STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235290	A. BUILDING _____ B. WING _____	06/24/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MISSION POINT NSG & PHY REHAB CTR OF GREENVILLE	828 E WASHINGTON ST GREENVILLE, MI 48838

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 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake number MI 249. Based on observation, interview, and record review, the facility failed to consistently ensure nurse supervision for seven Residents (#1, #2, #3, #8, #4, #5, and #6), potentially affecting all residents residing on the COVID unit, resulting in residents not being assessed and missed ordered treatments by licensed staff. Findings include: The facility designated a unit for COVID residents by closing off an entire hallway within the building. Closed double fire doors secured the area and staff posted signage indicating it was a restricted area. After passing through the double doors, the first rooms across from each other staff used as a nursing station and the other room was a supply storage area. Past these rooms staff had placed an opaque plastic barrier leading to resident rooms and care areas. The plastic wall had a zippered opening staff used to enter and exit the quarantined area. The hallway space, vestibule between the double fire doors and plastic wall, staff used to don and doff (put on and take off) personal protective equipment (PPE). Staff observed on [DATE] at approximately 6:35 AM, donning a N-95 respirator, face shield, gown, foot covers, and gloves and performed hand hygiene appropriately, prior to entering the COVID unit through the zippered door. This surveyor was not able to visualize residents until entering the COVID unit and walking down the hallway. Resident #1 According to the Minimum Data Set (MDS) Assessment, dated [DATE], Resident #1 admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. This same assessment indicated Resident #1 was moderately cognitively impaired and required extensive assistance of one person for moving in bed, dressing, eating, and hygiene needs including bathing and using the toilet. Resident #1's Admission Record, dated [DATE], indicated Resident #1 was diagnosed with [REDACTED]. At the time of the survey, Resident #1 no longer resided at the facility. Review of Resident #1's [DATE] Medication Administration Record revealed on [DATE] at midnight and 4:00 AM, Resident #1 did not receive scheduled doses of [MEDICATION NAME] (a medication for anxiety ordered every four hours around the clock). The checkboxes for those administration times were signed out by the Director of Nursing (DON) and coded as a 5 guiding the reader to the progress notes. Review of Resident #1's progress notes revealed a late entry on [DATE] entered at 7:07 and 7:09 AM, authored by the DON, indicating [MEDICATION NAME] was held at midnight and 4:00 AM due to patient resting. No s/sx (signs or symptoms) of pain or anxiety noted. Doc (doctor) aware. Medication held. However, during an interview on [DATE] at 3:09 PM, the DON stated she was not in the facility during the ordered medication administration times and that she did not assess the resident for the medication need. There were no progress notes indicating Resident #1 had any nursing assessment between 9:01 PM on [DATE] until the DON entered the progress notes at 7:05 AM on [DATE] thus there is no way to identify how the resident tolerated the night without the ordered antianxiety medications. During that same interview on [DATE], the DON stated she had entered Resident #1's progress notes on [DATE] at 7:05 and 7:07 AM from home and had not completed a physical assessment of the resident at those times either. Review of Resident #1's [DATE] Medication and Treatment Administration Record revealed the following: -Pain assessment signature box for NOC on [DATE] contained LPN A's initials for doing check. However, LPN A stated she does not go on the COVID unit to provide care (see written statement dated [DATE]). -Monitoring for side effects of medications (e.g. blurred vision, altered mental status, irregular heartbeat, etc.) signature box for NOC on [DATE] contained LPN A's initials for doing check. However, LPN A stated she does not go on the COVID unit to provide care (see LPN A's written statement dated [DATE]). Review of Resident #1's [DATE] Medication and Treatment Administration Record revealed the following: -Pain assessment signature block for NOC on [DATE] was blank. -Monitoring for side effects of medications (e.g. flushing, blurred vision, dry mouth, altered mental statues, irregular heartbeat, etc.) signature block for NOC on [DATE] was blank. -Med Pass 2.0 (a nutritional supplement) signature block for 2100 on [DATE] was blank. -Palm protector to remain in place except for bathing/hygiene signature block for NOC on [DATE] was blank. Initials in the signature box indicated staff provided the treatment to the resident. Therefore, lack of initials indicated staff did not provide the treatment to the resident. Resident #3 According to the MDS Assessment, dated [DATE], Resident #3 admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. This same assessment indicated Resident #3 was cognitively intact and required extensive assistance of two staff members for moving in bed, transferring, dressing, and hygiene needs including using the bathroom. During an interview and observation on [DATE] at 5:35 AM, Resident #3 was awake and lying in bed. When asked about his feeding tube (G tube), Resident #3 stated that it was infected and that he was on an antibiotic. Resident #3 pulled the covers away from his abdomen and revealed a G tube covered with an undated dry dressing. According to Resident #3's hospital records history and physical, dated [DATE], Resident #3 had a gastric tube (G tube) (feeding tube inserted directly into the stomach) that was surgically placed on [DATE] (19 days prior to Resident #3's admission to the facility). Review of Resident #3's progress notes beginning [DATE] to [DATE] revealed two assessments of this surgical site. A progress note, dated [DATE], revealed Resident #3 complained about his G tube, and the nurse reported no changes or issues noted. The other assessment, dated [DATE], indicated the site was clean and changed. During an interview on [DATE] at 11:48 AM, when this Surveyor asked the Director of Nursing (DON) about documentation on a new surgical site, specifically Resident #3's gastric tube insertion site, the DON stated staff chart by exception (i.e. the nurses only document negative assessment findings). It should be noted that daily progress notes had normal findings recorded for other areas of assessment i.e. lung sounds, bowels sounds, etc. The DON referred to a Weekly Skin Sweep, dated [DATE], and stated that is where she would expect to find concerns related to the G tube. Review of Weekly Skin Sweep, dated [DATE], revealed staff checked the box indicating None-Skin Intact for Resident #3. This Weekly Skin Sweep document included other options to select, including Surgical wound site, which was not checked. A Weekly Skin Sweep, dated [DATE], staff checked the box for None-Skin intact and did not indicate Resident #3 had a Surgical wound site. A physician note, dated [DATE], revealed Resident #3 had an infection around the G tube site. The doctor ordered an antibiotic and Resident #3 started it that same day. During an interview on [DATE] at 11:48 AM, Clinical Care Coordinator (CCC) P stated that Resident #3 missed an appointment on [DATE] to have the fasteners removed from the G tube. During a follow up interview on [DATE] at 12:43 PM, CCC P reported the missed appointment contributed to the infection that occurred and that the G tube site looked horrible and did not look like staff had cleaned it. During a telephone interview on [DATE] at 2:20 PM, CNA J stated on [DATE] she was working the midnight shift on the COVID Hall for the first time. CNA J states that she was the only staff member assigned and working the COVID Unit and there was no nurse assigned to that hall. CNA J stated that she told LPN A that Resident #3 complained of pain and asked for Tylenol. CNA J stated that LPN A asked CNA J to bring the medication cart to the plastic barrier wall (opaque sheet of plastic), get into the medication cart, retrieve a medication for Resident #3 and Resident #5. CNA J stated LPN A had her hold up the cards and told her which tablet to give to each resident. When asked if either of the medications were in a double locked drawer, CNA J stated, No, just one key opened the cart. CNA J stated she had two medication cups. She gave Resident #5 (who was closest to the door) his medication and

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

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Review of Resident #3's [DATE] Medication and Treatment Administration Record revealed the following: -[MEDICATION NAME] solution 650 mg (milligrams) signature block was blank for 0000 (midnight) on [DATE]. Review of Resident #3's [DATE] Medication and Treatment Administration Record revealed the following: -[MEDICATION NAME] (an antibiotic) Ointment signature block was blank for NOC (night) on [DATE]. -Infection Note: [MEDICAL CONDITION] around G tube (a feeding tube in the stomach) site signature block was black for NOC on [DATE]. -Monitor pain every shift signature block was blank for NOC on [DATE]. -Enteral feed order three times a day flush G tube with 80 ml water signature block was blank for 1800 on [DATE]. -Enteral feed order three time a day via G tube 1 hour after meals bolus 240 ml [MEDICATION NAME] (a nutritional supplement) 1.5 signature block was blank for 1800 on [DATE]. -Assess lung sounds and bowel sounds every shift signature block was blank on [DATE] and [DATE] for eve (evening). Initials in the signature box indicated staff provided the treatment to the resident. Therefore, lack of initials indicated staff did not provide the treatment to the resident. According to facility policy Pain Management, revised ,[DATE], staff assess resident pain, reassess for pain regularly for effectiveness and/or adverse consequences, and revise pain management as indicated. According to facility policy Medication Administration - General Guidelines, revised ,[DATE], medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medication do so only after they have been properly oriented to the facility's medication distribution system. The facility has sufficient staff and a medication distribution system to ensure safe administration of medications without unnecessary interruptions and medications are administered only by licensed nursing or medical personnel. According to the facility provided job description, Charge Nurse LPN, revised [DATE], Licensed Practical Nurses (LPN's) assess resident conditions to implement intervention and develop care plans. Accurately record resident observations in PCC (Point click Care, an electronic medical record) and follow through on care plans, make regular rounds of residents independently and with a physician: observe and evaluate resident symptoms, progress, and reactions to treatments and medications and implements interventions as necessary, provide preventative, supportive, maintenance, and rehabilitative care directed to the physiologic and psychosocial needs and well-being of residents, provide care to residents, monitor and assist CNA's with personal resident care duties, administer medication to residents according to the Public Health Code, Nursing Department Policies, and standards and procedures as prescribed by the physician, perform comprehensive and focused nursing assessments in conjunction with changes in condition and scheduled programs, and adheres to the Nurse Practice Act. According to the facility provided job description, Certified Nurse Aide, revised [DATE], CNA's provide quality nursing care to residents, including attending to the individual needs of the residents, including grooming, bathing, oral hygiene, feeding, incontinence care ., observes residents for changes in condition or behavior and promptly reports these changes to the Charge Nurse, and performs various tasks assigned by the charge nurse, including checking vital signs, weighing residents, applying creams/ointments and collecting specimens. The job description did not include assessing or administrating medications to a resident. Resident #8 According to the MDS Assessment, dated [DATE], Resident #8 admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. This same assessment indicated Resident #8 cognitively intact and required extensive assistance of two staff members for moving in bed, transferring, dressing, and other hygiene needs including using the bathroom. At the time of the survey, Resident #8 no longer resided at the facility. During an interview on [DATE] at 9:14 PM, Certified Nursing Assistant (CNA) K reported working with Resident #8 on [DATE] during the night shift. CNA K reported working with CNA O when Resident #8 had difficulty breathing. CNA K reported that she and CNA O laid Resident #8 down to assist with changing him and he coughed up a loogie. CNA's O and K sat Resident #8 upright and Resident #8 began to chocking and gagging on it. CNA K reported that Resident #8's oxygen was low, heart rate was elevated, and Resident #8 had increased anxiety. CNA K stated, Our nurse (RN N) came in for shift but never came on the (COVID) unit, I called to tell her what was going on and I was put on hold. CNA K reported giving the phone to CNA O and going to the utility room to obtain an oxygen concentrator; then CNA K placed oxygen on Resident #8 per nasal canula. During an interview on [DATE] at 10:10 AM, CNA O stated that often times she has worked the COVID unit with no nurse assigned and that there was no nurse for the COVID unit on [DATE] around 10:00 or 11:00 PM when Resident #8 had trouble breathing. CNA O reported she had called nurses about Resident #8's breathing and that those nurses reported they were passing medications, she then called respiratory therapy and told them Resident #8's respiratory rate was 62 (normal ,[DATE] breaths per minute) and they said it would be about 15 minutes before someone could get here. I told them he would be dead in 15 minutes. CNA O stated that the nurse had to come from the other side of the building and don PPE prior to assisting them with Resident #8 on the COVID unit that night ([DATE]). During an interview on [DATE] at 10:10 AM, CNA O stated that the COVID unit needed a nurse assigned every night and that when we (CNA's) can't get ahold of a nurse, we have to take problems into our own hands, we can't let people not breathe. An interview with Registered Nurse (RN) N on [DATE] at 9:35 AM revealed RN N was assigned to the COVID unit the night of [DATE] but upon arrival to work that day at 6:30 PM, she was reassigned to work another unit. RN N stated, There was no nurse to work the COVID unit and that she had not entered the COVID unit until receiving the call from the CNA's regarding Resident #8. RN N reported CNA K had initiated the oxygen for Resident #8 without RN N's direction and that when RN N arrived and assessed Resident #8, he required transfer to the emergency room , Resident #8 died en route to the hospital. Resident #8's progress notes, dated [DATE], revealed at 10:43 PM the facility received an order to transfer Resident #8 to the emergency room and that documents were faxed to hospital at approximately 11:00 PM. (No nurse was on the COVID unit from the time day shift nurse left until this episode occurred- approximately 4 hours.) During a follow up interview on [DATE] at 3:09 PM, the Director of Nursing (DON), stated that she was aware that there was no nurse assigned to Resident #8 for four hours on [DATE] and that she was not aware the CNA's had initiated oxygen. The DON indicated that she felt there was no problem with CNA's initiating oxygen as CNA's put oxygen on residents already receiving oxygen. The DON further stated that the CNA's could assess resident needs and report those to nursing staff. The DON stated she was also available by phone if CNA's required assistance but also stated that she had been shutting her phone off when she is not on call. The DON failed to acknowledge that a CNA performed outside their scope of practice when assessing and initiating a PRN (as needed) physician order [REDACTED].#8's [DATE] Medication and Treatment Administration Record revealed the following: -Monitor open areas to coccyx and right buttock for signs of infection and deterioration signature block for NOC on [DATE] contained LPN A's initials for doing check. However, LPN A stated she does not go on the COVID unit to provide care (see LPN A's written statement dated [DATE]). -Monitoring for side effects of medications signature block was blank for NOC on [DATE]; for NOC on [DATE] and [DATE] contained LPN A's initials for doing check. However, LPN A stated she does not go on the COVID unit to provide care (see LPN A's written statement dated [DATE]). -[MEDICATION NAME] HCL Solution 25 milligrams per milliliter signature block 0000 was blank on both [DATE] and [DATE]. Review of Resident #8's [DATE] Medication and Treatment Administration Record revealed D5W (an intravenous infusion for low sodium) signature block 2100 for [DATE] was blank. Initials in the signature box indicated staff provided the treatment to the resident. Therefore, lack of initials indicated staff did not provide the treatment to the resident. During an interview on [DATE] at 3:09 PM, the DON stated she was aware there was a staffing problem, that she had contacted corporate regarding the problem, and that she can't do anything regarding the lack of licensed nurse coverage for the COVID unit. The DON defined neglect as not providing adequate care and withholding services. During an interview on [DATE] at 9:50 AM, Scheduler R stated that the Director of Nursing (DON) told her she did not have to schedule a licensed nurse for the COVID unit because staff changed resident medication administrations times to day shift. Scheduler R also reported that until Licensed Practical Nurse F started (first shift without trainer was nights on [DATE]), Registered Nurse (RN) N was the only night nurse and she had only worked three nights a week (leaving no nurse routinely scheduled four nights a week). The current schedule, dated [DATE] to [DATE], did not have a licensed nurse scheduled for the 12-hour midnight COVID unit shift on [DATE], [DATE], and [DATE]. An interview on [DATE] at 2:51 PM, Nurse Practitioner M confirmed that she was asked by the facility to change resident medication administration times to day shift hours from midnight shift hours. During an interview on [DATE] at 10:00 AM, LPN Y stated that the facility did not schedule licensed nurses most night on the COVID unit and that during those times residents went without (nursing) assessments for those 12 hours. LPN Y stated that the south hall nurse was not allowed on the COVID unit and that most often there was only one Certified Nursing Assistant (CNA) scheduled on the COVID unit midnight shift. During

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F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 2) an interview on [DATE] at 6:10 AM, the Director of Nursing (DON) stated that if staff are not leaving the facility after entering the COVID unit that they must bring in a change of clothes and shoes before going into the general area of the facility. During an interview on [DATE] at 1:34 PM, the Administrator (NHA) stated that she was aware of staffing concerns on the COVID unit. The NHA stated it was challenging getting staff to work that unit. The NHA stated that the CNA's took care of the resident needs when there was not a nurse assigned and that this sounds terrible and does not look good on paper. The NHA stated that there were CNA's scheduled to work when there was no nurse scheduled and that the CNA's were qualified to assess and monitor resident health status and needs. The NHA stated that the facility continued to admit residents to the COVID unit despite not having midnight licensed nurses scheduled on the COVID unit. When asked what would constitute neglect, the NHA stated, intentional failure to provide goods and services. Resident #2 Review of the Face Sheet and Minimum Data Set (MDS) note dated [DATE] revealed Resident #2 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Resident #2 required the assistance of 2 staff for bed mobility and ,[DATE] for all other activities of daily living. The Brief Interview for Mental Status (BIMS), reflected a score of 10 out of 15 which represents Resident #2 had moderate cognitive impairment. Resident #5 Review of the Face Sheet and Minimum Data Set (MDS), dated [DATE], revealed Resident #5 was readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Resident #5 required the assistance of 2 staff for bed mobility and 1 to 2 for all other activities of daily living. The Brief Interview for Mental Status (BIMS), reflected a score of 0 out of 15 which represents Resident #5 had severe cognitive impairment. The facility provided a copy of a Corrective Action Form dated [DATE]. The form reflected that certified nursing assistant (CNA) J was given a final written warning for administering medication to a resident for a nurse on [DATE]. During a telephone interview on [DATE] at 2:20 PM, CNA J stated on [DATE] she was working the midnight shift on the COVID Hall for the first time. CNA J states that she was the only staff member assigned and working the COVID Unit and there was no nurse assigned to that hall. CNA J stated that at approximately 5:30 AM, she observed Resident #2 on the floor in his room. CNA J stated that she notified Licensed Practical Nurse (LPN) A about Resident #2's fall and she (LPN A) called the Director of Nursing (DON), 2 of the Clinical Care Coordinators (CCC's), and the morning nurse to see if anyone could come in. When asked what she did next CNA J stated, I tried to get him up, but I couldn't. I took his vital signs and stayed with him. CNA J stated that she didn't see the day nurse until she came in after 6:15 AM. CNA J stated that she later learned that Resident #2 was legally blind and that the staff was not informed of that prior to taking shift. CNA J stated that she told LPN A that Resident #3 (another resident) complained of pain and asked for Tylenol. CNA J stated that LPN A asked CNA J to bring the medication cart to the plastic barrier wall (non-transparent sheet of plastic), get into the medication cart and retrieve a medication for Resident #3 and Resident #5 (a routine medication). CNA J stated LPN A had her hold up the cards and told her which tablet to give to each resident. When asked if either of the medications were in a double locked drawer, CNA J stated, No, just one key opened the cart. According to the facility policy for controlled substances, all controlled substances shall be maintained under a two-lock system. CNA J stated she had two medication cups. She gave Resident #5 (who was closest to the door) his medication and Resident #3 (who was in the same room but next to the window) his medication. CNA J stated that LPN A could not see her administer the medication to Resident #3 because he was in his bed next to the window. The facility provided a copy of a Corrective Action Form, dated [DATE]. The form reflected that LPN A directed CNA J to pass medication and waited for the oncoming day nurse to assess a resident after a fall instead of entering the COVID Unit and assessing the resident timely on [DATE]. A review of Resident #5's physician orders [REDACTED]. During a telephone interview on [DATE] at 9:13 AM, LPN A stated no one was assigned to the COVID Unit on the midnight shift of [DATE]. LPN A stated she was assigned to the South Unit that evening and no nurse was assigned to the COVID Unit. LPN A stated that she was unable to work the COVID Unit due to health reasons and the facility scheduler and administration knew that. LPN A stated that CNA J informed her of Resident #2's fall on [DATE] at approximately 5:30 AM and she called the DON, 2 of the CCC's and the oncoming day nurse to have someone come in and have him assessed. LPN A stated that the day nurse arrived at 6:15 AM and when they attempted to move him, he had guarding and reported pain to his hip, so they sent him to the hospital. LPN A stated that she received a write up for not responding to the fall timely and for asking a CNA to pass medication. LPN A stated that she felt it was unjustified and wrote a response on the written warning. LPN A stated she worked only 2 to 3 midnight shifts per week and there was no nurse assigned to the COVID unit the nights that she had worked. CNA J told her that a resident was in pain, had her get the keys from the top of the medication cart, and directed her what medication to give. LPN A stated the medication, including the controlled substance, were kept under one key and not a double lock system as the facility policy reflects. When asked who would sign the MAR (medication administration record) or TAR (treatment administration record), LPN A stated, I would, or no one would. Maybe the day nurse. When asked who would assess for pain, give routine scheduled pain meds, and monitor for signs and symptoms of medication side effects, LPN A stated, I would or leave it blank. Most residents didn't have routine meds (medications). When asked how she recorded the narcotics on the count down sheet and the shift to shift narcotic count, LPN A stated, I never recorded on them. I only signed out the meds on the MAR and report to the day nurse (assigned to COVID Unit) what I did. The facility provided copies of the actual hours worked on each unit from [DATE] to [DATE] for review. The schedules reflect either a blank or dashes in for the name of the North Nurse (COVID Unit) assigned on the following dates: [DATE] to [DATE], [DATE] to [DATE], [DATE], [DATE], [DATE], [DATE], [DATE]. The record reflected that there was no nurse assigned for 25 of 42 days. On [DATE] to [DATE], [DATE], [DATE], and [DATE] only one CNA was assigned to care for all the residents on the COVID Unit despite resident care plans reflecting the need for 2 staff assistance required for ADL's (activities of daily living). Review of Resident #5's [DATE] MAR and TAR revealed the following: -Pain assessment signature blocks for NOC (night shift) on [DATE], [DATE], and [DATE] were blank (reflecting assessments were not performed). - Monitoring for side effects of medications (e.g. flushing, blurred vision, dry mouth, altered mental statues, irregular heartbeat, etc.) signature blocks for NOC on [DATE], [DATE] and [DATE] were blank. -Initials in the signature block indicated staff provided the treatment to the resident. Therefore, lack of initials indicated staff did not provide the treatment to the resident. The facility provided a copy of education that was provided to the nursing staff on [DATE]. The education reflected, 1) The key to the medication cart on the COVID hall is NEVER to be left on top of the medication cart. The key should always remain with the nurse. If there is not a night nurse on schedule, then the day shift nurse needs to return the key to the South hall night shift nurse. 2) The controlled medications need to be counted at the end of each shift, just as we do on every other unit in the building. If there is not another nurse to count with, you still need to count. The narcotic count sheet will be placed in the front of the narcotic book on the COVID hall. The surveyors requested the shift to shift narcotic count (with two nurses) from the date the COVID Unit reopened on [DATE] to [DATE]. The facility was only able to locate the records from [DATE] to [DATE]. There were 6 days ([DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]) when there was not a shift to shift count done by an oncoming and an off going nurse. The record reflected missing nursing signatures for 6 of 41 days. During a telephone interview on [DATE] at 1:30 PM, when asked how many shifts from [DATE] to [DATE] were not staffed with a nurse, and the NHA (Nursing Home Administrator) stated, I'll have to get back with you on that. The NHA stated that there were always 2 CNA's scheduled when there was not a nurse assigned. The NHA sent a written response to the question via email on [DATE] at 11:00 AM. The NHA response reflected, Regarding the nurse shifts the COVID unit ([DATE] - current) - The only uncovered shift was the evening of [DATE] in which the nurse refused, due to personal reasons, to enter the COVID unit. All CNAs are trained to identify, report and document an applicable change in condition in residents. The facility utilizes various tools to assist in this process including the use of (name of assessment tools) in (name of computer program). As soon as the facility identified there was a concern with the nurse refusing to enter the COVID unit, the facility provided all nurses re-education and instruction to enter the COVID unit as the need were to arise. The facility plan was effective as evidenced by other nurses entering the unit as the need arose. The facility failed to appropriately delegate nursing responsibilities to assess, monitor, and report changes in condition to the physicians for the residents that resided on the COVID Unit on the night shifts. A resignation letter from CCC V, dated [DATE], written to the DON was reviewed. The letter reflected the following reasons for resigning, I fear at this time my nursing license is in jeopardy due to poor patient care, safety risk factors, staffing issues, and unrealistic workload all related to the COVID unit . During a telephone interview [DATE] at 10:30 AM, CCC V stated, I resigned on ,[DATE] (2020). I was asked what needed to change to stay and I said ,[DATE] nursing coverage (on COVID Unit) and adequate CNA coverage for 2 people assists. CCC V stated, Everything got put on the day nurses, it is too much. I didn't rescind my notice. They said they have everything covered and they don't. A resignation letter from the DON, dated [DATE] written to the NHA was reviewed. The letter reflected the following reasons for resigning, Unfortunately, due to the increased work responsibility,

