no order for Transmission Based Precautions. A review of Resident #21's Care Plans revealed a care plan dated [DATE], Resident has need for isolation related to active infectious disease related to fever. Influenza swabbed obtained. Placed on droplet isolation. There was no documentation of the results of the Influenza test and the Care Plan was not initiated until the resident's 2nd episode of respiratory infection. Per the Antibiotic Usage Report dated [DATE], Resident #21 received an antibiotic upon readmission from [DATE]-[DATE] for [MEDICAL CONDITION], fever and congestion. Resident #24: A review of the electronic medical record Face Sheet and MDS assessment indicated Resident #24 was admitted to the facility on [DATE] with Diagnoses: [REDACTED]. The MDS dated [DATE] revealed the resident had full cognitive abilities with a BIMS of ,[DATE] and needed assistance with care. A review of the progress notes revealed the resident had a potential respiratory exposure and was tested for Influenza on [DATE] that was negative. He fell on [DATE] and a chest x-ray ordered after the fall indicated the resident had slight bibasilar infiltrate (pneumonia). The resident started on antibiotics from [DATE]-[DATE]. A review of the Antibiotic Usage Report said the resident was placed on antibiotics on [DATE]-[DATE] for bibasilar infiltrates identified after a fall. A review of the physician orders [REDACTED]. A review of the resident's Care Plans indicated there was no Care Plan for Transmission Based Precautions. The eleven residents with signs and symptoms of respiratory illness noted on the [DATE] Antibiotic Usage Report, were inconsistently placed in Transmission Based Precautions to aid in the prevention of the illness. The residents with a productive cough did not have sputum cultures to attempt to i |