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F 0600 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 3) increased staffing concerns, and new and ongoing challenges of COVID-19, I have decided that it is time for me to step down as Director of Nursing . During a telephone interview on [DATE] at 1:03 PM, RN H stated that she worked full time day shift on the COVID Unit working 12-hour shifts. When asked about the staffing on the midnight shift and who would take over for her after her shift, RN H stated, No one. I had many, many sleepless nights worrying. That's not okay. RN H stated, I can't physically do it for 16 hours in a N-95. I can barely do it for 12 ho
F 0607 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake MI 249. Based on observation, interview and record review, the facility failed to implement abuse policy and procedures for seven Residents (#1, #2, #3, #8, #4, #5, and #6) out of seven residents reviewed for abuse on the COVID unit, and potentially affecting all residents residing on the COVID unit. This deficient practice resulted in incomplete investigations of alleged abuse and neglect; the potential for allegations of abuse and neglect to go unrecognized, unreported and not investigated, and the potential for inadequate care following an allegation of abuse and neglect in accordance with facility policy for all facility residents. Findings include: According to facility policy, Abuse, Neglect and Exploitation, revised ,[DATE], It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property, Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial wellbeing, Neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress, the facility will develop and implement written policies and procedures that . b. establish policies and procedures to investigate any such allegation, Establish a safe environment. Identifying, correcting and intervening in a situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur with the deployment of trained and qualified to meet the needs of the residents, and assure that the staff assigned have knowledge of individual residents' care needs, An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur, responding immediately to protect the alleged victim and integrity of the investigation; B. Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed; C. Room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator, Reporting of all alleged violation to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do no result in serious bodily injury, and taking necessary actions as a result of the investigation. Resident #1 According to the Minimum Data Set (MDS) Assessment, dated [DATE], Resident #1 admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. This same assessment indicated Resident #1 was moderately cognitively impaired and required extensive assistance of one person for moving in bed, dressing, eating, and hygiene needs including bathing and using the toilet. Resident #1's Admission Record, dated [DATE], indicated Resident #1 was diagnosed with [REDACTED]. At the time of the survey, Resident #1 no longer resided at the facility. A reasonable person would expect to receive physician ordered care and assessments by qualified staff. During an interview on [DATE] at 12:30 PM, Confidential Management Staff AA stated that Administrative staff (Director of Nursing and Administrator) were aware that there was no nurse scheduled to work the COVID unit and that Resident #1 was ordered [MEDICATION NAME] (a medication for anxiety) every four hours and there was no staff scheduled to give that medication on [DATE]. Review of Resident #1's [DATE] Medication Administration Record revealed on [DATE] at midnight and 4:00 AM, Resident #1 did not receive scheduled doses of [MEDICATION NAME] (ordered every four hours around the clock). The checkboxes for those administration times were signed out by the Director of Nursing (DON) and coded as a 5 guiding the reader to the progress notes. Review of Resident #1's progress notes revealed a late entry on [DATE] entered at 7:07 and 7:09 AM, authored by the DON, indicating [MEDICATION NAME] was held at midnight and 4:00 AM due to patient resting. No s/sx (signs or symptoms) of pain or anxiety noted. Doc (doctor) aware. Medication held. However, during an interview on [DATE] at 3:09 PM, the DON stated she was not in the facility during the ordered medication administration times and that she did not assess the resident for the medication need. There were no progress notes indicating Resident #1 had any nursing assessment between 9:01 PM on [DATE] until the DON entered the progress notes at 7:05 AM on [DATE] thus there is no way to identify how the resident tolerated the night without the ordered antianxiety medications. During that same interview on [DATE], the DON stated she had entered Resident #1's progress notes on [DATE] at 7:05 and 7:07 AM from home and had not completed a physical assessment of the resident at those times either. Review of Resident #1's [DATE] Medication and Treatment Administration Record revealed a missed pain assessment and an assessment for medication side effects. Review of Resident #1's [DATE] Medication and Treatment Administration Record revealed four ordered treatments and/or assessments that were not provided by facility staff. Resident #3 According to the MDS Assessment, dated [DATE], Resident #3 admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. This same assessment indicated Resident #3 was cognitively intact and required extensive assistance of two staff members for moving in bed, transferring, dressing, and hygiene needs including using the bathroom. During an interview and observation on [DATE] at 5:35 AM, Resident #3 was awake and lying in bed. When asked about his feeding tube (G tube), Resident #3 stated that it was infected and that he was on an antibiotic. Resident #3 pulled the covers away from his abdomen and revealed a G tube covered with an undated dry dressing. According to Resident #3's hospital records history and physical, dated [DATE], Resident #3 had a gastric tube (G tube) (feeding tube inserted directly into the stomach) that was surgically placed on [DATE] (19 days prior to Resident #3's admission to the facility). Review of Resident #3's progress notes beginning [DATE] to [DATE] revealed two assessments of this surgical site. A progress note, dated [DATE], revealed Resident #3 complained about his G tube, and the nurse reported no changes or issues noted. The other assessment, dated [DATE], indicated the site was clean and changed. During an interview on [DATE] at 11:48 AM, when this Surveyor asked the Director of Nursing (DON) about documentation on a new surgical site, specifically Resident #3's gastric tube insertion site, the DON stated staff chart by exception (i.e. the nurses only document negative assessment findings). It should be noted that daily progress notes had normal findings recorded for other areas of assessment i.e. lung sounds, bowel sounds, etc. The DON referred to a Weekly Skin Sweep, dated [DATE], and stated that is where she would expect to find concerns related to the G tube. Review of Weekly Skin Sweep, dated [DATE], revealed staff checked the box indicating None-Skin Intact for Resident #3. This Weekly Skin Sweep document included other options to select, including Surgical wound site, which was not checked. A Weekly Skin Sweep, dated [DATE], staff checked the box for None-Skin intact and did not indicate Resident #3 had a Surgical wound site. A physician note, dated [DATE], revealed Resident #3 had an infection around the G tube site. The doctor ordered an antibiotic and Resident #3 started it that same day. During an interview on [DATE] at 11:48 AM, Clinical Care Coordinator (CCC) P stated that Resident #3 missed an appointment on [DATE] to have the fasteners removed from the G tube. During a follow up interview on [DATE] at 12:43 PM, CCC P reported the missed appointment contributed to the infection that occurred and that the G tube site looked horrible and did not look like staff had cleaned it. During a telephone interview on [DATE] at 2:20 PM, CNA J stated on [DATE] she was working the midnight shift on the COVID Hall for the first time. CNA J states that she was the only staff member assigned and working the COVID Unit and there was no nurse assigned to that hall. CNA J stated that she told LPN A that Resident #3 complained of pain and asked for Tylenol. CNA J stated that LPN A asked CNA J to bring the medication cart to the plastic barrier wall (opaque sheet of plastic), get into the medication cart, retrieve a medication for Resident #3 and Resident #5. CNA J stated LPN A had her hold up the cards and told her which tablet to give to each resident. When asked if either of the medications were in a double locked drawer, CNA J stated, No, just one key opened the cart. CNA J stated she had two medication cups. She gave Resident #5 (who was closest to the door) his medication and Resident #3 (who was in the same room but next to the window) his medication. CNA J stated that LPN A could not see her administer the medication to Resident #3 because he was in his bed next to the window. LPN A did not enter the COVID unit (see written statement dated [DATE]) nor did she complete a pain assessment on Resident #3 prior to CNA J administering the pain medication. Review of physician orders, dated [DATE], revealed Resident #3 had Tylenol ordered to be given via G tube every six hours for pain. During a follow up interview on [DATE] at 9:20 AM, CNA J clarified that she had given Resident #3 liquid Tylenol via syringe into the mouth and that she was uncomfortable doing it. CNA J denied the facility talking to her regarding this matter in the last couple of days despite notification to the DON of this event on [DATE] at 3:09 PM by this surveyor. There was no incident report received by the end of this survey despite multiple requests for such. Review of

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	235290	A. BUILDING _____ B. WING _____	06/24/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MISSION POINT NSG & PHY REHAB CTR OF GREENVILLE	828 E WASHINGTON ST GREENVILLE, MI 48838

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F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 4) Resident #3's [DATE] Medication and Treatment Administration Record revealed a missed dose of [MEDICATION NAME] (pain medication) on a midnight shift. Review of Resident #3's [DATE] Medication and Treatment Administration Record revealed five nursing interventions and or assessments that were not provided. Resident #8 According to the MDS Assessment, dated [DATE], Resident #8 admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. This same assessment indicated Resident #8 cognitively intact and required extensive assistance of two staff members for moving in bed, transferring, dressing, and other hygiene needs including using the bathroom. At the time of the survey, Resident #8 no longer resided at the facility. A reasonable person would expect to receive physician ordered care and assessments by qualified staff. During an interview on [DATE] at 9:14 PM, Certified Nursing Assistant (CNA) K reported working with Resident #8 on [DATE] during the night shift. CNA K reported working with CNA O when Resident #8 had difficulty breathing. CNA K reported that she and CNA O laid Resident #8 down to assist with changing him and he coughed up a loogie. CNA's O and K sat Resident #8 upright and Resident #8 began to chocking and gagging on it. CNA K reported that Resident #8's oxygen was low, heart rate was elevated, and had increased anxiety. CNA K stated, Our nurse (RN N) came in for shift but never came on the (COVID) unit, I called to tell her what was going on and I was put on hold. CNA K reported giving the phone to CNA O and going to the utility room to obtain an oxygen concentrator; then CNA K placed oxygen on Resident #8 per nasal canula. During an interview on [DATE] at 10:10 AM, CNA O stated that often times she has worked the COVID unit with no nurse assigned and that there was no nurse for the COVID unit on [DATE] around 10:00 or 11:00 PM when Resident #8 had trouble breathing. CNA O reported she had called nurses in the building and that those nurses reported they were passing medications, she then called respiratory therapy and told them Resident #8's respiratory rate was 62 (normal ,[DATE] breaths per minute) and they said it would be about 15 minutes before someone could get here. I told them he would be dead in 15 minutes. CNA O stated that the nurse had to come from the other side of the building to get to the COVID unit that night ([DATE]). During an interview on [DATE] at 10:10 AM, CNA O stated that the COVID unit needed a nurse assigned every night and that when we (CNA's) can't get ahold of a nurse, we have to take problems into our own hands, we can't let people not breathe. An interview with Registered Nurse (RN) N on [DATE] at 9:35 AM revealed RN N was assigned to the COVID unit the night of [DATE] but upon arrival to work that day at 6:30 PM, she was reassigned to work another unit. RN N stated, There was no nurse to work the COVID unit and that she had not entered the COVID unit until receiving the call from the CNA's regarding Resident #8. RN N reported CNA K had initiated the oxygen for Resident #8 without RN N's direction and that when RN N arrived and assessed Resident #8, he required transfer to the emergency room , Resident #8 died en route to the hospital. Resident #8's progress notes, dated [DATE], revealed at 10:43 PM the facility received an order to transfer Resident #8 to the emergency room and that documents were faxed to hospital at approximately 11:00 PM. (No nurse was on the COVID unit from the time day shift nurse left until this episode occurred- approximately 4 hours.) During a follow up interview on [DATE] at 3:09 PM, the Director of Nursing (DON), stated that she was aware that there was no nurse assigned to Resident #8 for four hours on [DATE] and that she was not aware the CNA's had initiated oxygen. The DON indicated that she felt there was no problem with CNA's initiating oxygen as CNA's put oxygen on residents already receiving oxygen. The DON further stated that the CNA's could assess resident needs and report those to nursing staff. The DON stated she was also available by phone if CNA's required assistance but also stated that she had been shutting her phone off when she is not on call. The DON failed to acknowledge that a CNA performed outside their scope of practice when assessing and initiating a PRN (as needed) physician order [REDACTED].#8's [DATE] Medication and Treatment Administration Record revealed missed nursing assessments, medication side effect monitoring, and two missed doses of an antibiotic. Review of Resident #8's [DATE] Medication and Treatment Administration Record revealed staff missed intravenous assessments. During an interview on [DATE] at 9:50 AM, Scheduler R stated that the Director of Nursing (DON) told her she did not have to schedule a licensed nurse for the COVID unit because resident medication administrations times changed to day shift. Scheduler R also reported that until Licensed Practical Nurse F started (first shift without trainer was nights on [DATE]), Registered Nurse (RN) N was the only night nurse and she had only worked three nights a week (leaving no nurse routinely scheduled four nights a week). The current schedule, dated [DATE] to [DATE], did not have a licensed nurse scheduled for the 12-hour midnight COVID unit shift on [DATE], [DATE], and [DATE]. An interview on [DATE] at 2:51 PM, Nurse Practitioner M confirmed that she was asked by the facility to change resident medication administration times to day shift hours from midnight shift hours. During an interview on [DATE] at 10:00 AM, LPN Y stated that the facility did not schedule licensed nurses most night on the COVID unit and that during those times residents went without (nursing) assessments for those 12 hours. LPN Y stated that the south hall nurse was not allowed on the COVID unit and that most often there was only one Certified Nursing Assistant (CNA) scheduled on the COVID unit during midnight shift despite multiple two assist residents. During an interview on [DATE] at 6:10 AM, the Director of Nursing (DON) stated that if staff are not leaving the facility after entering the COVID unit that they must bring in a change of clothes and shoes before going into the general care area of the facility. During an interview on [DATE] at 3:09 PM, the Director of Nursing (DON) stated she had talked with the Administrator and corporate staff regarding safety issues with lack of staff (nurses) approximately three weeks earlier. The DON stated she could not do anything about the lack of nurses and listed changes she had already made including limiting admissions but then reported she had 15 admissions in 15 days, and changing medication administration times to day shift. The DON revealed that staff were very open regarding lack of staffing (licensed nurses on the COVID unit). When asked about Resident #8, the DON stated, all staff are burnt out and I don't know how to fix this (staffing concerns). A request was made at this time of audits and investigations the DON reportedly completed for identified deficiencies. No audits or additional investigations were provided by the end of the survey. When asked what would constitute neglect the DON stated, not providing adequate care and withholding services. During an interview on [DATE] at 1:34 PM, the Administrator (NHA) stated that she was aware of staffing concerns on the COVID unit. The NHA stated it was challenging getting staff to work that unit. The NHA stated that the CNA's took care of the resident needs when there was not a nurse assigned and that this sounds terrible and does not look good on paper. The NHA stated that there were CNA's scheduled to work when there was no nurse scheduled and that the CNA's were qualified to assess and monitor resident health status and needs. The NHA stated that the facility continued to admit residents to the COVID unit despite not having licensed nurses scheduled for midnight shifts on the COVID unit. When asked what would constitute neglect, the NHA stated, intentional failure to provide goods and services. Additional requests for audits and incident reports were made at this time and not provided by the end of the survey. Resident #2 Review of the Face Sheet and Minimum Data Set (MDS) note dated [DATE] revealed Resident #2 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Resident #2 required the assistance of 2 staff for bed mobility and ,[DATE] for all other activities of daily living. The Brief Interview for Mental Status (BIMS), reflected a score of 10 out of 15 which represents Resident #2 had moderate cognitive impairment. Resident #5 Review of the Face Sheet and Minimum Data Set (MDS), dated [DATE], revealed Resident #5 was readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Resident #5 required the assistance of 2 staff for bed mobility and 1 to 2 for all other activities of daily living. The Brief Interview for Mental Status (BIMS), reflected a score of 0 out of 15 which represents Resident #5 had severe cognitive impairment. The facility provided a copy of a Corrective Action Form dated [DATE]. The form reflected that certified nursing assistant (CNA) J was given a final written warning for administering medication to a resident for a nurse on [DATE]. During a telephone interview on [DATE] at 2:20 PM, CNA J stated on [DATE] she was working the midnight shift on the COVID Hall for the first time. CNA J states that she was the only staff member assigned and working the COVID Unit and there was no nurse assigned to that hall. CNA J stated that at approximately 5:30 AM, she observed Resident #2 on the floor in his room. CNA J stated that she notified Licensed Practical Nurse (LPN) A about Resident #2's fall and she (LPN A) called the Director of Nursing (DON), 2 of the Clinical Care Coordinators (CCC's), and the morning nurse to see if anyone could come in. When asked what she did next CNA J stated, I tried to get him up, but I couldn't. I took his vital signs and stayed with him. CNA J stated that she didn't see the day nurse until she came in after 6:15 AM. CNA J stated that she later learned that Resident #2 was legally blind and that the staff was not informed of that prior to taking shift. CNA J stated that she told LPN A that Resident #3 (another resident) complained of pain and asked for Tylenol. CNA J stated that LPN A asked CNA J to bring the medication cart to the plastic barrier wall (non-transparent sheet of plastic), get into the medication cart and retrieve a medication for Resident #3 and Resident #5 (a routine medication). CNA J stated LPN A had her hold up the cards and told her which tablet to give to each resident. When asked if either of the medications were in a double locked drawer, CNA J stated, No, just one key opened the cart. According to the facility policy for controlled substances, all controlled substances shall be maintained under a two-lock system. CNA J stated she had two medication

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F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 5) cups. She gave Resident #5 (who was closest to the door) his medication and Resident #3 (who was in the same room but next to the window) his medication. CNA J stated that LPN A could not see her administer the medication to Resident #3 because he was in his bed next to the window. The facility provided a copy of a Corrective Action Form, dated [DATE]. The form reflected that LPN A directed CNA J to pass medication and waited for the oncoming day nurse to assess a resident after a fall instead of entering the COVID Unit and assessing the resident timely on [DATE]. A review of Resident #5's physician orders [REDACTED]. During a telephone interview on [DATE] at 9:13 AM, LPN A stated no one was assigned to the COVID Unit on the midnight shift of [DATE]. LPN A stated she was assigned to the South Unit that evening and no nurse was assigned to the COVID Unit. LPN A stated that she was unable to work the COVID Unit due to health reasons and the facility scheduler and administration knew that. LPN A stated that CNA J informed her of Resident #2's fall on [DATE] at approximately 5:30 AM and she called the DON, 2 of the CCC's and the oncoming day nurse to have someone come in and have him assessed. LPN A stated that the day nurse arrived at 6:15 AM and when they attempted to move him, he had guarding and reported pain to his hip, so they sent him to the hospital. LPN A stated that she received a write up for not responding to the fall timely and for asking a CNA to pass medication. LPN A stated that she felt it was unjustified and wrote a response on the written warning. LPN A stated she worked only 2 to 3 midnight shifts per week and there was no nurse assigned to the COVID unit the nights that she had worked. CNA J told her that a resident was in pain, had her get the keys from the top of the medication cart, and directed her what medication to give. LPN A stated the medication, including the controlled substance, were kept under one key and not a double lock system as the facility policy reflects. When asked who would sign the MAR (medication administration record) or TAR (treatment administration record), LPN A stated, I would, or no one would. Maybe the day nurse. When asked who would assess for pain, give routine scheduled pain meds, and monitor for signs and symptoms of medication side effects, LPN A stated, I would or leave it blank. Most residents didn't have routine meds (medications). When asked how she recorded the narcotics on the count down sheet and the shift to shift narcotic count, LPN A stated, I never recorded on them. I only signed out the meds on the MAR and report to the day nurse (assigned to COVID Unit) what I did. The facility provided copies of the actual hours worked on each unit from [DATE] to [DATE] for review. The schedules reflect either a blank or dashes in for the name of the North Nurse (COVID Unit) assigned on the following dates: [DATE] to [DATE], [DATE] to [DATE], [DATE], [DATE], [DATE], [DATE], [DATE]. The record reflected that there was no nurse assigned for 25 of 42 days. On [DATE] to [DATE], [DATE], [DATE], and [DATE] only one CNA was assigned to care for all the residents on the COVID Unit despite resident care plans reflecting the need for 2 staff assistance required for ADL's (activities of daily living). Review of Resident #5's [DATE] MAR and TAR revealed the following: -Pain assessment signature blocks for NOC (night shift) on [DATE], [DATE], and [DATE] were blank (reflecting assessments were not performed). - Monitoring for side effects of medications (e.g. flushing, blurred vision, dry mouth, altered mental statues, irregular heartbeat, etc.) signature blocks for NOC on [DATE], [DATE] and [DATE] were blank. -Initials in the signature block indicated staff provided the treatment to the resident. Therefore, lack of initials indicated staff did not provide the treatment to the resident. The facility provided a copy of education that was provided to the nursing staff on [DATE]. The education reflected, 1) The key to the medication cart on the COVID hall is NEVER to be left on top of the medication cart. The key should always remain with the nurse. If there is not a night nurse on schedule, then the day shift nurse needs to return the key to the South hall night shift nurse. 2) The controlled medications need to be counted at the end of each shift, just as we do on every other unit in the building. If there is not another nurse to count with, you still need to count. The narcotic count sheet will be placed in the front of the narcotic book on the COVID hall. The surveyors requested the shift to shift narcotic count (with two nurses) from the date the COVID Unit reopened on [DATE] to [DATE]. The facility was only able to locate the records from [DATE] to [DATE]. There were 6 days ([DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]) when there was not a shift to shift count done by an oncoming and an off going nurse. The record reflected missing nursing signatures for 6 of 41 days. During a telephone interview on [DATE] at 1:30 PM, when asked how many shifts from [DATE] to [DATE] were not staffed with a nurse, and the NHA (Nursing Home Administrator) stated, I'll have to get back with you on that. The NHA stated that there were always 2 CNA's scheduled when there was not a nurse assigned. The NHA sent a written response to the question via email on [DATE] at 11:00 AM. The NHA response reflected, Regarding the nurse shifts the COVID unit ([DATE] - current) - The only uncovered shift was the evening of [DATE] in which the nurse refused, due to personal reasons, to enter the COVID unit. All CNAs are trained to identify, report and document an applicable change in condition in residents. The facility utilizes various tools to assist in this process including the use of (name of assessment tools) in (name of computer program). As soon as the facility identified there was a concern with the nurse refusing to enter the COVID unit, the facility provided all nurses re-education and instruction to enter the COVID unit as the need were to arise. The facility plan was effective as evidenced by other nurses entering the unit as the need arose. The facility failed to appropriately delegate nursing responsibilities to assess, monitor, and report changes in condition to the physicians for the residents that resided on the COVID Unit on the night shifts. A resignation letter from CCC V, dated [DATE], written to the DON was reviewed. The letter reflected the following reasons for resigning, I fear at this time my nursing license is in jeopardy due to poor patient care, safety risk factors, staffing issues, and unrealistic workload all related to the COVID unit . During a telephone interview [DATE] at 10:30 AM, CCC V stated, I resigned on ,[DATE] (2020). I was asked what needed to change to stay and I said ,[DATE] nursing coverage (on COVID Unit) and adequate CNA coverage for 2 people assists. CCC V stated, Everything got put on the day nurses, it is too much. I didn't rescind my notice. They said they have everything covered and they don't. A resignation letter from the DON, dated [DATE] written to the NHA was reviewed. The letter reflected the following reasons for resigning, Unfortunately, due to the increased work responsibility, increased staffing concerns, and new and ongoing challenges of COVID-19, I have decided that it is time for me to step down as Director of Nursing . During a telephone interview on [DATE] at 1:03 PM, RN H stated that she worked full time day shift on the COVID Unit working 12-hour shifts. When asked about the staffing on the midnight shift and who would take over for her after her shift, RN H stated, No one. I had many, many sleepless nights worrying. That's not okay. RN H stated, I can't physically do it for 16 hours in a N-95. I can barely do it for 12 hours. During a telephone interview on [DATE] at approximately 3:00 PM, LPN Y stated that she worked full time on the day shift on the COVID Unit working 12-hour shifts. When asked about the staffing on midnight shifts, LPN Y stated, I was having heart palpations before coming into work. It was so stressful knowing no one was on the night shift. Resident #4 A review of Resident #4's Admission Record, dated [DATE], revealed Resident #4 was a [AGE] year-old resident admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. A review of Resident #4's [DATE] Treatment Administration Record (TAR) revealed the following: - Maintain isolation for droplet precautions R/T (related to) covid-19. All services to be provided in room every shift signature block blank for [DATE] on the NOC (night) shift. - Maintain isolation for droplet precautions R/T covid-19. All services to be provided in room every shift on the NOC shift- Licensed Practical Nurse (LPN) A's initials for doing check on [DATE] and [DATE]. However, LPN A stated she does not go on the COVID unit to provide care (see statements below). A review of Resident #4's [DATE] Medication Administration Record (MAR) revealed the following: - Monitoring for side effects of medications (e.g. flushing, blurred irregular heart beat/pulse, palpitations, lightheadedness, shortness of breath, excessive sweating, chest/arm pain, increased blood pressure, weight gain, agitation, distress) signature block was blank for [DATE] on the NOC shift. - Flush for intermittent infusion 10 ml (milliliters) NS (normal saline) before and after medication followed with 3 ml 10 units/ml (units per milliliter) [MEDICATION NAME] every 6 hours for [MEDICATION NAME] signature blocks were blank on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE] for the midnight (0000) time. - Meropenem (an antibiotic) 500 mg (milligrams) signature block was blank on [DATE] for the midnight (0000) dose. Resident #6 A review of Resident #6's Admission Record, dated [DATE], revealed Resid
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake MI 249. Based on interview and record review, the facility failed to report allegations of neglect in a timely manner for seven Residents (#1, #2, #3, #8, #4, #5, and #6) out of seven residents reviewed for neglect on the COVID unit, and affecting all residents residing on the COVID unit, resulting in an allegations of neglect to not be reported to the State Agency timely and the potential for further allegations of neglect to go unreported and not

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 6) thoroughly investigated. Findings include: Resident #1 According to the Minimum Data Set (MDS) Assessment, dated [DATE], Resident #1 admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. This same assessment indicated Resident #1 was moderately cognitively impaired and required extensive assistance of one person for moving in bed, dressing, eating, and hygiene needs including bathing and using the toilet. Resident #1's Admission Record, dated [DATE], indicated Resident #1 was diagnosed with [REDACTED]. At the time of the survey, Resident #1 no longer resided at the facility. During an interview on [DATE] at 12:30 PM, Confidential Management Staff AA stated that Administrative staff (Director of Nursing and Administrator) were aware that there was no nurse scheduled to work the COVID unit and that Resident #1 was ordered [MEDICATION NAME] (a medication for anxiety) every four hours and there was no staff scheduled to give that medication on [DATE]. Review of Resident #1's [DATE] Medication Administration Record revealed on [DATE] at midnight and 4:00 AM, Resident #1 did not receive scheduled doses of [MEDICATION NAME] (ordered every four hours around the clock). The checkboxes for those administration times were signed out by the Director of Nursing (DON) and coded as a 5 guiding the reader to the progress notes. Review of Resident #1's progress notes revealed a late entry on [DATE] entered at 7:07 and 7:09 AM, authored by the DON, indicating [MEDICATION NAME] was held at midnight and 4:00 AM due to patient resting. No s/sx (signs or symptoms) of pain or anxiety noted. Doc (doctor) aware. Medication held. However, during an interview on [DATE] at 3:09 PM, the DON stated she was not in the facility during the ordered medication administration times and that she did not assess the resident for the medication need. There were no progress notes indicating Resident #1 had any nursing assessment between 9:01 PM on [DATE] until the DON entered the progress notes at 7:05 AM on [DATE] thus there is no way to identify how the resident tolerated the night without the ordered antianxiety medications. During that same interview on [DATE], the DON stated she had entered Resident #1's progress notes on [DATE] at 7:05 and 7:07 AM from home and had not completed a physical assessment of the resident at those times either. Review of Resident #1's May and [DATE] Medication and Treatment Administration Record revealed multiple unsigned treatments and medications indicating Resident #1 did not receive care and services as ordered by the physician. This surveyor requested, on [DATE] at 3:38 PM and on [DATE] at 12:02 PM, incident and accident reports with investigations for Resident #1 since [DATE], the facility did not provide any by the end of the survey. The facility did not report Resident #1 missing multiple medications and treatments. Resident #3 According to the MDS Assessment, dated [DATE], Resident #3 admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. This same assessment indicated Resident #3 was cognitively intact and required extensive assistance of two staff members for moving in bed, transferring, dressing, and hygiene needs including using the bathroom. During an interview and observation on [DATE] at 5:35 AM, Resident #3 was awake and lying in bed. When asked about his feeding tube (G tube), Resident #3 stated that it was infected and that he was on an antibiotic. Resident #3 pulled the covers away from his abdomen and revealed a G tube covered with an undated dry dressing. According to Resident #3's hospital records history and physical, dated [DATE], Resident #3 had a gastric tube (G tube) (feeding tube inserted directly into the stomach) that was surgically placed on [DATE] (19 days prior to Resident #3's admission to the facility). A physician note, dated [DATE], revealed Resident #3 had an infection around the G tube site. The doctor ordered an antibiotic and Resident #3 started it that same day. Review of Resident #3's progress notes beginning [DATE] to [DATE] revealed two assessments of this surgical site. A progress note, dated [DATE], revealed Resident #3 complained about his G tube, and the nurse reported no changes or issues noted. The other assessment, dated [DATE], indicated the site was clean and changed. No other nursing assessments regarding the surgical site, prior to the infection identified on [DATE], was provided by the end of this survey. During an interview on [DATE] at 11:48 AM, when this Surveyor asked the Director of Nursing (DON) about documentation on a new surgical site, specifically Resident #3's gastric tube insertion site, the DON stated staff chart by exception (i.e. the nurses only document negative assessment findings). It should be noted that daily progress notes had normal findings recorded for other areas of assessment i.e. lung sounds, bowel sounds, etc. The DON referred to a Weekly Skin Sweep, dated [DATE], and stated that is where she would expect to find concerns related to the G tube. This document indicted Resident #3 had intact skin and did not indicate Resident #3 had a surgical site. During an interview on [DATE] at 11:48 AM, Clinical Care Coordinator (CCC) P stated that Resident #3 missed an appointment on [DATE] to have the fasteners removed from the G tube. During a follow up interview on [DATE] at 12:43 PM, CCC P reported the missed appointment contributed to the infection that occurred and that the G tube site looked horrible and did not look like staff had cleaned it. This was not reported to the State Agency nor did the facility initiate an investigation. During a telephone interview on [DATE] at 2:20 PM, CNA J stated on [DATE] she was working the midnight shift on the COVID Hall for the first time. CNA J states that she was the only staff member assigned and working the COVID Unit and there was no nurse assigned to that hall. CNA J stated that she had given Resident #3 pain medication by mouth as no nurse was assigned to the COVID hall. Review of physician orders, dated [DATE], revealed Resident #3 had Tylenol ordered to be given via G tube every six hours for pain. During a follow up interview on [DATE] at 9:20 AM, CNA J clarified that she had given Resident #3 liquid Tylenol via syringe into the mouth and that she was uncomfortable doing it. CNA J denied the facility talking to her regarding this matter in the last couple of days despite notification to the DON of this event on [DATE] at 3:09 PM by this surveyor. There was no incident report or facility investigation received by the end of this survey despite requests by this surveyor on [DATE] at 11:48 AM, [DATE] at 3:09 PM, and [DATE] at 1:34 PM (six days after this surveyor notified the DON). Review of Resident #3's May and [DATE] Medication and Treatment Administration Record revealed multiple unsigned treatments and medications indicating Resident #3 did not receive care and services as ordered by the physician. This surveyor requested, on [DATE] at 3:38 PM and on [DATE] at 12:02 PM, incident and accident reports with investigations for Resident #3 since [DATE], the facility did not provide any by the end of the survey. The facility did not report Resident #3 missing multiple medications and treatments. Resident #8 According to the MDS Assessment, dated [DATE], Resident #8 admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. This same assessment indicated Resident #8 cognitively intact and required extensive assistance of two staff members for moving in bed, transferring, dressing, and other hygiene needs including using the bathroom. At the time of the survey, Resident #8 no longer resided at the facility. A reasonable person would expect to receive physician ordered care and assessments by qualified staff. During an interview on [DATE] at 9:14 PM, Certified Nursing Assistant (CNA) K reported working with Resident #8 on [DATE] during the night shift. CNA K reported working with CNA O when Resident #8 had difficulty breathing. CNA K reported that she and CNA O laid Resident #8 down to assist with changing him and he coughed up a loogie. CNA's O and K sat Resident #8 upright and Resident #8 began to chocking and gagging on it. CNA K reported that Resident #8's oxygen was low, heart rate was elevated, and had increased anxiety. CNA K stated, Our nurse (RN N) came in for shift but never came on the (COVID) unit, I called to tell her what was going on and I was put on hold. CNA K reported giving the phone to CNA O and going to the utility room to obtain an oxygen concentrator; then CNA K placed oxygen on Resident #8 per nasal canula. During an interview on [DATE] at 10:10 AM, CNA O stated that often times she has worked the COVID unit with no nurse assigned and that there was no nurse for the COVID unit on [DATE] around 10:00 or 11:00 PM when Resident #8 had trouble breathing. During an interview on [DATE] at 10:10 AM, CNA O stated that the COVID unit needed a nurse assigned every night and that when we (CNA's) can't get ahold of a nurse, we have to take problems into our own hands, we can't let people not breathe. An interview with Registered Nurse (RN) N on [DATE] at 9:35 AM revealed RN N was assigned to the COVID unit the night of [DATE] but upon arrival to work that day at 6:30 PM, she was reassigned to work another unit. RN N stated, There was no nurse to work the COVID unit and that she had not entered the COVID unit until receiving the call from the CNA's regarding Resident #8. RN N reported CNA K had initiated the oxygen for Resident #8 without RN N's direction and that when RN N arrived and assessed Resident #8, he required transfer to the emergency room , Resident #8 died en route to the hospital. Resident #8's progress notes, dated [DATE], revealed at 10:43 PM the facility received an order to transfer Resident #8 to the emergency room and that documents were faxed to hospital at approximately 11:00 PM. (No nurse was on the COVID unit from the time day shift nurse left until this episode occurred- approximately 4 hours.) During a follow up interview on [DATE] at 3:09 PM, the Director of Nursing (DON), stated that she was aware that there was no nurse assigned to Resident #8 for four hours on [DATE] and that she was not aware the CNA's had initiated oxygen. The DON indicated that she felt there was no problem with CNA's initiating oxygen as CNA's put oxygen on residents already receiving oxygen. The DON further stated that the CNA's could assess resident needs and report those to nursing staff. The DON stated she was also available by phone if CNA's required assistance but also stated that she had been shutting her phone off when she is not on call. The DON failed to acknowledge that a CNA performed outside their scope of practice when assessing and initiating a PRN (as needed) physician order [REDACTED]. Review of Resident #8's May and [DATE] Medication and Treatment Administration Record revealed multiple unsigned treatments and medications indicating Resident #8 did not receive care and services as ordered by the physician. The facility did not report or perform an investigation regarding Resident #8's missing multiple medications and treatments. During an interview on [DATE]

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	235290	A. BUILDING _____ B. WING _____	06/24/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 7) at 10:00 AM, LPN Y stated that the facility did not schedule licensed nurses most night on the COVID unit and that during those times residents went without (nursing) assessments for those 12 hours. LPN Y stated that the south hall nurse was not allowed on the COVID unit and that most often there was only one Certified Nursing Assistant (CNA) scheduled on the COVID unit during midnight shift despite multiple two assist residents. During an interview on [DATE] at 3:09 PM, the Director of Nursing (DON) stated she had talked with the Administrator and corporate staff regarding safety issues with lack of staff (nurses) approximately three weeks earlier. The DON stated she could not do anything about the lack of nurses and listed changes she had already made including limiting admissions but then reported she had 15 admissions in 15 days, and changing medication administration times to day shift. The DON revealed that staff were very open regarding lack of staffing (licensed nurses on the COVID unit). When asked about Resident #8, the DON stated, all staff are burnt out and I don't know how to fix this (staffing concerns). A request was made at this time of audits and investigations the DON reportedly completed for identified deficiencies. No audits or additional investigations were provided by the end of the survey. When asked what would constitute neglect the DON stated, not providing adequate care and withholding services. During an interview on [DATE] at 1:34 PM, the Administrator (NHA) stated that she was aware of staffing concerns on the COVID unit. The NHA stated it was challenging getting staff to work that unit. The NHA stated that the CNA's took care of the resident needs when there was not a nurse assigned and that this sounds terrible and does not look good on paper. The NHA stated that there were CNA's scheduled to work when there was no nurse scheduled and that the CNA's were qualified to assess and monitor resident health status and needs. The NHA stated that the facility continued to admit residents to the COVID unit despite not having licensed nurses scheduled for midnight shifts on the COVID unit. When asked what would constitute neglect, the NHA stated, intentional failure to provide goods and services. Additional requests for audits and incident reports were made at this time and not provided by the end of the survey. Resident #2 Review of the Face Sheet and Minimum Data Set (MDS) note dated [DATE] revealed Resident #2 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Resident #2 required the assistance of 2 staff for bed mobility and ,[DATE] for all other activities of daily living. The Brief Interview for Mental Status (BIMS), reflected a score of 10 out of 15 which represents Resident #2 had moderate cognitive impairment. Resident #5 Review of the Face Sheet and Minimum Data Set (MDS), dated [DATE], revealed Resident #5 was readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Resident #5 required the assistance of 2 staff for bed mobility and 1 to 2 for all other activities of daily living. The Brief Interview for Mental Status (BIMS), reflected a score of 0 out of 15 which represents Resident #5 had severe cognitive impairment. The facility provided a copy of a Corrective Action Form dated [DATE]. The form reflected that certified nursing assistant (CNA) J was given a final written warning for administering medication to a resident for a nurse on [DATE]. During a telephone interview on [DATE] at 2:20 PM, CNA J stated on [DATE] she was working the midnight shift on the COVID Hall for the first time. CNA J states that she was the only staff member assigned and working the COVID Unit and there was no nurse assigned to that hall. CNA J stated that at approximately 5:30 AM, she observed Resident #2 on the floor in his room. CNA J stated that she notified Licensed Practical Nurse (LPN) A about Resident #2's fall and she (LPN A) called the Director of Nursing (DON), 2 of the Clinical Care Coordinators (CCC's), and the morning nurse to see if anyone could come in. When asked what she did next CNA J stated, I tried to get him up, but I couldn't. I took his vital signs and stayed with him. CNA J stated that she didn't see the day nurse until she came in after 6:15 AM. CNA J stated that she later learned that Resident #2 was legally blind and that the staff was not informed of that prior to taking shift. CNA J stated that she told LPN A that Resident #3 (another resident) complained of pain and asked for Tylenol. CNA J stated that LPN A asked CNA J to bring the medication cart to the plastic barrier wall (non-transparent sheet of plastic), get into the medication cart and retrieve a medication for Resident #3 and Resident #5 (a routine medication). CNA J stated LPN A had her hold up the cards and told her which tablet to give to each resident. When asked if either of the medications were in a double locked drawer, CNA J stated, No, just one key opened the cart. According to the facility policy for controlled substances, all controlled substances shall be maintained under a two-lock system. CNA J stated she had two medication cups. She gave Resident #5 (who was closest to the door) his medication and Resident #3 (who was in the same room but next to the window) his medication. CNA J stated that LPN A could not see her administer the medication to Resident #3 because he was in his bed next to the window. The facility provided a copy of a Corrective Action Form, dated [DATE]. The form reflected that LPN A directed CNA J to pass medication and waited for the oncoming day nurse to assess a resident after a fall instead of entering the COVID Unit and assessing the resident timely on [DATE]. A review of Resident #5's physician orders [REDACTED]. During a telephone interview on [DATE] at 9:13 AM, LPN A stated no one was assigned to the COVID Unit on the midnight shift of [DATE]. LPN A stated she was assigned to the South Unit that evening and no nurse was assigned to the COVID Unit. LPN A stated that she was unable to work the COVID Unit due to health reasons and the facility scheduler and administration knew that. LPN A stated that CNA J informed her of Resident #2's fall on [DATE] at approximately 5:30 AM and she called the DON, 2 of the CCC's and the oncoming day nurse to have someone come in and have him assessed. LPN A stated that the day nurse arrived at 6:15 AM and when they attempted to move him, he had guarding and reported pain to his hip, so they sent him to the hospital. LPN A stated that she received a write up for not responding to the fall timely and for asking a CNA to pass medication. LPN A stated that she felt it was unjustified and wrote a response on the written warning. LPN A stated she worked only 2 to 3 midnight shifts per week and there was no nurse assigned to the COVID unit the nights that she had worked. CNA J told her that a resident was in pain, had her get the keys from the top of the medication cart, and directed her what medication to give. LPN A stated the medication, including the controlled substance, were kept under one key and not a double lock system as the facility policy reflects. When asked who would sign the MAR (medication administration record) or TAR (treatment administration record), LPN A stated, I would, or no one would. Maybe the day nurse. When asked who would assess for pain, give routine scheduled pain meds, and monitor for signs and symptoms of medication side effects, LPN A stated, I would or leave it blank. Most residents didn't have routine meds (medications). When asked how she recorded the narcotics on the count down sheet and the shift to shift narcotic count, LPN A stated, I never recorded on them. I only signed out the meds on the MAR and report to the day nurse (assigned to COVID Unit) what I did. The facility provided copies of the actual hours worked on each unit from [DATE] to [DATE] for review. The schedules reflect either a blank or dashes in for the name of the North Nurse (COVID Unit) assigned on the following dates: [DATE] to [DATE], [DATE] to [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE]. The record reflected that there was no nurse assigned for 25 of 42 days. On [DATE] to [DATE], [DATE], [DATE], and [DATE] only one CNA was assigned to care for all the residents on the COVID Unit despite resident care plans reflecting the need for 2 staff assistance required for ADL's (activities of daily living). Review of Resident #5's [DATE] MAR and TAR revealed the following: -Pain assessment signature blocks for NOC (night shift) on [DATE], [DATE], and [DATE] were blank (reflecting assessments were not performed). - Monitoring for side effects of medications (e.g. flushing, blurred vision, dry mouth, altered mental statues, irregular heartbeat, etc.) signature blocks for NOC on [DATE], [DATE] and [DATE] were blank. -Initials in the signature block indicated staff provided the treatment to the resident. Therefore, lack of initials indicated staff did not provide the treatment to the resident. The facility provided a copy of education that was provided to the nursing staff on [DATE]. The education reflected, 1) The key to the medication cart on the COVID hall is NEVER to be left on top of the medication cart. The key should always remain with the nurse. If there is not a night nurse on schedule, then the day shift nurse needs to return the key to the South hall night shift nurse. 2) The controlled medications need to be counted at the end of each shift, just as we do on every other unit in the building. If there is not another nurse to count with, you still need to count. The narcotic count sheet will be placed in the front of the narcotic book on the COVID hall. The surveyors requested the shift to shift narcotic count (with two nurses) from the date the COVID Unit reopened on [DATE] to [DATE]. The facility was only able to locate the records from [DATE] to [DATE]. There were 6 days ([DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]) when there was not a shift to shift count done by an oncoming and an off going nurse. The record reflected missing nursing signatures for 6 of 41 days. During a telephone interview on [DATE] at 1:30 PM, when asked how many shifts from [DATE] to [DATE] were not staffed with a nurse, and the NHA (Nursing Home Administrator) stated, I'll have to get back with you on that. The NHA stated that there were always 2 CNA's scheduled when there was not a nurse assigned. The NHA sent a written response to the question via email on [DATE] at 11:00 AM. The NHA response reflected, Regarding the nurse shifts the COVID unit ([DATE] - current) - The only uncovered shift was the evening of [DATE] in which the nurse refused, due to personal reasons, to enter the COVID unit. All CNAs are trained to identify, report and document an applicable change in condition in residents. The facility utilizes various tools to assist in this process including the use of (name of assessment tools) in (name of computer program). As soon as the facility identified there was a concern with the nurse refusing to enter the COVID unit,

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F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 8) the facility provided all nurses re-education and instruction to enter the COVID unit as the need were to arise. The facility plan was effective as evidenced by other nurses entering the unit as the need arose. The facility failed to appropriately delegate nursing responsibilities to assess, monitor, and report changes in condition to the physicians for the residents that resided on the COVID Unit on the night shifts. A resignation letter from CCC V, dated [DATE], written to the DON was reviewed. The letter reflected the following reasons for resigning, I fear at this time my nursing license is in jeopardy due to poor patient care, safety risk factors, staffing issues, and unrealistic workload all related to the COVID unit . During a telephone interview [DATE] at 10:30 AM, CCC V stated, I resigned on ,[DATE] (2020). I was asked what needed to change to stay and I said ,[DATE] nursing coverage (on COVID Unit) and adequate CNA coverage for 2 people assists. CCC V stated, Everything got put on the day nurses, it is too much. I didn't rescind my notice. They said they have everything covered and they don't. A resignation letter from the DON, dated [DATE] written to the NHA was reviewed. The letter reflected the following reasons for resigning, Unfortunately, due to the increased work responsibility, increased staffing concerns, and new and ongoing challenges of COVID-19, I have decided that it is time for me to step down as Director of Nursing . During a telephone interview on [DATE] at 1:03 PM, RN H stated that she worked full time day shift on the COVID Unit working 12-hour shifts. When asked about the staffing on the midnight shift and who would take over for her after her shift, RN H stated, No one. I had many, many sleepless nights worrying. That's not okay. RN H stated, I can't physically do it for 16 hours in a N-95. I can barely do it for 12 hours. During a telephone interview on [DATE] at approximately 3:00 PM, LPN Y stated that she worked full time on the day shift on the COVID Unit working 12-hour shifts. When asked about the staffing on midnight shifts, LPN Y stated, I was having heart palpations before coming into work. It was so stressful knowing no one was on the night shift. Resident #4 A review of Resident #4's Admission Record, dated [DATE], revealed Resident #4 was a [AGE] year-old resident admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. A review of Resident #4's [DATE] Treatment Administration Record (TAR) revealed the following: - Maintain isolation for droplet precautions R/T (related to) covid-19. All services to be provided in room every shift signature block blank for [DATE] on the NOC (night) shift. - Maintain isolation for droplet precautions R/T covid-19. All services to be provided in room every shift on the NOC shift- Licensed Practical Nurse (LPN) A's initials for doing check on [DATE] and [DATE]. However, LPN A stated she does not go on the COVID unit to provide care (see statements below). A review of Resident #4's [DATE] Medication Administration Record (MAR) revealed the following: - Monitoring for side effects of medications (e.g. flushing, blurred irregular heart beat/pulse, palpitations, lightheadedness, shortness of breath, excessive sweating, chest/arm pain, increased blood pressure, weight gain, agitation, distress) signature block was blank for [DATE] on the NOC shift. - Flush for intermittent infusion 10 ml (milliliters) NS (normal saline) before and after medication followed with 3 ml 10 units/ml (units per milliliter) [MEDICATION NAME] every 6 hours for [MEDICATION NAME] signature blocks were blank on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE] for the midnight (0000) time. - Meropenem (an antibiotic) 500 mg (milligrams) signature block was blank on [DATE] for the midnight (0000) dose. Resident #6 A review of Resident #6's Admission Record, dated [DATE], revealed Resident #6 was a [AGE] year-old resident admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. A review of Resident #6's [DATE] Treatment Administration Record (TAR) revealed the following: - Maintain isolation for droplet precautions R/T covid-19. All services to be provided in room every shift signature block blank on [DATE] for NOC shift. - Maintain isolation for droplet precautions R/T covid-19. All services to be provided in room every shift for NOC shift- LPN A's initials for doing check on [DATE], [DATE], and [DATE]. However, LPN A stated she does not go on the COVID unit to provide care (see statement. A review of Resident #6's [DATE] Treatment Administration Record (TAR) revealed the following: - Maintain isolation for droplet precautions R/T covid-19. All services to be provided in room every shift signature block blank on [DATE] for NOC shift. A review of Resident #4's [DATE] Medication Administration Record (MAR) revealed the following: - Monitor laceration to right upper lip for healing and signs/symptoms of infection for NOC shift- LPN A's initials for doing the check on [DATE], [DATE], and [DATE]. However, LPN A stated she does not go on the COVID unit to provide care. - Monitor laceration to right upper lip for healing and signs/symptoms of infection signature block was blank for [DATE], [DATE], [DATE], and [DATE] on the NOC shift. - Medication side effect monitoring- LPN A's initials for doing the check on [DATE], [DATE], & [DATE]. However, LPN A stated she does not go on the COVID unit to provide care. - Medication side effect monitoring signature block was blank on [DATE], [DATE], [DATE], and [DATE]- for the NOC shift. A review of Resident #4's [DATE] Medication Administration Record (MAR) revealed the following: - Monitor laceration to right upper lip for healing and signs/symptoms of infection signature block was blank on [DATE] for the NOC shift. - Medication side effect monitoring signature block was blank on [DATE] for the NOC shift. - Check PVR (post void residual- amount of urine still in the bladder after the resident urinated) signature block was blank on [DATE] for 2300. - Check PVR signature block was blank on [DATE] for 0300. During an interview on [DATE] at 7:15 AM, the Director of Nursing (DON) stated they (the facility) was aware of concerns with the staff. The DON stated she was aware of issues with the nurses not wanting to work on the COVID unit. She stated the nurses did not want to go onto the COVID unit at night unless they had to be down there. She stated because of this, the facility had worked with the care providers to change medication administration times so that the majority of medications (especially those given only once a day) were scheduled to be given during the first 12 hours of the day. That way there would be a minimum amount of medications that had to be given during the night shift on the COVID unit. During an interview on [DATE] at 7:15 AM, the DON stated one night ([DATE]) a resident on the COVID unit requested a pain medication and Licensed Practical Nurse (LPN) A had an aide (later discovered to be certified nursing assistant (CNA) J) bring the resident and the medication cart to the plastic barrier that separated the COVID unit from the rest of the facility because she (LPN A) did not want to physically go on the COVID unit. She stated the nurse (LPN A) watched the aide open the medication cart, remove the medication (a narcotic) from the medication cart, LPN A verified the medication and the dosage, and the aide administered the medication to the resident while the nurse watched. The DON stated she had written the nurse (LPN A) up for having the aide give the narcotic to a resident. She stated when the incident occurred, the facility was short a night nurse and there was not a nurse that was specifically assigned only to the COVID unit. The DON stated there was a dedicated aide that worked the COVID unit and a nurse would cover the COVID unit that also worked on a non-COVID unit. A review of the DON's e-mail, dated [DATE], revealed the DON was aware LPN A has made it very clear she is not willing to jeopardize her health by working the COVID unit. A review of LPN A's written statement, dated [DATE],
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake MI 249. Based on interview and record review, the facility failed to thoroughly investigate a neglect allegation to the abuse coordinator and or the State Agency for eight Residents and prevent abuse for seven Residents (#1, #2, #3, #8, #4, #5, and #6) out of seven residents reviewed for abuse and neglect reporting and with the potential to affect all residents on the COVID unit. This deficient practice resulted in management staff not reporting allegations of abuse and neglect with the potential for ongoing abuse and neglect to occur. Findings include: Resident #1 According to the Minimum Data Set (MDS) Assessment, dated [DATE], Resident #1 admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. This same assessment indicated Resident #1 was moderately cognitively impaired and required extensive assistance of one person for moving in bed, dressing, eating, and hygiene needs including bathing and using the toilet. Resident #1's Admission Record, dated [DATE], indicated Resident #1 was diagnosed with [REDACTED]. At the time of the survey, Resident #1 no longer resided at the facility. During an interview on [DATE] at 12:30 PM, Confidential Management Staff AA stated that Administrative staff (Director of Nursing and Administrator) were aware that there was no nurse scheduled to work the COVID unit and that Resident #1 was ordered [MEDICATION NAME] (a medication for anxiety) every four hours and there was no staff scheduled to give that medication on [DATE]. Review of Resident #1's [DATE] Medication Administration Record revealed on [DATE] at midnight and 4:00 AM, Resident #1 did not receive scheduled doses of [MEDICATION NAME] (ordered every four hours around the clock). The checkboxes for those administration times were signed out by the Director of Nursing (DON) and coded as a 5 guiding the reader to the progress notes. Review of Resident #1's progress notes revealed a late entry on [DATE] entered at 7:07 and 7:09 AM, authored by the DON, indicating [MEDICATION NAME] was held at midnight and 4:00 AM due to patient resting. No s/sx (signs or symptoms) of pain or anxiety noted. Doc (doctor) aware. Medication held. However, during an interview on [DATE] at 3:09 PM, the DON stated she was not in the facility during the ordered medication administration times and that she did not assess the resident for the medication need. There were no progress notes indicating Resident #1 had any nursing assessment between 9:01 PM on [DATE] until the

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F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 9) DON entered the progress notes at 7:05 AM on [DATE] thus there is no way to identify how the resident tolerated the night without the ordered antianxiety medications. During that same interview on [DATE], the DON stated she had entered Resident #1's progress notes on [DATE] at 7:05 and 7:07 AM from home and had not completed a physical assessment of the resident at those times either. Review of Resident #1's May and [DATE] Medication and Treatment Administration Record revealed multiple unsigned treatments and medications indicating Resident #1 did not receive care and services as ordered by the physician. This surveyor requested, on [DATE] at 3:38 PM and on [DATE] at 12:02 PM, incident and accident reports with investigations for Resident #1 since [DATE], the facility did not provide any by the end of the survey. The facility did not report Resident #1 missing multiple medications and treatments. Resident #3 According to the MDS Assessment, dated [DATE], Resident #3 admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. This same assessment indicated Resident #3 was cognitively intact and required extensive assistance of two staff members for moving in bed, transferring, dressing, and hygiene needs including using the bathroom. During an interview and observation on [DATE] at 5:35 AM, Resident #3 was awake and lying in bed. When asked about his feeding tube (G tube), Resident #3 stated that it was infected and that he was on an antibiotic. Resident #3 pulled the covers away from his abdomen and revealed a G tube covered with an undated dry dressing. According to Resident #3's hospital records history and physical, dated [DATE], Resident #3 had a gastric tube (G tube) (feeding tube inserted directly into the stomach) that was surgically placed on [DATE] (19 days prior to Resident #3's admission to the facility). A physician note, dated [DATE], revealed Resident #3 had an infection around the G tube site. The doctor ordered an antibiotic and Resident #3 started it that same day. Review of Resident #3's progress notes beginning [DATE] to [DATE] revealed two assessments of this surgical site. A progress note, dated [DATE], revealed Resident #3 complained about his G tube, and the nurse reported no changes or issues noted. The other assessment, dated [DATE], indicated the site was clean and changed. No other nursing assessments regarding the surgical site, prior to the infection identified on [DATE], was provided by the end of this survey. During an interview on [DATE] at 11:48 AM, when this Surveyor asked the Director of Nursing (DON) about documentation on a new surgical site, specifically Resident #3's gastric tube insertion site, the DON stated staff chart by exception (i.e. the nurses only document negative assessment findings). It should be noted that daily progress notes had normal findings recorded for other areas of assessment i.e. lung sounds, bowel sounds, etc. The DON referred to a Weekly Skin Sweep, dated [DATE], and stated that is where she would expect to find concerns related to the G tube. This document indicted Resident #3 had intact skin and did not indicate Resident #3 had a surgical site. During an interview on [DATE] at 11:48 AM, Clinical Care Coordinator (CCC) P stated that Resident #3 missed an appointment on [DATE] to have the fasteners removed from the G tube. During a follow up interview on [DATE] at 12:43 PM, CCC P reported the missed appointment contributed to the infection that occurred and that the G tube site looked horrible and did not look like staff had cleaned it. This was not reported to the State Agency nor did the facility initiate an investigation. During a telephone interview on [DATE] at 2:20 PM, CNA J stated on [DATE] she was working the midnight shift on the COVID Hall for the first time. CNA J states that she was the only staff member assigned and working the COVID Unit and there was no nurse assigned to that hall. CNA J stated that she had given Resident #3 pain medication by mouth as no nurse was assigned to the COVID hall. Review of physician orders, dated [DATE], revealed Resident #3 had Tylenol ordered to be given via G tube every six hours for pain. During a follow up interview on [DATE] at 9:20 AM, CNA J clarified that she had given Resident #3 liquid Tylenol via syringe into the mouth and that she was uncomfortable doing it. CNA J denied the facility talking to her regarding this matter in the last couple of days despite notification to the DON of this event on [DATE] at 3:09 PM by this surveyor. There was no incident report or facility investigation received by the end of this survey despite requests by this surveyor on [DATE] at 11:48 AM, [DATE] at 3:09 PM, and [DATE] at 1:34 PM (six days after this surveyor notified the DON). Review of Resident #3's [DATE] Medication and Treatment Administration Record revealed multiple unsigned treatments and medications indicating Resident #3 did not receive care and services as ordered by the physician. This surveyor requested, on [DATE] at 3:38 PM and on [DATE] at 12:02 PM, incident and accident reports with investigations for Resident #3 since [DATE], the facility did not provide any by the end of the survey. The facility did not report Resident #3 missing multiple medications and treatments. Resident #8 According to the MDS Assessment, dated [DATE], Resident #8 admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. This same assessment indicated Resident #8 cognitively intact and required extensive assistance of two staff members for moving in bed, transferring, dressing, and other hygiene needs including using the bathroom. At the time of the survey, Resident #8 no longer resided at the facility. A reasonable person would expect to receive physician ordered care and assessments by qualified staff. During an interview on [DATE] at 9:14 PM, Certified Nursing Assistant (CNA) K reported working with Resident #8 on [DATE] during the night shift. CNA K reported working with CNA O when Resident #8 had difficulty breathing. CNA K reported that she and CNA O laid Resident #8 down to assist with changing him and he coughed up a loogie. CNA's O and K sat Resident #8 upright and Resident #8 began to chocking and gagging on it. CNA K reported that Resident #8's oxygen was low, heart rate was elevated, and had increased anxiety. CNA K stated, Our nurse (RN N) came in for shift but never came on the (COVID) unit, I called to tell her what was going on and I was put on hold. CNA K reported giving the phone to CNA O and going to the utility room to obtain an oxygen concentrator; then CNA K placed oxygen on Resident #8 per nasal canula. During an interview on [DATE] at 10:10 AM, CNA O stated that often times she has worked the COVID unit with no nurse assigned and that there was no nurse for the COVID unit on [DATE] around 10:00 or 11:00 PM when Resident #8 had trouble breathing. During an interview on [DATE] at 10:10 AM, CNA O stated that the COVID unit needed a nurse assigned every night and that when we (CNA's) can't get ahold of a nurse, we have to take problems into our own hands, we can't let people not breathe. An interview with Registered Nurse (RN) N on [DATE] at 9:35 AM revealed RN N was assigned to the COVID unit the night of [DATE] but upon arrival to work that day at 6:30 PM, she was reassigned to work another unit. RN N stated, There was no nurse to work the COVID unit and that she had not entered the COVID unit until receiving the call from the CNA's regarding Resident #8. RN N reported CNA K had initiated the oxygen for Resident #8 without RN N's direction and that when RN N arrived and assessed Resident #8, he required transfer to the emergency room , Resident #8 died en route to the hospital. Resident #8's progress notes, dated [DATE], revealed at 10:43 PM the facility received an order to transfer Resident #8 to the emergency room and that documents were faxed to hospital at approximately 11:00 PM. (No nurse was on the COVID unit from the time day shift nurse left until this episode occurred- approximately 4 hours.) During a follow up interview on [DATE] at 3:09 PM, the Director of Nursing (DON), stated that she was aware that there was no nurse assigned to Resident #8 for four hours on [DATE] and that she was not aware the CNA's had initiated oxygen. The DON indicated that she felt there was no problem with CNA's initiating oxygen as CNA's put oxygen on residents already receiving oxygen. The DON further stated that the CNA's could assess resident needs and report those to nursing staff. The DON stated she was also available by phone if CNA's required assistance but also stated that she had been shutting her phone off when she is not on call. The DON failed to acknowledge that a CNA performed outside their scope of practice when assessing and initiating a PRN (as needed) physician order [REDACTED]. Review of Resident #8's May and [DATE] Medication and Treatment Administration Record revealed multiple unsigned treatments and medications indicating Resident #8 did not receive care and services as ordered by the physician. The facility did not report or perform an investigation regarding Resident #8's missing multiple medications and treatments. During an interview on [DATE] at 10:00 AM, LPN Y stated that the facility did not schedule licensed nurses most night on the COVID unit and that during those times residents went without (nursing) assessments for those 12 hours. LPN Y stated that the south hall nurse was not allowed on the COVID unit and that most often there was only one Certified Nursing Assistant (CNA) scheduled on the COVID unit during midnight shift despite multiple two assist residents. During an interview on [DATE] at 3:09 PM, the Director of Nursing (DON) stated she had talked with the Administrator and corporate staff regarding safety issues with lack of staff (nurses) approximately three weeks earlier. The DON stated she could not do anything about the lack of nurses and listed changes she had already made including limiting admissions but then reported she had 15 admissions in 15 days, and changing medication administration times to day shift. The DON revealed that staff were very open regarding lack of staffing (licensed nurses on the COVID unit). When asked about Resident #8, the DON stated, all staff are burnt out and I don't know how to fix this (staffing concerns). A request was made at this time of audits and investigations the DON reportedly completed for identified deficiencies. No audits or additional investigations were provided by the end of the survey. When asked what would constitute neglect the DON stated, not providing adequate care and withholding services. During an interview on [DATE] at 1:34 PM, the Administrator (NHA) stated that she was aware of staffing concerns on the COVID unit. The NHA stated it was challenging getting staff to work that unit. The NHA stated that the CNA's took care of the resident needs when there was not a nurse assigned and that this sounds terrible and does not look good on paper. It was reported that there were CNA's scheduled to work when there was no nurse scheduled and that the CNA's were qualified to assess and monitor resident health

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F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 10) status and needs. The NHA stated that the facility continued to admit residents to the COVID unit despite not having licensed nurses scheduled for midnight shifts on the COVID unit. When asked what would constitute neglect, the NHA stated, intentional failure to provide goods and services. Additional requests for audits and incident reports were made at this time and not provided by the end of the survey. Resident #2 Review of the Face Sheet and Minimum Data Set (MDS) note dated [DATE] revealed Resident #2 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Resident #2 required the assistance of 2 staff for bed mobility and ,[DATE] for all other activities of daily living. The Brief Interview for Mental Status (BIMS), reflected a score of 10 out of 15 which represents Resident #2 had moderate cognitive impairment. Resident #5 Review of the Face Sheet and Minimum Data Set (MDS), dated [DATE], revealed Resident #5 was readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Resident #5 required the assistance of 2 staff for bed mobility and 1 to 2 for all other activities of daily living. The Brief Interview for Mental Status (BIMS), reflected a score of 0 out of 15 which represents Resident #5 had severe cognitive impairment. The facility provided a copy of a Corrective Action Form dated [DATE]. The form reflected that certified nursing assistant (CNA) J was given a final written warning for administering medication to a resident for a nurse on [DATE]. During a telephone interview on [DATE] at 2:20 PM, CNA J stated on [DATE] she was working the midnight shift on the COVID Hall for the first time. CNA J states that she was the only staff member assigned and working the COVID Unit and there was no nurse assigned to that hall. CNA J stated that at approximately 5:30 AM, she observed Resident #2 on the floor in his room. CNA J stated that she notified Licensed Practical Nurse (LPN) A about Resident #2's fall and she (LPN A) called the Director of Nursing (DON), 2 of the Clinical Care Coordinators (CCC's), and the morning nurse to see if anyone could come in. When asked what she did next CNA J stated, I tried to get him up, but I couldn't. I took his vital signs and stayed with him. CNA J stated that she didn't see the day nurse until she came in after 6:15 AM. CNA J stated that she later learned that Resident #2 was legally blind and that the staff was not informed of that prior to taking shift. CNA J stated that she told LPN A that Resident #3 (another resident) complained of pain and asked for Tylenol. CNA J stated that LPN A asked CNA J to bring the medication cart to the plastic barrier wall (non-transparent sheet of plastic), get into the medication cart and retrieve a medication for Resident #3 and Resident #5 (a routine medication). CNA J stated LPN A had her hold up the cards and told her which tablet to give to each resident. When asked if either of the medications were in a double locked drawer, CNA J stated, No, just one key opened the cart. According to the facility policy for controlled substances, all controlled substances shall be maintained under a two-lock system. CNA J stated she had two medication cups. She gave Resident #5 (who was closest to the door) his medication and Resident #3 (who was in the same room but next to the window) his medication. CNA J stated that LPN A could not see her administer the medication to Resident #3 because he was in his bed next to the window. The facility provided a copy of a Corrective Action Form, dated [DATE]. The form reflected that LPN A directed CNA J to pass medication and waited for the oncoming day nurse to assess a resident after a fall instead of entering the COVID Unit and assessing the resident timely on [DATE]. A review of Resident #5's physician orders [REDACTED]. During a telephone interview on [DATE] at 9:13 AM, LPN A stated no one was assigned to the COVID Unit on the midnight shift of [DATE]. LPN A stated she was assigned to the South Unit that evening and no nurse was assigned to the COVID Unit. LPN A stated that she was unable to work the COVID Unit due to health reasons and the facility scheduler and administration knew that. LPN A stated that CNA J informed her of Resident #2's fall on [DATE] at approximately 5:30 AM and she called the DON, 2 of the CCC's and the oncoming day nurse to have someone come in and have him assessed. LPN A stated that the day nurse arrived at 6:15 AM and when they attempted to move him, he had guarding and reported pain to his hip, so they sent him to the hospital. LPN A stated that she received a write up for not responding to the fall timely and for asking a CNA to pass medication. LPN A stated that she felt it was unjustified and wrote a response on the written warning. LPN A stated she worked only 2 to 3 midnight shifts per week and there was no nurse assigned to the COVID unit the nights that she had worked. CNA J told her that a resident was in pain, had her get the keys from the top of the medication cart, and directed her what medication to give. LPN A stated the medication, including the controlled substance, were kept under one key and not a double lock system as the facility policy reflects. When asked who would sign the MAR (medication administration record) or TAR (treatment administration record), LPN A stated, I would, or no one would. Maybe the day nurse. When asked who would assess for pain, give routine scheduled pain meds, and monitor for signs and symptoms of medication side effects, LPN A stated, I would or leave it blank. Most residents didn't have routine meds (medications). When asked how she recorded the narcotics on the count down sheet and the shift to shift narcotic count, LPN A stated, I never recorded on them. I only signed out the meds on the MAR and report to the day nurse (assigned to COVID Unit) what I did. The facility provided copies of the actual hours worked on each unit from [DATE] to [DATE] for review. The schedules reflect either a blank or dashes in for the name of the North Nurse (COVID Unit) assigned on the following dates: [DATE] to [DATE], [DATE] to [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE]. The record reflected that there was no nurse assigned for 25 of 42 days. On [DATE] to [DATE], [DATE], [DATE], and [DATE] only one CNA was assigned to care for all the residents on the COVID Unit despite resident care plans reflecting the need for 2 staff assistance required for ADL's (activities of daily living). Review of Resident #5's [DATE] MAR and TAR revealed the following: -Pain assessment signature blocks for NOC (night shift) on [DATE], [DATE], and [DATE] were blank (reflecting assessments were not performed). - Monitoring for side effects of medications (e.g. flushing, blurred vision, dry mouth, altered mental statues, irregular heartbeat, etc.) signature blocks for NOC on [DATE], [DATE] and [DATE] were blank. -Initials in the signature block indicated staff provided the treatment to the resident. Therefore, lack of initials indicated staff did not provide the treatment to the resident. The facility provided a copy of education that was provided to the nursing staff on [DATE]. The education reflected, 1) The key to the medication cart on the COVID hall is NEVER to be left on top of the medication cart. The key should always remain with the nurse. If there is not a night nurse on schedule, then the day shift nurse needs to return the key to the South hall night shift nurse. 2) The controlled medications need to be counted at the end of each shift, just as we do on every other unit in the building. If there is not another nurse to count with, you still need to count. The narcotic count sheet will be placed in the front of the narcotic book on the COVID hall. The surveyors requested the shift to shift narcotic count (with two nurses) from the date the COVID Unit reopened on [DATE] to [DATE]. The facility was only able to locate the records from [DATE] to [DATE]. There were 6 days ([DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]) when there was not a shift to shift count done by an oncoming and an off going nurse. The record reflected missing nursing signatures for 6 of 41 days. During a telephone interview on [DATE] at 1:30 PM, when asked how many shifts from [DATE] to [DATE] were not staffed with a nurse, and the NHA (Nursing Home Administrator) stated, I'll have to get back with you on that. The NHA stated that there were always 2 CNA's scheduled when there was not a nurse assigned. The NHA sent a written response to the question via email on [DATE] at 11:00 AM. The NHA response reflected, Regarding the nurse shifts the COVID unit ([DATE] - current) - The only uncovered shift was the evening of [DATE] in which the nurse refused, due to personal reasons, to enter the COVID unit. All CNAs are trained to identify, report and document an applicable change in condition in residents. The facility utilizes various tools to assist in this process including the use of (name of assessment tools) in (name of computer program). As soon as the facility identified there was a concern with the nurse refusing to enter the COVID unit, the facility provided all nurses re-education and instruction to enter the COVID unit as the need were to arise. The facility plan was effective as evidenced by other nurses entering the unit as the need arose. The facility failed to appropriately delegate nursing responsibilities to assess, monitor, and report changes in condition to the physicians for the residents that resided on the COVID Unit on the night shifts. A resignation letter from CCC V, dated [DATE], written to the DON was reviewed. The letter reflected the following reasons for resigning, I fear at this time my nursing license is in jeopardy due to poor patient care, safety risk factors, staffing issues, and unrealistic workload all related to the COVID unit . During a telephone interview [DATE] at 10:30 AM, CCC V stated, I resigned on ,[DATE] (2020). I was asked what needed to change to stay and I said ,[DATE] nursing coverage (on COVID Unit) and adequate CNA coverage for 2 people assists. CCC V stated, Everything got put on the day nurses, it is too much. I didn't rescind my notice. They said they have everything covered and they don't. A resignation letter from the DON, dated [DATE] written to the NHA was reviewed. The letter reflected the following reasons for resigning, Unfortunately, due to the increased work responsibility, increased staffing concerns, and new and ongoing challenges of COVID-19, I have decided that it is time for me to step down as Director of Nursing . During a telephone interview on [DATE] at 1:03 PM, RN H stated that she worked full time day shift on the COVID Unit working 12-hour shifts. When asked about the staffing on the midnight shift and who would take over for her after her shift, RN H stated, No one. I had many, many sleepless nights worrying. That's not okay. RN H stated, I can't physically do it for 16 hours in a N-95. I can barely do it for 12 hours. During a telephone interview on [DATE] at

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F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 11) approximately 3:00 PM, LPN Y stated that she worked full time on the day shift on the COVID Unit working 12-hour shifts. When asked about the staffing on midnight shifts, LPN Y stated, I was having heart palpations before coming into work. It was so stressful knowing no one was on the night shift. Resident #4 A review of Resident #4's Admission Record, dated [DATE], revealed Resident #4 was a [AGE] year-old resident admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. A review of Resident #4's [DATE] Treatment Administration Record (TAR) revealed the following: - Maintain isolation for droplet precautions R/T (related to) covid-19. All services to be provided in room every shift signature block blank for [DATE] on the NOC (night) shift. - Maintain isolation for droplet precautions R/T covid-19. All services to be provided in room every shift on the NOC shift- Licensed Practical Nurse (LPN) A's initials for doing check on [DATE] and [DATE]. However, LPN A stated she does not go on the COVID unit to provide care (see statements below). A review of Resident #4's [DATE] Medication Administration Record (MAR) revealed the following: - Monitoring for side effects of medications (e.g. flushing, blurred irregular heart beat/pulse, palpitations, lightheadedness, shortness of breath, excessive sweating, chest/arm pain, increased blood pressure, weight gain, agitation, distress) signature block was blank for [DATE] on the NOC shift. - Flush for intermittent infusion 10 ml (milliliters) NS (normal saline) before and after medication followed with 3 ml 10 units/ml (units per milliliter) [MEDICATION NAME] every 6 hours for [MEDICATION NAME] signature blocks were blank on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE] for the midnight (0000) time. - Meropenem (an antibiotic) 500 mg (milligrams) signature block was blank on [DATE] for the midnight (0000) dose. Resident #6 A review of Resident #6's Admission Record, dated [DATE], revealed Resident #6 was a [AGE] year-old resident admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. A review of Resident #6's [DATE] Treatment Administration Record (TAR) revealed the following: - Maintain isolation for droplet precautions R/T covid-19. All services to be provided in room every shift signature block blank on [DATE] for NOC shift. - Maintain isolation for droplet precautions R/T covid-19. All services to be provided in room every shift for NOC shift- LPN A's initials for doing check on [DATE], [DATE], and [DATE]. However, LPN A stated she does not go on the COVID unit to provide care (see statement. A review of Resident #6's [DATE] Treatment Administration Record (TAR) revealed the following: - Maintain isolation for droplet precautions R/T covid-19. All services to be provided in room every shift signature block blank on [DATE] for NOC shift. A review of Resident #4's [DATE] Medication Administration Record (MAR) revealed the following: - Monitor laceration to right upper lip for healing and signs/symptoms of infection for NOC shift- LPN A's initials for doing the check on [DATE], [DATE], and [DATE]. However, LPN A stated she does not go on the COVID unit to provide care. - Monitor laceration to right upper lip for healing and signs/symptoms of infection signature block was blank for [DATE], [DATE], [DATE], and [DATE] on the NOC shift. - Medication side effect monitoring- LPN A's initials for doing the check on [DATE], [DATE], & [DATE]. However, LPN A stated she does not go on the COVID unit to provide care. - Medication side effect monitoring signature block was blank on [DATE], [DATE], [DATE], and [DATE]- for the NOC shift. A review of Resident #4's [DATE] Medication Administration Record (MAR) revealed the following: - Monitor laceration to right upper lip for healing and signs/symptoms of infection signature block was blank on [DATE] for the NOC shift. - Medication side effect monitoring signature block was blank on [DATE] for the NOC shift. - Check PVR (post void residual- amount of urine still in the bladder after the resident urinated) signature block was blank on [DATE] for 2300. - Check PVR signature block was blank on [DATE] for 0300. During an interview on [DATE] at 7:15 AM, the Director of Nursing (DON) stated they (the facility) was aware of concerns with the staff. The DON stated she was aware of issues with the nurses not wanting to work on the COVID unit. She stated the nurses did not want to go onto the COVID unit at night unless they had to be down there. She stated because of this, the facility had worked with the care providers to change medication administration times so that the majority of medications (especially those given only once a day) were scheduled to be given during the first 12 hours of the day. That way there would be a minimum amount of medications that had to be given during the night shift on the COVID unit. During an interview on [DATE] at 7:15 AM, the DON stated one night ([DATE]) a resident on the COVID unit requested a pain medication and Licensed Practical Nurse (LPN) A had an aide (later discovered to be certified nursing assistant (CNA) J) bring the resident and the medication cart to the plastic barrier that separated the COVID unit from the rest of the facility because she (LPN A) did not want to physically go on the COVID unit. She stated the nurse (LPN A) watched the aide open the medication cart, remove the medication (a narcotic) from the medication cart, LPN A verified the medication and the dosage, and the aide administered the medication to the resident while the nurse watched. The DON stated she had written the nurse (LPN A) up for having the aide give the narcotic to a resident. She stated when the incident occurred, the facility was short a night nurse and there was not a nurse that was specifically assigned only to the COVID unit. The DON stated there was a dedicated aide that worked the COVID unit and a nurse would cover the COVID unit that also worked on a non-COVID unit. A review of the DON's e-mail, dated [DATE], revealed the DON was aware LPN A has made it very clear she is not willing to jeopardize her health by working the COVID unit.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake number MI 249. Based on interview and record review, the facility failed to develop and implement a care plan for two Residents (#3 and #5) out of four residents reviewed for care planned needs. This deficient practice resulted in the facility providing one staff to assist residents when the resident required the assistance of two staff. Findings include: Resident #3 According to the MDS Assessment, dated 6/5/20, Resident #3 admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. This same assessment indicated Resident #3 was cognitively intact and required extensive assistance of two staff members for moving in bed, transferring, dressing, and hygiene needs including using the bathroom. Review of Resident #3's Activities of Daily Living Care Plan, last review date of 6/18/20, revealed Resident #3 required assistance of two staff members, since 6/1/20, for transferring. Resident #5 Review of the Face Sheet and Minimum Data Set (MDS) note dated 6/4/20 revealed Resident #5 was readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Resident #5 required the assistance of 2 staff for bed mobility and 1-2 for all other activities of daily living. The Brief Interview for Mental Status (BIMS), reflected a score of 0 out of 15 which represents Resident #5 had severe cognitive impairment. The MDS reflected that Resident #5 was incontinent of bowel and bladder, required 2-person assistance with transferring in bed, dressing, toileting, and had impaired movement on the left side. According to the Activities of Daily Living Care Plan with an initiated date of 5/29/20 reflected, Resident #5 required the assistance of 2 people to reposition, turn and incontinence care while in bed. During a telephone interview on 6/23/20 at 1:30 PM, when asked how many shifts from 5/6- 6/23 were not staffed with a nurse, and the NHA stated, I'll have to get back with you on that. The NHA stated that there was always 2 CNA's scheduled when there was not a nurse assigned. The NHA sent a written response to the question via email on 6/24/20 at 11:00 AM. The NHA response reflected, Regarding the nurse shifts the COVID unit (May 6, 2020 - current) - The only uncovered shift was the evening of May 31, 2020 in which the nurse refused, due to personal reasons, to enter the COVID unit. All CNAs are trained to identify, report and document an applicable change in condition in residents. The facility utilizes various tools to assist in this process including the use of E-interact and Stop and Watch in POC. As soon as the facility identified there was a concern with the nurse refusing to enter the COVID unit, the facility provided all nurses re-education and instruction to enter the COVID unit as the need were to arise. The facility plan was effective as evidenced by other nurses entering the unit as the need arose. The facility failed to appropriately delegate nursing responsibilities to assess, monitor, and report changes in condition to the physicians for the residents that resided on the COVID Unit on the night shifts. The facility provided copies of the actual hours worked on each unit from 5/6/20 - 6/17/20 for review. The schedules reflect either a blank or dashes in for the name of the North Nurse (COVID Unit) assigned on the following dates: 5/6-5/16, 5/18-5/26, 5/30, 5/31, 6/6, 6/7, 6/8. The record reflected that there was no nurse assigned for 25 of 42 days. On 5/23-5/31, 6/6, 6/7, and 6/8 only one CNA was assigned to care for all the residents on the COVID Unit despite resident care plans reflecting the need for 2 staff assistance required for ADL's.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate treatment and care according to orders, resident's preferences and goals.**

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	235290	A. BUILDING _____ B. WING _____	06/24/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MISSION POINT NSG & PHY REHAB CTR OF GREENVILLE	828 E WASHINGTON ST GREENVILLE, MI 48838

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 12) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake number MI 249. This DPS statement contains two parts A and B: DPS A Based on interview and record review, the facility failed to follow physician orders [REDACTED].#1 and #3) out of eight residents reviewed for physician orders. This deficient practice resulted in Resident #1 receiving half doses of pain medication and Resident #3 not getting laboratory testing nor attending a physician appointment. Findings include: Resident #1 According to the Minimum Data Set (MDS) Assessment, dated 5/28/20, Resident #1 admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. This same assessment indicated Resident #1 was moderately cognitively impaired and required extensive assistance of one person for moving in bed, dressing, eating, and hygiene needs including bathing and using the toilet. An Admission Record dated, 6/17/20, indicated Resident #1 was diagnosed with [REDACTED]. Resident #1 no longer resided within the facility. During an interview on 6/18/20 at 1:21 PM, Licensed Practical Nurse (LPN) F stated that she was training under RN N the night of 6/10/20 and that night she (LPN F) had made a medication error by giving Resident #1 only 0.25 ml instead of 0.5 ml of [MEDICATION NAME] multiple times. LPN F stated the errors occurred when RN N had left the unit. LPN F reported she had told RN N about the medication error before the end of the shift and that RN N had crossed out the documentation error on the Resident #1's [MEDICATION NAME] daily sign out sheet (Controlled Drug Receipt/Record/Disposition Form). LPN F told Human Resource Director W the next day about the medication error and had requested a different trainer. Review of Physician orders, dated 6/10/20, Resident #1 was to receive 0.5 milliliters (ml) (10 mg) of [MEDICATION NAME] Solution 20 mg per ml every hour related to COVID-19. Review of Resident #1's Controlled Substance Proof-of-Use Record - [MEDICATION NAME], dated 6/9/20 to 6/11/20, indicated Licensed Practical Nurse (LPN) F signed out 0.25 ml (half of the physician ordered amount) of [MEDICATION NAME] on 6/10/20 at 2000, 2053, 2150, 2251 and on 6/11/20 at 0000. However, when compared to the administration times on the June 2020 Medication Administration Record [REDACTED]. Review of Resident #1's June 2020 Medication Administration Record [REDACTED]. The checkboxes for those administration times were signed out by the Director of Nursing (DON) and coded as a 5 guiding the reader to the progress notes. Review of Resident #1's progress notes revealed a late entry on 6/9/20 entered at 7:07 and 7:09 AM, authored by the DON, indicating [MEDICATION NAME] was held due to patient resting. No s/sx (signs or symptoms) of pain or anxiety noted. Doc (doctor) aware. Medication held. However, during an interview on 6/17/20 at 3:09 PM, the DON stated she was not in the facility during the ordered medication administration times and that she did not assess the resident for the medication need. The facility was asked for any incident reports related to Resident #1's medications. The Administrator replied via email on 6/24/20 at 11:00 AM, Regarding the concern with the June 10th [MEDICATION NAME] ([MEDICATION NAME])/[MEDICATION NAME] potential medication error - this also was not identified as a medication error; however, it was determined to be an error in documentation. The nurse provided the correct medication and correct dosage but signed out the wrong medication. The nurse corrected the error appropriately. There were no incident reports provided by the facility by the end of the survey. After asking multiple times regarding the medication error, the facility failed to recognize Resident #1 had received, on at least four separate occasions, half of the ordered dose of [MEDICATION NAME]. Review of facility policy Medication Administration-General Guidelines, revised January 2018, reads in part; Personnel authorized to administer medications do so only after they have been properly oriented to the facility's medication distribution system, Medications are administered in accordance with the written orders of the prescriber, The person who prepares the dose for administration is the person who administers the dose, and The nurse who administers the medication records the administration on the resident's MAR indicated [REDACTED]. This policy also describes a manner to triple check medications prior to administration: when the nurse selects the medication, when removing the medication from the container, and immediately after the dose is prepared. With each check, the preparer is to ensure the Five Rights: Right Resident, Right Drug, Right Dose, Right Route, and Right Time are followed. Resident #3 According to the MDS Assessment, dated 6/5/20, Resident #3 admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. This same assessment indicated Resident #3 was cognitively intact and required extensive assistance of two staff members for moving in bed, transferring, dressing, and hygiene needs including using the bathroom. Resident #3's hospital discharge records, dated 5/30/20, revealed Resident #3 had a scheduled appointment on 6/8/20 at 9:00 AM and was ordered laboratory blood tests including a basic metabolic panel, magnesium, and phosphorus with an expected completion date of 6/3/20. Resident #3's EMR (electronic medical record) indicated the ordered laboratory blood test was completed on 6/10/2020. Review of Resident #3's progress notes revealed no progress notes were entered for 6/8/20 indicating resident had attended an appointment. A progress note dated 6/9/2020 at 13:16 (1:16 PM) read, Late Entry: Note Text: Spoke with (name of facility) re (regarding): 3 stays (device to stabilize gastric tube while healing) that needed to be removed. Per (name of radiologist), the stays are usually removed 2 weeks following placement. Patient currently is being treated for [REDACTED]. Site is red and swollen, noted pus around top stay. Patient reports its panful with movement. Will notify (name of nurse practitioner) about removal. (sic) During an interview on 6/16/20 at 11:48 AM, the Director of Nursing (DON) stated that she was unaware that Resident #3 had missed an appointment. The DON called Clinical Care Coordinator (CCC) P to clarify surveyor findings. CCC P stated that Resident #3 missed an appointment on the 6/8/20 to remove the stays holding the gastric tube in place and that when the missed appointment was discovered, Resident #3 had developed an infection in the top stay. DPS B Based on interview and record review the facility failed to ensure timely assessments for 3 of 8 residents (Resident #2, #3, and #8) reviewed for timely assessments on the COVID Hall. This deficient practice resulted in a delay in assessment and treatment for [REDACTED].#3 who developed an infection, and Resident #8 who suffered breathing difficulties. Findings include Resident #3 According to the Minimum Data Set (MDS) Assessment, dated 6/5/20, Resident #3 admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. This same assessment indicated Resident #3 was cognitively intact and required extensive assistance of two staff members for moving in bed, transferring, dressing, and hygiene needs including using the bathroom. During an interview and observation on 6/15/20 at 5:35 AM, Resident #3 was awake and lying in bed. When asked about his feeding tube (G tube), Resident #3 stated that it was infected and that he was on an antibiotic. Resident #3 pulled the covers away from his abdomen and revealed a G tube covered with an undated dry dressing. According to Resident #3's hospital records history and physical, dated 5/29/20, and located within the EMR (electronic medical record), Resident #3 had a gastric tube (G tube) (feeding tube inserted directly into the stomach) that was surgically placed on 5/18/20 (19 days prior to Resident #3's admission to the facility). Review of Resident #3's progress notes, dated 5/30/20 to 6/8/20, revealed two assessments of this surgical site. A progress note, dated 6/3/20, revealed Resident #3 complained about his G tube, and the nurse reported no changes or issues noted. The other assessment, dated 6/7/20, indicated the site was clean and changed. During an interview on 6/16/20 at 11:48 AM, when this Surveyor asked the Director of Nursing (DON) about documentation on a new surgical site, specifically Resident #3's gastric tube insertion site, the DON stated staff chart by exception (i.e. the nurses only document negative assessment findings). It should be noted that daily progress notes had normal findings recorded for other areas of assessment i.e. lung sounds, bowels sounds, etc. The DON referred to a Weekly Skin Sweep, dated 6/6/20, and stated that is where she would expect to find concerns related to the G tube. Review of Weekly Skin Sweep, dated 6/6/20, revealed staff checked the box indicating None-Skin Intact for Resident #3. This Weekly Skin Sweep document included other options to select, including Surgical wound site, which was not checked. A Weekly Skin Sweep, dated 6/13/20, staff checked the box for None-Skin intact and did not indicate Resident #3 had a Surgical wound site. A physician note, dated 6/8/20, revealed Resident #3 had an infection around the G tube site. An antibiotic was ordered and started that same day. Nursing staff did not document an assessment of the G tube until the next day, 6/9/20, when staff completed a late entry progress note and an infection report. The Infection Report, dated 6/9/20, described the G tube site as being warm, red, with swelling, and having tenderness or pain. Staff failed to document assessment of a new surgical site until after development of an infection. A review of Clinical Nursing Skills and Techniques (Perry and Potter), dated 2014, revealed when caring for gastrostomy tube (G tube), nurses are to assess the exit site for evidence of excoriation, drainage, infection, or bleeding and document in nurses' notes and electronic health records appearance of exit site, drainage noted, and dressing application. (Chapter 31, page 794). A review of the nurses service organization (nso) website revealed, There are numerous variations to charting by exception. Virtually every facility that uses such a system does it differently. But the general rule is that only unusual or unexpected findings, or those outside the norm, are recorded. Charting by exception does not necessarily result in patient records that give an incomplete picture, but minimizing documentation is risky. Nurses' notes with few explanations, little description of key findings, or no mention of periodic patient checks could be construed as negligence by a plaintiff's attorney guided by the premise, not charted, not done. A lack of detail could compromise patient safety as well. A patient's medical record is expected to accurately reflect his current condition, and a chart that's missing pertinent

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 13) information could fail to alert other clinicians to potential problems or complications. (Charting by exception: the legal risks, 2018, https://www.nso.com/Learning/Artifacts/Articles/Charting-by-exception-the-legal-risks). Resident #8 According to the MDS Assessment, dated 5/30/20, Resident #8 admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. This same assessment indicated Resident #8 cognitively intact and required extensive assistance of two staff members for moving in bed, transferring, dressing, and other hygiene needs including using the bathroom. Resident #8 no longer resided in the facility. During an interview on 6/16/20 at 9:14 PM, Certified Nursing Assistant (CNA) K reported working with Resident #8 on 6/4/20 during the night shift. CNA K reported working with CNA O when Resident #8 had difficulty breathing. CNA K reported that she and CNA O laid Resident #8 down to assist with changing him and he coughed up a loogie. CNA's O and K sat Resident #8 upright and Resident #8 began chocking and gagging on it. CNA K reported that Resident #8's oxygen was low, heart rate was elevated, and Resident #8 had increased anxiety. CNA K stated, Our nurse (RN N) came in for shift but never came on the (COVID) unit, I called to tell her what was going on and I was put on hold. CNA K reported giving the phone to CNA O and going to the utility room to obtain an oxygen concentrator; then CNA K placed oxygen on Resident #8 per nasal canula. Resident #8 had a potential obstructed airway (loogie), oxygen placement may or may not have been the appropriate intervention as the CNA is not qualtified to assess lung sounds or respiratory status and determine the best intervention for the Resident's safety. During an interview on 6/17/20 at 10:10 AM, CNA O stated that often times she has worked the COVID unit with no nurse assigned and that there was no nurse for the COVID unit on 6/4/20 around 10:00 or 11:00 PM when Resident #8 had trouble breathing. CNA O reported she had called nurses in the building and that those nurses reported they were passing medications, she then called respiratory therapy and told them Resident #8's respiratory rate was 62 (normal 12-16 breaths per minute) they said it would be about 15 minutes before someone could get here. I told them he would be dead in 15 minutes. CNA O stated that the nurse had to come from the other side of the building and don PPE prior to entering the COVID unit that night (6/4/20). During an interview on 6/17/20 at 10:10 AM, CNA O stated that the COVID unit needed a nurse assigned every night and that when we (CNA's) can't get ahold of a nurse, we have to take problems into our own hands. We can't let people not breathe. An interview with Registered Nurse (RN) N on 6/17/20 at 9:35 AM revealed RN N was assigned to the COVID unit the night of 6/4/20. Upon arrival to work that day (6/4/20) at 6:30 PM, she was reassigned to work another unit. RN N stated, There was no nurse to work the COVID unit and that she had not entered the COVID unit until receiving the call from the CNA's regarding Resident #8. RN N reported CNA K had initiated the oxygen for Resident #8 without RN N's direction and that when RN N arrived and assessed Resident #8, he required transfer to the emergency room . Progress notes dated 6/4/20 revealed at 10:43 PM a progress note indicating the facility received an order to transfer Resident #8 to the emergency room and that documents were faxed to hospital at approximately 11:00 PM. (No nurse was on the COVID unit from the time day shift nurse left until this episode occurred- approximately 4 hours.) A review of Clinical Nursing Skills and Techniques (Perry and Potter), dated 2014, revealed, The skill of applying a nasal cannula or oxygen mask (not adjusting oxygen flow rate) can be delegated to nursing assistive personnel (CNA's). The nurse is responsible for the assessing the patient's respiratory system, response to oxygen therapy and setup of the oxygen therapy and liter flow, including the adjustment of oxygen flow rate. (Chapter 23, page 590-591). During a follow up interview on 6/17/20 at 3:09 PM, the Director of Nursing (DON), stated that she was aware that there was no nurse assigned to Resident #8 for four hours on 6/4/20 and that she was not aware the CNA's had initiated oxygen. The DON indicated that she felt there was no problem with CNA's initiating oxygen as CNA's put oxygen on residents already receiving oxygen. The DON further stated that the CNA's could assess resident needs and report those to nursing staff. The DON stated she was also available by phone if CNA's required assistance but also stated that she had been shutting her phone off when she is not on call. The DON failed to acknowledge that a CNA performed outside their scope of practice when assessing and initiating a PRN (as needed) physician order [REDACTED].> The facility provided the Falls Reduction Policy dated 2/02, last revised on 4/19 for review. The policy reflected, When any resident experiences a fall, the facility will: a. Assess the resident . Resident #2 Review of the Face Sheet and Minimum Data Set (MDS) note dated 5/29/20 revealed Resident #2 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Resident #2 required the assistance of 2 staff for bed mobility and 1-2 for all other activities of daily living. The Brief Interview for Mental Status (BIMS), reflected a score of 10 out of 15 which represents Resident #2 had moderate cognitive impairment. During a telephone interview on 6/15/20 at 2:20 PM, CNA J stated on 5/31/20 she was working the midnight shift on the COVID Hall for the first time. CNA J states that she was the only staff member assigned and working the COVID Unit and there was no nurse assigned to that hall. CNA J stated that at approximately 5:30 AM, she observed Resident #2 on the floor in his room. CNA J stated that she notified LPN A about Resident #2's fall and she (LPN A) called the DON, 2 of the CCC's, and the morning nurse to see if anyone could come in. When asked what she did next CNA J stated, I tried to get him up, but I couldn't. I took his vital signs and stayed with him. CNA J stated that she didn't see the day nurse until she came in after 6:15 AM. CNA J stated that she later learned that Resident #2 was legally blind and that the staff was not informed of that prior to taking shift. During a telephone interview on 6/16/20 at 9:13 AM, LPN A stated no one was assigned to the COVID unit on the midnight shift of 5/31. LPN A stated she was assigned to the South Unit that evening and no nurse was assigned to the COVID Unit. LPN A stated that she was unable to work the COVID Unit due to health reasons. LPN A stated that CNA J informed her of Resident #2's fall on 5/31/20 at approximately 5:30 AM and she called the DON, 2 of the CCC's and the oncoming day nurse to have someone come in and have him assessed. LPN A stated that the day nurse arrived at 6:15 AM and when they attempted to move him, he had guarding and reported pain to his hip, so they sent him to the hospital. During a telephone interview on 6/22/20 at 3:00 PM, LPN Y stated that she received a call from LPN A and asked her to come in early due to Resident #2's fall. LPN Y stated that she arrived at 6:10, donned her PPE, entered the COVID Unit and assessed Resident #2 at approximately 6:15 AM. LPN Y stated that after the staff attempted to stand Resident #2, he had complaints of hip pain and was later transferred to the hospital for further evaluation and treatment. LPN Y stated that Resident #2 returned to the facility at 1:30 PM and had no acute fractures. The facility failed to timely assess Resident #2 after he sustained a fall on 5/31/20 when he laid on the floor of his room and waited to be assessed by a nurse from 5:30 AM until 6:15 AM.
F 0725 **Level of harm** - Minimal harm or potential for actual harm **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 intake number MI 249. Based on observation, interview and record review, the facility failed to complete a facility assessment and deploy staff in sufficient numbers to meet resident needs according to the individualized care plans for 7 residents (Resident #1, #2, #3, #4, #5, #6 and #8) reviewed for staffing on the COVID Unit. This deficient practice resulted in lack of nursing assessments, mediation errors by underdosing and omission), medications dispensed by non-licensed staff, an untimely assessment after a fall, difficulty breathing, infection, and not carrying out physician orders. Findings include: The facility designated a unit for COVID residents by closing off an entire hallway within the building. Closed double fire doors secured the area and staff posted signage indicating it was a restricted area. After passing through the double doors, the first rooms across from each other staff used as a nursing station and the other room was a supply storage area. Past these rooms staff had placed an opaque plastic barrier leading to resident rooms and care areas. The plastic wall had a zippered opening staff used to enter and exit the quarantined area. The hallway space, vestibule between the double fire doors and plastic wall, staff used to don and doff (put on and take off) personal protective equipment (PPE). Staff observed on [DATE] at approximately 6:35 AM, donning a N-95 respirator, face shield, gown, foot covers, and gloves and performed hand hygiene appropriately, prior to entering the COVID unit through the zippered door. This surveyor was not able to visualize residents until entering the COVID unit and walking down the hallway. Resident #2 Review of the Face Sheet and Minimum Data Set (MDS) note dated [DATE] revealed Resident #2 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Resident #2 required the assistance of 2 staff for bed mobility and ,[DATE] for all other activities of daily living. The Brief Interview for Mental Status (BIMS), reflected a score of 10 out of 15 which represents Resident #2 had moderate cognitive impairment. Resident #5 Review of the Face Sheet and Minimum Data Set (MDS), dated [DATE], revealed Resident #5 was readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Resident #5 required the assistance of 2 staff for bed mobility and 1 to 2 for all other activities of daily living. The Brief Interview for Mental Status (BIMS), reflected a score of 0 out of 15 which represents Resident #5 had severe cognitive impairment. The facility provided a copy of a Corrective Action Form dated [DATE]. The form reflected that

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F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 14) certified nursing assistant (CNA) J was given a final written warning for administering medication to a resident for a nurse on [DATE]. During a telephone interview on [DATE] at 2:20 PM, CNA J stated on [DATE] she was working the midnight shift on the COVID Hall for the first time. CNA J states that she was the only staff member assigned and working the COVID Unit and there was no nurse assigned to that hall. CNA J stated that at approximately 5:30 AM, she observed Resident #2 on the floor in his room. CNA J stated that she notified Licensed Practical Nurse (LPN) A about Resident #2's fall and she (LPN A) called the Director of Nursing (DON), 2 of the Clinical Care Coordinators (CCC's), and the morning nurse to see if anyone could come in. When asked what she did next CNA J stated, I tried to get him up, but I couldn't. I took his vital signs and stayed with him. CNA J stated that she didn't see the day nurse until she came in after 6:15 AM. CNA J stated that she later learned that Resident #2 was legally blind and that the staff was not informed of that prior to taking shift. CNA J stated that she told LPN A that Resident #3 (another resident) complained of pain and asked for Tylenol. CNA J stated that LPN A asked CNA J to bring the medication cart to the plastic barrier wall (non-transparent sheet of plastic), get into the medication cart and retrieve a medication for Resident #3 and Resident #5 (a routine medication). CNA J stated LPN A had her hold up the cards and told her which tablet to give to each resident. When asked if either of the medications were in a double locked drawer, CNA J stated, No, just one key opened the cart. According to the facility policy for controlled substances, all controlled substances shall be maintained under a two-lock system. CNA J stated she had two medication cups. She gave Resident #5 (who was closest to the door) his medication and Resident #3 (who was in the same room but next to the window) his medication. CNA J stated that LPN A could not see her administer the medication to Resident #3 because he was in his bed next to the window. The facility provided a copy of a Corrective Action Form, dated [DATE]. The form reflected that LPN A directed CNA J to pass medication and waited for the oncoming day nurse to assess a resident after a fall instead of entering the COVID Unit and assessing the resident timely on [DATE]. A review of Resident #5's physician orders [REDACTED]. During a telephone interview on [DATE] at 9:13 AM, LPN A stated no one was assigned to the COVID Unit on the midnight shift of [DATE]. LPN A stated she was assigned to the South Unit that evening and no nurse was assigned to the COVID Unit. LPN A stated that she was unable to work the COVID Unit due to health reasons and the facility scheduler and administration knew that. LPN A stated that CNA J informed her of Resident #2's fall on [DATE] at approximately 5:30 AM and she called the DON, 2 of the CCC's and the oncoming day nurse to have someone come in and have him assessed. LPN A stated that the day nurse arrived at 6:15 AM and when they attempted to move him, he had guarding and reported pain to his hip, so they sent him to the hospital. LPN A stated that she received a write up for not responding to the fall timely and for asking a CNA to pass medication. LPN A stated that she felt it was unjustified and wrote a response on the written warning. LPN A stated she worked only 2 to 3 midnight shifts per week and there was no nurse assigned to the COVID unit the nights that she had worked. CNA J told her that a resident was in pain, had her get the keys from the top of the medication cart, and directed her what medication to give. LPN A stated the medication, including the controlled substance, were kept under one key and not a double lock system as the facility policy reflects. When asked who would sign the MAR (medication administration record) or TAR (treatment administration record), LPN A stated, I would, or no one would. Maybe the day nurse. When asked who would assess for pain, give routine scheduled pain meds, and monitor for signs and symptoms of medication side effects, LPN A stated, I would or leave it blank. Most residents didn't have routine meds (medications). When asked how she recorded the narcotics on the count down sheet and the shift to shift narcotic count, LPN A stated, I never recorded on them. I only signed out the meds on the MAR and report to the day nurse (assigned to COVID Unit) what I did. The facility provided copies of the actual hours worked on each unit from [DATE] to [DATE] for review. The schedules reflect either a blank or dashes in for the name of the North Nurse (COVID Unit) assigned on the following dates: [DATE] to [DATE], [DATE] to [DATE], [DATE], [DATE], [DATE], [DATE], [DATE]. The record reflected that there was no nurse assigned for 25 of 42 days. On [DATE] to [DATE], [DATE], [DATE], and [DATE] only one CNA was assigned to care for all the residents on the COVID Unit despite resident care plans reflecting the need for 2 staff assistance required for ADL's (activities of daily living). Review of Resident #5's [DATE] MAR and TAR revealed the following: -Pain assessment signature blocks for NOC (night shift) on [DATE], [DATE], and [DATE] were blank (reflecting assessments were not performed). -Monitoring for side effects of medications (e.g. flushing, blurred vision, dry mouth, altered mental statues, irregular heartbeat, etc.) signature blocks for NOC on [DATE], [DATE] and [DATE] were blank. -Initials in the signature block indicated staff provided the treatment to the resident. Therefore, lack of initials indicated staff did not provide the treatment to the resident. The facility provided a copy of education that was provided to the nursing staff on [DATE]. The education reflected, 1) The key to the medication cart on the COVID hall is NEVER to be left on top of the medication cart. The key should always remain with the nurse. If there is not a night nurse on schedule, then the day shift nurse needs to return the key to the South hall night shift nurse. 2) The controlled medications need to be counted at the end of each shift, just as we do on every other unit in the building. If there is not another nurse to count with, you still need to count. The narcotic count sheet will be placed in the front of the narcotic book on the COVID hall. The surveyors requested the shift to shift narcotic count (with two nurses) from the date the COVID Unit reopened on [DATE] to [DATE]. The facility was only able to locate the records from [DATE] to [DATE]. There were 6 days ([DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]) when there was not a shift to shift count done by an oncoming and an off going nurse. The record reflected missing nursing signatures for 6 of 41 days. During a telephone interview on [DATE] at 1:30 PM, when asked how many shifts from [DATE] to [DATE] were not staffed with a nurse, and the NHA (Nursing Home Administrator) stated, I'll have to get back with you on that. The NHA stated that there were always 2 CNA's scheduled when there was not a nurse assigned. The NHA sent a written response to the question via email on [DATE] at 11:00 AM. The NHA response reflected, Regarding the nurse shifts the COVID unit ([DATE] - current) - The only uncovered shift was the evening of [DATE] in which the nurse refused, due to personal reasons, to enter the COVID unit. All CNAs are trained to identify, report and document an applicable change in condition in residents. The facility utilizes various tools to assist in this process including the use of (name of assessment tools) in (name of computer program). As soon as the facility identified there was a concern with the nurse refusing to enter the COVID unit, the facility provided all nurses re-education and instruction to enter the COVID unit as the need were to arise. The facility plan was effective as evidenced by other nurses entering the unit as the need arose. The facility failed to appropriately delegate nursing responsibilities to assess, monitor, and report changes in condition to the physicians for the residents that resided on the COVID Unit on the night shifts. A resignation letter from CCC V, dated [DATE], written to the DON was reviewed. The letter reflected the following reasons for resigning, I fear at this time my nursing license is in jeopardy due to poor patient care, safety risk factors, staffing issues, and unrealistic workload all related to the COVID unit . During a telephone interview [DATE] at 10:30 AM, CCC V stated, I resigned on ,[DATE] (2020). I was asked what needed to change to stay and I said ,[DATE] nursing coverage (on COVID Unit) and adequate CNA coverage for 2 people assists. CCC V stated, Everything got put on the day nurses, it is too much. I didn't rescind my notice. They said they have everything covered and they don't. A resignation letter from the DON, dated [DATE] written to the NHA was reviewed. The letter reflected the following reasons for resigning, Unfortunately, due to the increased work responsibility, increased staffing concerns, and new and ongoing challenges of COVID-19, I have decided that it is time for me to step down as Director of Nursing . During a telephone interview on [DATE] at 1:03 PM, RN H stated that she worked full time day shift on the COVID Unit working 12-hour shifts. When asked about the staffing on the midnight shift and who would take over for her after her shift, RN H stated, No one. I had many, many sleepless nights worrying. That's not okay. RN H stated, I can't physically do it for 16 hours in a N-95. I can barely do it for 12 hours. During a telephone interview on [DATE] at approximately 3:00 PM, LPN Y stated that she worked full time on the day shift on the COVID Unit working 12-hour shifts. When asked about the staffing on midnight shifts, LPN Y stated, I was having heart palpations before coming into work. It was so stressful knowing no one was on the night shift. Resident #1 According to the Minimum Data Set (MDS) Assessment, dated [DATE], Resident #1 admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. This same assessment indicated Resident #1 was moderately cognitively impaired and required extensive assistance of one person for moving in bed, dressing, eating, and hygiene needs including bathing and using the toilet. Resident #1's Admission Record, dated [DATE], indicated Resident #1 was diagnosed with [REDACTED]. At the time of the survey, Resident #1 no longer resided at the facility. Review of Resident #1's [DATE] Medication Administration Record revealed on [DATE] at midnight and 4:00 AM, Resident #1 did not receive scheduled doses of [MEDICATION NAME] (a medication for anxiety ordered every four hours around the clock). The checkboxes for those administration times were signed out by the Director of Nursing (DON) and coded as a 5 guiding the reader to the progress notes. Review of Resident #1's progress notes revealed a late entry on [DATE] entered at 7:07 and 7:09 AM, authored by the

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 15) DON, indicating [MEDICATION NAME] was held at midnight and 4:00 AM due to patient resting. No s/sx (signs or symptoms) of pain or anxiety noted. Doc (doctor) aware. Medication held. However, during an interview on [DATE] at 3:09 PM, the DON stated she was not in the facility during the ordered medication administration times and that she did not assess the resident for the medication need. There were no progress notes indicating Resident #1 had any nursing assessment between 9:01 PM on [DATE] until the DON entered the progress notes at 7:05 AM on [DATE] thus there is no way to identify how the resident tolerated the night without the ordered antianxiety medications. During that same interview on [DATE], the DON stated she had entered Resident #1's progress notes on [DATE] at 7:05 and 7:07 AM from home and had not completed a physical assessment of the resident at those times either. Review of Resident #1's May and [DATE] Medication and Treatment Administration Record revealed no signatures indicating physician ordered medications, treatments, and/or assessments were not completed on multiple occasions. Resident #3 According to the MDS Assessment, dated [DATE], Resident #3 admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. This same assessment indicated Resident #3 was cognitively intact and required extensive assistance of two staff members for moving in bed, transferring, dressing, and hygiene needs including using the bathroom. During an interview and observation on [DATE] at 5:35 AM, Resident #3 was awake and lying in bed. When asked about his feeding tube (G tube), Resident #3 stated that it was infected and that he was on an antibiotic. Resident #3 pulled the covers away from his abdomen and revealed a G tube covered with an undated dry dressing. According to Resident #3's hospital records history and physical, dated [DATE], Resident #3 had a gastric tube (G tube) (feeding tube inserted directly into the stomach) that was surgically placed on [DATE] (19 days prior to Resident #3's admission to the facility). Review of Resident #3's progress notes beginning [DATE] to [DATE] revealed two assessments of this surgical site. A progress note, dated [DATE], revealed Resident #3 complained about his G tube, and the nurse reported no changes or issues noted. The other assessment, dated [DATE], indicated the site was clean and changed. During an interview on [DATE] at 11:48 AM, when this Surveyor asked the Director of Nursing (DON) about documentation on a new surgical site, specifically Resident #3's gastric tube insertion site, the DON stated staff chart by exception (i.e. the nurses only document negative assessment findings). It should be noted that daily progress notes had normal findings recorded for other areas of assessment i.e. lung sounds, bowel sounds, etc. The DON referred to a Weekly Skin Sweep, dated [DATE], and stated that is where she would expect to find concerns related to the G tube. A physician note, dated [DATE], revealed Resident #3 had an infection around the G tube site. The doctor ordered an antibiotic and Resident #3 started it that same day. During an interview on [DATE] at 12:43 PM, CCC P reported that the G tube site looked horrible and did not look like staff had cleaned it. During a telephone interview on [DATE] at 2:20 PM, CNA J stated on [DATE] she was working the midnight shift on the COVID Hall for the first time. CNA J states that she was the only staff member assigned and working the COVID Unit and there was no nurse assigned to that hall. CNA J stated that she told LPN A that Resident #3 complained of pain and asked for Tylenol. CNA J stated that LPN A asked CNA J to bring the medication cart to the plastic barrier wall (opaque sheet of plastic), get into the medication cart, retrieve a medication for Resident #3 and Resident #5. CNA J stated LPN A had her hold up the cards and told her which tablet to give to each resident. When asked if either of the medications were in a double locked drawer, CNA J stated, No, just one key opened the cart. CNA J stated she had two medication cups. She gave Resident #5 (who was closest to the door) his medication and Resident #3 (who was in the same room but next to the window) his medication. CNA J stated that LPN A could not see her administer the medication to Resident #3 because he was in his bed next to the window. LPN A did not enter the COVID unit (see written statement dated [DATE]) nor did she complete a pain assessment on Resident #3 prior to CNA J administering the pain medication. Review of physician orders, dated [DATE], revealed Resident #3 had Tylenol ordered to be given via G tube every six hours for pain. During a follow up interview on [DATE] at 9:20 AM, CNA J clarified that she had given Resident #3 liquid Tylenol via syringe into the mouth and that she was uncomfortable doing it. Review of Resident #3's [DATE] Medication and Treatment Administration Record revealed multiple unsigned treatments and medications indicating Resident #3 did not receive care and services as ordered by the physician. According to facility policy Pain Management, revised ,[DATE], staff assess resident pain, reassess for pain regularly for effectiveness and/or adverse consequences, and revise pain management as indicated. According to facility policy Medication Administration - General Guidelines, revised ,[DATE], medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medication do so only after they have been properly oriented to the facility's medication distribution system. The facility has sufficient staff and a medication distribution system to ensure safe administration of medications without unnecessary interruptions and medications are administered only by licensed nursing or medical personnel. According to the facility provided job description, Charge Nurse LPN, revised [DATE], Licensed Practical Nurses (LPN's) assess resident conditions to implement intervention and develop care plans. Accurately record resident observations in PCC (Point click Care, an electronic medical record) and follow through on care plans, make regular rounds of residents independently and with a physician: observe and evaluate resident symptoms, progress, and reactions to treatments and medications and implements interventions as necessary, provide preventative, supportive, maintenance, and rehabilitative care directed to the physiologic and psychosocial needs and well-being of residents, provide care to residents, monitor and assist CNA's with personal resident care duties, administer medication to residents according to the Public Health Code, Nursing Department Policies, and standards and procedures as prescribed by the physician, perform comprehensive and focused nursing assessments in conjunction with changes in condition and scheduled programs, and adheres to the Nurse Practice Act. According to the facility provided job description, Certified Nurse Aide, revised [DATE], CNA's provide quality nursing care to residents, including attending to the individual needs of the residents, including grooming, bathing, oral hygiene, feeding, incontinence care ., observes residents for changes in condition or behavior and promptly reports these changes to the Charge Nurse, and performs various tasks assigned by the charge nurse, including checking vital signs, weighing residents, applying creams/ointments and collecting specimens. The job description does not include assessing or administrating medications to a resident. Resident #8 According to the MDS Assessment, dated [DATE], Resident #8 admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. This same assessment indicated Resident #8 cognitively intact and required extensive assistance of two staff members for moving in bed, transferring, dressing, and other hygiene needs including using the bathroom. At the time of the survey, Resident #8 no longer resided at the facility. During an interview on [DATE] at 9:14 PM, Certified Nursing Assistant (CNA) K reported working with Resident #8 on [DATE] during the night shift. CNA K reported working with CNA O when Resident #8 had difficulty breathing. CNA K reported that she and CNA O laid Resident #8 down to assist with changing him and he coughed up a loogie. CNA's O and K sat Resident #8 upright and Resident #8 began to chocking and gagging on it. CNA K reported that Resident #8's oxygen was low, heart rate was elevated, and had increased anxiety. CNA K stated, Our nurse (RN N) came in for shift but never came on the (COVID) unit, I called to tell her what was going on and I was put on hold. CNA K reported giving the phone to CNA O and going to the utility room to obtain an oxygen concentrator; then CNA K placed oxygen on Resident #8 per nasal canula. During an interview on [DATE] at 10:10 AM, CNA O stated that often times she has worked the COVID unit with no nurse assigned and that there was no nurse for the COVID unit on [DATE] around 10:00 or 11:00 PM when Resident #8 had trouble breathing. CNA O reported she had called nurses in the building and that those nurses reported they were passing medications, she then called respiratory therapy and told them Resident #8's respiratory rate was 62 (normal ,[DATE] breaths per minute) and they said it would be about 15 minutes before someone could get here. I told them he would be dead in 15 minutes. CNA O stated that the nurse had to come from the other side of the building to get to the COVID unit that night ([DATE]). During an interview on [DATE] at 10:10 AM, CNA O stated that the COVID unit needed a nurse assigned every night and that when we (CNA's) can't get ahold of a nurse, we have to take problems into our own hands, we can't let people not breathe. An interview with Registered Nurse (RN) N on [DATE] at 9:35 AM revealed RN N was assigned to the COVID unit the night of [DATE] but upon arrival to work that day at 6:30 PM, she was reassigned to work another unit. RN N stated, There was no nurse to work the COVID unit and that she had not entered the COVID unit until receiving the call from the CNA's regarding Resident #8. RN N reported CNA K had initiated the oxygen for Resident #8 without RN N's direction and that when RN N arrived and assessed Resident #8, he required transfer to the emergency room , Resident #8 died en route to the hospital. Resident #8's progress notes, dated [DATE], revealed at 10:43 PM the facility received an order to transfer Resident #8 to the emergency room and that documents were faxed to hospital at approximately 11:00 PM. (No nurse was on the COVID unit from the time day shift nurse left until this episode occurred- approximately 4 hours.) During a follow up interview on [DATE] at 3:09 PM, the Director of Nursing (DON), stated that she was aware that there was no nurse assigned to Resident #8 for four hours on [DATE] and that she was not aware the CNA's had initiated oxygen. The DON indicated that she felt there was no problem with CNA's initiating oxygen as CNA's put oxygen on residents already receiving oxygen. The DON further stated that the CNA's could

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F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 16) assess resident needs and report those to nursing staff. The DON stated she was also available by phone if CNA's required assistance but also stated that she had been shutting her phone off when she is not on call. Review of Resident #8's May and [DATE] Medication and Treatment Administration Record revealed multiple unsigned treatments and medications indicating Resident #8 did not receive care and services as ordered by the physician. During an interview on [DATE] at 3:09 PM, the DON stated she was aware there was a staffing problem, that she had contacted corporate regarding the problem, and that she can't do anything regarding the lack of licensed nurse coverage for the COVID unit. The DON defined neglect as not providing adequate care and withholding services. During an interview on [DATE] at 9:50 AM, Scheduler R stated that the Director of Nursing (DON) told her she did not have to schedule a licensed nurse for the COVID unit because resident medication administrations times changed to day shift. Scheduler R also reported that until Licensed Practical Nurse F started (first shift without trainer was nights on [DATE]), Registered Nurse (RN) N was the only night nurse and she had only worked three nights a week (leaving no nurse routinely scheduled four nights a week). The current schedule, dated [DATE] to [DATE], did not have a licensed nurse scheduled for the 12-hour midnight COVID unit shift on [DATE], [DATE], and [DATE]. An interview on [DATE] at 2:51 PM, Nurse Practitioner M confirmed that she was asked by the facility to change resident medication administration times to day shift hours from midnight shift hours. During an interview on [DATE] at 10:00 AM, LPN Y stated that the facility did not schedule licensed nurses most nights on the COVID unit and that during those times residents went without (nursing) assessments for those 12 hours. LPN Y stated that the south hall nurse was not allowed on the COVID unit and that most often there was only one Certified Nursing Assistant (CNA) scheduled on the COVID unit midnight shift. During an interview on [DATE] at 6:10 AM, the Director of Nursing (DON) stated that if staff are not leaving the facility after entering the COVID unit that they must bring in a change of clothes and shoes before going into the general area of the facility, i.e staff could not easily re-enter the general care area of the facility after entering the COVID unit therefore, making it difficult for staff to work both the COVID unit and the general units on the same shift. During an interview on [DATE] at 1:34 PM, the Administrator (NHA) stated that she was aware of staffing concerns on the COVID unit. The NHA stated it was challenging getting staff to work that unit. The NHA stated that the CNA's took care of the resident needs when there was not a nurse assigned and that this sounds terrible and does not look good on paper. The NHA stated that there were CNA's scheduled to work when there was no nurse scheduled and that the CNA's were qualified to assess and monitor resident health status and needs. The NHA stated that the facility continued to admit residents to the COVID unit despite not having midnight licensed nurses scheduled on the COVID unit. When asked what would constitute neglect, the NHA stated, intentional failure to provide goods and services. Resident #4 A review of Resident #4's Admission Record, dated [DATE], revealed Resident #4 was a [AGE] year-old resident admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. A review of Resident #4's [DATE] Treatment Administration Record (TAR) revealed the following: - Maintain isolation for droplet precautions R/T (related to) covid-19. All services to be provided in room every shift signature block blank for [DATE] on the NOC (night) shift. - Maintain isolation for droplet precautions R/T covid-19. All services to be provided in room every shift on the NOC shift- Licensed Practical Nurse (LPN) A's initials for doing check on [DATE] and [DATE]. However, LPN A stated she does not go on the COVID unit to provide care (see statements below). A review of Resident #4's [DATE] Medication Administration Record (MAR) revealed the following: - Monitoring for side effects of medications (e.g. flushing, blurred irregular heart beat/pulse, palpitations, lightheadedness, shortness of breath, excessive sweating, chest/arm pain, increased blood pressure, weight gain, agitation, distress) signature block was blank for [DATE] on the NOC shift. - Flush for intermittent infusion 10 ml (milliliters) NS (normal saline) before and after medication followed with 3 ml 10 units/ml (units per milliliter) [MEDICATION NAME] every 6 hours for [MEDICATION NAME] signature blocks were blank on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE] for the midnight (0000) time. - Meropenem (an antibiotic) 500 mg (milligrams) signature block was blank on [DATE] for the midnight (0000) dose. Resident #6 A review of Resident #6's Admission Record, dated [DATE], revealed Resident #6 was a [AGE] year-old resident admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. A review of Resident #6's [DATE] Treatment Administration Record (TAR) revealed the following: - Maintain isolation for droplet precautions R/T covid-19. All services to be provided in room every shift signature block blank on [DATE] for NOC shift. - Maintain isolation for droplet precautions R/T covid-19. All services to be provided in room every shift for NOC shift- LPN A's initials for doing check on [DATE], [DATE], and [DATE]. However, LPN A stated she does not go on the COVID unit to provide care (see statement. A review of Resident #6's [DATE] Treatment Administration Record (TAR) revealed the following: - Maintain isolation for droplet precautions R/T covid-19. All services to be provided in room every shift signature block blank on [DATE] for NOC shift. A review of Resident #4's [DATE] Medication Administration Record (MAR) revealed the following: - Monitor laceration to right upper lip for healing and signs/symptoms of infection for NOC shift- LPN A's initials for doing the check on [DATE], [DATE], and [DATE]. However, LPN A stated
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake MI 249. Based on observation, interview, and record review, the facility failed to provide necessary pharmacy services to two Residents (#3 and #5) out of four residents reviewed for medication management, failed to accurately reconcile controlled substance records, and failed to ensure systems to reconcile controlled medications. This deficient practice resulted in unlicensed staff passing medications for Resident #3, missing narcotic counts sheets for Resident #5, two nurses not performing narcotic counts at change of shift, and missing narcotic card sheets for the COVID unit. Findings include: Resident #3 According to the Minimum Data Set (MDS) Assessment, dated 6/5/20, Resident #3 admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. This same assessment indicated Resident #3 was cognitively intact and required extensive assistance of two staff members for moving in bed, transferring, dressing, and hygiene needs including using the bathroom. According to Resident #3's hospital records history and physical, dated 5/29/20, and located within the EMR (electronic medical record), Resident #3 had a gastric tube (G tube) (feeding tube inserted directly into the stomach) that was surgically placed on 5/18/20 (19 days prior to Resident #3's admission to the facility). During a telephone interview on 6/15/20 at 2:20 PM, CNA J stated on 5/30/20 she was working the midnight shift on the COVID Hall for the first time. CNA J states that she was the only staff member assigned and working the COVID Unit and there was no nurse assigned to that hall. CNA J stated that she told LPN A that Resident #3 complained of pain and asked for Tylenol. CNA J stated that LPN A asked CNA J to bring the medication cart to the plastic barrier wall (opaque sheet of plastic), get into the medication cart, retrieve a medication for Resident #3 and Resident #5. CNA J stated LPN A had her hold up the cards and told her which tablet to give to each resident. CNA J stated that LPN A could not see her administer the medication to Resident #3 because he was in his bed next to the window. LPN A did not enter the COVID unit (see written statement dated 6/8/20) nor did she complete a pain assessment on Resident #3 prior to CNA J administering the pain medication. Review of physician orders, dated 5/30/20, revealed Resident #3 had Tylenol ordered to be given via G tube every six hours for pain. During a follow up interview on 6/18/20 at 9:20 AM, CNA J clarified that she had given Resident #3 liquid Tylenol via syringe into the mouth and that she was uncomfortable doing it. According to facility policy Medication Administration - General Guidelines, revised 1/18, medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medication do so only after they have been properly oriented to the facility's medication distribution system. The facility has sufficient staff and a medication distribution system to ensure safe administration of medications without unnecessary interruptions and medications are administered only by licensed nursing or medical personnel. According to the facility provided job description, Charge Nurse LPN, revised 4/27/20, Licensed Practical Nurses (LPN's) assess resident conditions to implement intervention and develop care plans. Accurately record resident observations in PCC (Point click Care, an electronic medical record) and follow through on care plans, make regular rounds of residents independently and with a physician: observe and evaluate resident symptoms, progress, and reactions to treatments and medications and implements interventions as necessary, provide preventative, supportive, maintenance, and rehabilitative care directed to the physiologic and psychosocial needs and well-being of residents, provide care to residents, monitor and assist CNA's with personal resident care duties, administer medication to residents according to the Public Health Code, Nursing Department Policies, and standards and procedures as prescribed by the physician, perform comprehensive and focused nursing

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F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 17) assessments in conjunction with changes in condition and scheduled programs, and adheres to the Nurse Practice Act. According to the facility provided job description, Certified Nurse Aide, revised 4/23/20, CNA's provide quality nursing care to residents, including attending to the individual needs of the residents, including grooming, bathing, oral hygiene, feeding, incontinence care ., observes residents for changes in condition or behavior and promptly reports these changes to the Charge Nurse, and performs various tasks assigned by the charge nurse, including checking vital signs, weighing residents, applying creams/ointments and collecting specimens. The job description does not include assessing or administrating medications to a resident. COVID unit Narcotic Management During an interview on 6/16/20 at 12:48 PM, Registered Nurse (RN) H stated she had not counted narcotics with another nurse at shift changes when the facility did not schedule a night shift nurse. RN H reported CNA's would verify the count but that the CNA's could not sign the narcotic sheets. During an interview on 6/17/20 at 2:40 PM, RN Q sated that she has counted narcotics with the CNA's and that there was not another nurse available to give the medication cart keys to or do narcotic counts with on nights when no nurse was scheduled on the COVID unit. During an interview on 6/18/20 at 9:50 AM, Scheduler R stated that the Director of Nursing (DON) told her she did not have to schedule a licensed nurse for the COVID unit because resident medication administrations times changed to day shift. Scheduler R also reported that until Licensed Practical Nurse F started (first shift without trainer was nights on 6/14/20), Registered Nurse (RN) N was the only night nurse and she had only worked three nights a week (leaving no nurse routinely scheduled four nights a week). The current schedule, dated 6/18/20 to 6/30/20, did not have a licensed nurse scheduled for the 12-hour midnight COVID unit shift on 6/19/20, 6/23/20, and 6/27/20. Scheduler R reported that now there was at least one night weekly that no nurse was routinely scheduled. During an interview on 6/17/20 at 12:43 PM, Clinical Care Coordinator P, stated that when she became aware that two nurses were not counting narcotics at shift change, she discussed this with the management team and staff were educated. When asked if a comprehensive narcotic count was performed at that time, she stated that it was not done and that she didn't think of it at the time. An interview with the DON on 6/17/20 at 3:09 PM revealed that narcotics had been stored inappropriately (not double locked) and that the pharmacy wanted $3,500 for another cart. When the DON became aware of the medication cart keys being stored on the medication cart, she instructed staff to give the keys to another nurse. When asked about two nurses signing the daily narcotic count sheets, the DON reported that she was aware two nurses were not performing a narcotic count and that the nurses would just count when they came on shift (by themselves). It was reported that there were three narcotic count shift to shift sheets for the COVID unit missing (month of May). When asked if a comprehensive narcotic count and investigation was performed to ensure all narcotics were accounted for, the DON stated, it got missed, I did not think about it. The facility provided a copy of nursing staff education that was provided on 6/5/20. The education reflected, 1) The key to the medication cart on the COVID hall is NEVER to be left on top of the medication cart. The key should always remain with the nurse. If there is not a night nurse on schedule, then the day shift nurse needs to return the key to the South hall night shift nurse. 2) The controlled medications need to be counted at the end of each shift, just as we do on every other unit in the building. If there is not another nurse to count with, you still need to count. The narcotic count sheet will be placed in the front of the narcotic book on the COVID hall. Review of Narcotic Count Sheet, dated 6/5/20 through 6/14/20 (after the education), there were six (6/7, 6/8, 6/9, 6/11, 6/12, and 6/13) out of nine days when there was not a shift to shift narcotic count for the COVID unit done by an oncoming and an off going nurse. According to facility policy Medication Administration - General Guidelines, revised 1/18, medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medication do so only after they have been properly oriented to the facility's medication distribution system. The facility has sufficient staff and a medication distribution system to ensure safe administration of medications without unnecessary interruptions and medications are administered only by licensed nursing or medical personnel. Facility policy Controlled Substances, dated 6/19, read, In accordance with the federal and state laws and regulations, medication which are classified as controlled substances by the Drug Enforcement Administration (DEA) are subject to special handling, storage, disposal, and recordkeeping in the facility, Only authorized licensed nursing and pharmacy personnel have access to controlled substances, All controlled substances are stored in a permanently affixed, double locked compartment separate from all other medications, and Accurate accountability of the inventory of all controlled substances is maintained at all times. Facility policy Controlled Substances Storage, dated 6/10, read, At each shift change or when keys are transferred, a physical inventory of all controlled substances, including refrigerated items, is conducted by two licensed nurses and is documented, Current controlled substance accountability records are kept in the Medication Administration Record [REDACTED]. Resident #5 Review of the Face Sheet and Minimum Data Set (MDS) note dated 6/4/20 revealed Resident #5 was readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Resident #5 required the assistance of 2 staff for bed mobility and 1-2 for all other activities of daily living. The Brief Interview for Mental Status (BIMS), reflected a score of 0 out of 15 which represents Resident #2 had severe cognitive impairment. According to the Medication Administration Record [REDACTED]. The June 2020 MAR indicated [REDACTED]. The narcotic count down sheet for [MEDICATION NAME]-[MEDICATION NAME] 10-325 mg was requested for 6/2/20-6/14/20 via email from the NHA and the DON on 6/24/20 at 10:58 AM and 12:43 AM. This Surveyor received count down sheets covering 5/24/20-6/1/20 and 6/15/20-6/17/20. This missing information was clarified with the facility. The facility was unable to locate and provide the count down sheet for review before the exit of this survey. The facility failed to maintain a complete and accurate medical records for reconciling controlled substance medications. During a telephone interview on 6/23/20 at 1:30 PM, when asked how many shifts from 5/6- 6/23 were not staffed with a nurse, and the NHA stated, I'll have to get back with you on that. The NHA stated that there was always 2 CNA's scheduled when there was not a nurse assigned. The NHA sent a written response to the question via email on 6/24/20 at 11:00 AM. The NHA response reflected, Regarding the nurse shifts the COVID unit (May 6, 2020 - current) - The only uncovered shift was the evening of May 31, 2020 in which the nurse refused, due to personal reasons, to enter the COVID unit. All CNAs are trained to identify, report and document an applicable change in condition in residents. The facility utilizes various tools to assist in this process including the use of E-interact and Stop and Watch in POC. As soon as the facility identified there was a concern with the nurse refusing to enter the COVID unit, the facility provided all nurses re-education and instruction to enter the COVID unit as the need were to arise. The facility plan was effective as evidenced by other nurses entering the unit as the need arose. The facility failed to appropriately delegate nursing responsibilities to assess, monitor, and report changes in condition to the physicians for the residents that resided on the COVID Unit on the night shifts. During an interview on 6/15/20 at 7:05 AM, LPN S stated she was in possession of the East Hall medication narcotic keys and had already started passing medications to the East Hall Residents. When asked if the cart was counted with the midnight nurse before the keys were exchanged, LPN S stated, No. LPN S stated that she had counted the cart herself about 10 minutes prior and had already started passing medications to the East Hall residents. When asked if the cart was to be counted with the off going nurse prior to accepting the keys, LPN S stated, Yes. LPN S stated, We are supposed to count it together. I wanted to get going on my med pass. According to the facility controlled substance policy the count will be done together with the off going and oncoming nurse. During an interview on 6/15/20 at 7:30 AM, RN T stated she had worked the night shift and RN Z was working the day shift. RN Z stated that she had counted with RN T before taking over the keys to the medication cart. Record review of the Narcotic Count Sheet for the West cart reflected no signature for the oncoming nurse (RN Z) ensuring an accurate count was completed before accepting the keys to the medication cart.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake MI 249. Based on observation, interview and record review, the facility failed to safely store medications for one Resident (#3) out of four residents reviewed for medication storage and failed to monitor storage temperatures for one fridge with the potential to affect all residents receiving medications from that fridge. This deficient practice resulted in narcotics stored at bedside (Resident #3) and potential for misappropriation and no temperature monitoring of a medication refrigerator and potential for staff to administer immunizations and biological's

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	235290	A. BUILDING _____ B. WING _____	06/24/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 18) that are not effective. Findings include: Resident #3 According to the MDS Assessment, dated 6/5/20, Resident #3 admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. This same assessment indicated Resident #3 was cognitively intact and required extensive assistance of two staff members for moving in bed, transferring, dressing, and hygiene needs including using the bathroom. On 6/17/20 at 3:09 PM the Director of Nursing (DON) stated she gave Resident #3 a [MEDICATION NAME] (a controlled substance) securely, by placing it between two plastic cups on the table in front of Resident #3, and that staff were aware the [MEDICATION NAME] was there. Progress notes dated 6/2/20 read, Note Text: [MEDICATION NAME] Tablet 5-325 MG (milligrams) give 1 tablet via [DEVICE] every 4 hours as needed for Moderate Pain Patient requested to have addition [MEDICATION NAME] at 0000 for self-administration. Self-administration appropriate and assessment completed. Doc (doctor) aware. Facility policy Resident Self-Administration of Medication, revised 7/19, read, The medications provided to the resident for bedside storage are kept in the original containers. Facility policy Controlled Substances, dated 6/19, reads, In accordance with the federal and state laws and regulations, medication which are classified as controlled substances by the Drug Enforcement Administration (DEA) are subject to special handling, storage, disposal, and recordkeeping in the facility, Only authorized licensed nursing and pharmacy personnel have access to controlled substances, All controlled substances are stored in a permanently affixed, double locked compartment separate from all other medications, and Accurate accountability of the inventory of all controlled substances is maintained at all times. During an observation, interview and record review on 6/15/20 at approximately 7:10 AM, LPN S stated that the nursing staff check the medication storage refrigerator temperature twice daily. The Surveyor along with LPN S observed the East/West hall refrigerator. It had multiple medications stored in it. The refrigerator log reflected the last date the temperature logged on the form was 6/10/20. The refrigerator was not checked from 6/11/20 - 6/14/20. According to the log no one had checked the temperature for 4 days to ensure integrity of the medications. The Freezer/Refrigerator Temperature Logs sheet reflected a spot to check the temperature twice daily. The bottom of the form reflected, Freezer: -10 to 0 degrees Fahrenheit, Refrigerator: 36 to 40 degrees Fahrenheit, REPORT ABNORMAL TERMERATURES TO THE DIETARY MANAGER IMMEDIATELY.
F 0835 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Administer the facility in a manner that enables it to use its resources effectively and efficiently.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake number MI 249. Based on observation, interview, and record review the facility administration failed to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This deficient practice resulted in unmet care needs for the residents on the COVID Unit. Findings include: The facility designated a unit for COVID residents by closing off an entire hallway within the building. Closed double fire doors secured the area and staff posted signage indicating it was a restricted area. After passing through the double doors, the first rooms across from each other staff used as a nursing station and the other room was a supply storage area. Past these rooms staff had placed an opaque plastic barrier leading to resident rooms and care areas. The plastic wall had a zippered opening staff used to enter and exit the quarantined area. The hallway space, vestibule between the double fire doors and plastic wall, staff used to don and doff (put on and take off) personal protective equipment (PPE). Staff observed on 6/15/20 at approximately 6:35 AM, donning a N-95 respirator, face shield, gown, foot covers, and gloves and perform hand hygiene appropriately, prior to entering the COVID unit through the zippered door. This surveyor was not able to visualize residents until entering the COVID unit and walking down the hallway. The facility provided a copy of the Facility Assessment Tool with most recent assessment or updates of 3/11/20, 4/13/2020, 5/19/2020, 6/23/2020 for review. The document reflected the plan was last reviewed by QAA/QAPI committee in April 2020, The purpose of the assessment is to determine what resources are necessary to care for residents competently during day-to-day operations and emergencies. Use this assessment to make decisions about your direct care staff needs, as well as your capabilities to provide services to the residents in your facility. Using a competency-based approach focuses on ensuring that each resident is provided care that allows the resident to maintain, or attain their highest practicable physical, mental, and psychosocial well-being .How do we determine if we have sufficient staffing? Consider the following: Gather input from residents, family members, and/or resident representatives, CNA's, Licensed nurses providing direct care, and the local long-term care ombudsman about how well the current staffing plan has been working and any concerns, and make sure to consider this information when developing the staffing plan . During an interview on 6/16/20 at 9:14 PM, Certified Nursing Assistant (CNA) K reported working with Resident #8 on 6/4/20 during the night shift. CNA K reported working with CNA O when Resident #8 had difficulty breathing. CNA K reported that she and CNA O laid Resident #8 down to assist with changing him and he coughed up a loogie. CNA's O and K sat Resident #8 upright and Resident #8 began chocking and gagging on it. CNA K reported that Resident #8's oxygen was low, heart rate was elevated, and Resident #8 had increased anxiety. CNA K stated, Our nurse (RN N) came in for shift but never came on the (COVID) unit, I called to tell her what was going on and I was put on hold. CNA K reported giving the phone to CNA O and going to the utility room to obtain an oxygen concentrator; then CNA K placed oxygen on Resident #8 per nasal canula. Resident #8 had a potential obstructed airway (loogie), oxygen placement may or may not have been the appropriate intervention as the CNA is not qualtified to assess lung sounds or respiratory status and determine the best intervention for the Resident's safety. During an interview on 6/17/20 at 10:10 AM, CNA O stated that often times she has worked the COVID unit with no nurse assigned and that there was no nurse for the COVID unit on 6/4/20 around 10:00 or 11:00 PM when Resident #8 had trouble breathing. CNA O reported she had called nurses in the building and that those nurses reported they were passing medications, she then called respiratory therapy and told them Resident #8's respiratory rate was 62 (normal 12-16 breaths per minute) they said it would be about 15 minutes before someone could get here. I told them he would be dead in 15 minutes. CNA O stated that the nurse had to come from the other side of the building and don PPE prior to entering the COVID unit that night (6/4/20). During an interview on 6/17/20 at 10:10 AM, CNA O stated that the COVID unit needed a nurse assigned every night and that when we (CNA's) can't get ahold of a nurse, we have to take problems into our own hands. We can't let people not breathe. Progress notes dated 6/4/20 revealed at 10:43 PM a progress note indicating the facility received an order to transfer Resident #8 to the emergency room and that documents were faxed to hospital at approximately 11:00 PM. (No nurse was on the COVID unit from the time day shift nurse left until this episode occurred- approximately 4 hours.) During a follow up interview on 6/17/20 at 3:09 PM, the Director of Nursing (DON), stated that she was aware that there was no nurse assigned to Resident #8 for four hours on 6/4/20 and that she was not aware the CNA's had initiated oxygen. The DON indicated that she felt there was no problem with CNA's initiating oxygen as CNA's put oxygen on residents already receiving oxygen. The DON further stated that the CNA's could assess resident needs and report those to nursing staff. The DON stated she was also available by phone if CNA's required assistance but also stated that she had been shutting her phone off when she is not on call. The DON failed to acknowledge that a CNA performed outside their scope of practice when assessing and initiating a PRN (as needed) physician order [REDACTED]. The facility provided a copy of a Corrective Action Form, dated 6/1/20. The form reflected that LPN A directed CNA J to pass medication and waited for the oncoming day nurse to assess a resident after a fall instead of entering the COVID Unit and assessing the resident timely on 5/31/20. During an interview on 6/15/20 at 7:15 AM, the DON stated one night (5/31/20) a resident on the COVID unit requested a pain medication and Licensed Practical Nurse (LPN) A had an aide (later discovered to be certified nursing assistant (CNA) J) bring the resident and the medication cart to the plastic barrier that separated the COVID unit from the rest of the facility because she (LPN A) did not want to physically go on the COVID unit. She stated the nurse (LPN A) watched the aide open the medication cart, remove the medication (a narcotic) from the medication cart, LPN A verified the medication and the dosage, and the aide administered the medication to the resident while the nurse watched. The DON stated she had written the nurse (LPN A) up for having the aide give the narcotic to a resident. She stated when the incident occurred, the facility was short a night nurse and there was not a nurse that was specifically assigned only to the COVID unit. The DON stated there was a dedicated aide that worked the COVID unit and a nurse would cover the COVID unit that also worked on a non-COVID unit. A review of the DON's e-mail, dated 5/23/20, revealed the DON was aware LPN A has made it very clear she is not willing to jeopardize her health by working the COVID unit. A review of LPN A's written statement, dated 6/8/20, revealed LPN A refused to work on the COVID unit (wing). LPN A wrote, she had multiple health issues and (I) am considered high risk for the COVID 19 virus. If I were to go past the safe barrier of the COVID 19 unit I would have been putting myself at serious risk of contracting the [MEDICAL CONDITION]. This is something I preferred not to do. I

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F 0835 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 19) definitely prefer to remain health & feeling well. For these reasons I said no when asked if I would work the COVID wing. If I had gone past the safe barrier into the isolation unit (COVID unit)I don't believe I would have been permitted to return to the South hall to care and give medication to the healthy residents of that hall and continue my shift. There are 3 nurses on the night shift and 3 nursing desks I did not feel that those nurses could be allowed in the isolation unit and then return to care for the residents on the other wings due to the possible contamination of COVID-19. A resignation letter from CCC V, dated 6/1/20, written to the DON was reviewed. The letter reflected the following reasons for resigning, I fear at this time my nursing license is in jeopardy due to poor patient care, safety risk factors, staffing issues, and unrealistic workload all related to the COVID unit . During a telephone interview 6/18/20 at 10:30 AM, CCC V stated, I resigned on 6/1 (2020). I was asked what needed to change to stay and I said 24/7 nursing coverage (on COVID Unit) and adequate CNA coverage for 2 people assists. CCC V stated, Everything got put on the day nurses, it is too much. I didn't rescind my notice. They said they have everything covered and they don't. A resignation letter from the DON, dated 5/30/20 written to the NHA was reviewed. The letter reflected the following reasons for resigning, Unfortunately, due to the increased work responsibility, increased staffing concerns, and new and ongoing challenges of COVID-19, I have decided that it is time for me to step down as Director of Nursing . During a telephone interview on 6/18/20 at 1:03 PM, RN H stated that she worked full time day shift on the COVID Unit working 12-hour shifts. When asked about the staffing on the midnight shift and who would take over for her after her shift, RN H stated, No one. I had many, many sleepless nights worrying. That's not okay. RN H stated, I can't physically do it for 16 hours in a N-95. I can barely do it for 12 hours. During a telephone interview on 6/22/20 at approximately 3:00 PM, LPN Y stated that she worked full time on the day shift on the COVID Unit working 12-hour shifts. When asked about the staffing on midnight shifts, LPN Y stated, I was having heart palpations before coming into work. It was so stressful knowing no one was on the night shift. During an interview on 6/23/20 at 1:34 PM, the Administrator (NHA) stated that she was aware of staffing concerns on the COVID unit. The NHA stated it was challenging getting staff to work that unit. The NHA stated that the CNA's took care of the resident needs when there was not a nurse assigned and that this sounds terrible and does not look good on paper. The NHA stated that there were CNA's scheduled to work when there was no nurse scheduled and that the CNA's were qualified to assess and monitor resident health status and needs. The NHA stated that the facility continued to admit residents to the COVID unit despite not having midnight licensed nurses scheduled on the COVID unit. When asked what would constitute neglect, the NHA stated, intentional failure to provide goods and services. During a telephone interview on 6/23/20 at 1:30 PM, when asked how many shifts from 5/6/20 to 6/23/20 were not staffed with a nurse, and the NHA (Nursing Home Administrator) stated, I'll have to get back with you on that. The NHA stated that there were always 2 CNA's scheduled when there was not a nurse assigned. The NHA sent a written response to the question via email on 6/24/20 at 11:00 AM. The NHA response reflected, Regarding the nurse shifts the COVID unit (May 6, 2020 - current) - The only uncovered shift was the evening of May 31, 2020 in which the nurse refused, due to personal reasons, to enter the COVID unit. All CNAs are trained to identify, report and document an applicable change in condition in residents. The facility utilizes various tools to assist in this process including the use of (name of assessment tools) in (name of computer program). As soon as the facility identified there was a concern with the nurse refusing to enter the COVID unit, the facility provided all nurses re-education and instruction to enter the COVID unit as the need were to arise. The facility plan was effective as evidenced by other nurses entering the unit as the need arose. The facility failed to appropriately delegate nursing responsibilities to assess, monitor, and report changes in condition to the physicians for the residents that resided on the COVID Unit on the night shifts. The facility provided copies of the actual hours worked on each unit from 5/6/20 to 6/17/20 for review. The schedules reflect either a blank or dashes in for the name of the North Nurse (COVID Unit) assigned on the following dates: 5/6/20 to 5/16/20, 5/18/20 to 5/26/20, 5/30/20, 5/31/20, 6/6/20, 6/7/20, 6/8/20. The record reflected that there was no nurse assigned for 25 of 42 days. On 5/23/20 to 5/31/20, 6/6/20, 6/7/20, and 6/8/20 only one CNA was assigned to care for all the residents on the COVID Unit despite resident care plans reflecting the need for 2 staff assistance required for ADL's (activities of daily living). The surveyors requested the shift to shift narcotic count (with two nurses) from the date the COVID Unit reopened on 5/6/20 to 6/16/20. The facility was only able to locate the records from 6/5/20 to 6/16/20. There were 6 days (6/7/20, 6/8/20, 6/9/20, 6/11/20, 6/12/20, and 6/13/20) when there was not a shift to shift count done by an oncoming and an off going nurse. The record reflected missing nursing signatures for 6 of 41 days. According to facility policy Medication Administration - General Guidelines, revised 1/18, medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medication do so only after they have been properly oriented to the facility's medication distribution system. The facility has sufficient staff and a medication distribution system to ensure safe administration of medications without unnecessary interruptions and medications are administered only by licensed nursing or medical personnel. According to the facility provided job description, Charge Nurse LPN, revised 4/27/20, Licensed Practical Nurses (LPN's) assess resident conditions to implement intervention and develop care plans. Accurately record resident observations in PCC (Point click Care, an electronic medical record) and follow through on care plans, make regular rounds of residents independently and with a physician: observe and evaluate resident symptoms, progress, and reactions to treatments and medications and implements interventions as necessary, provide preventative, supportive, maintenance, and rehabilitative care directed to the physiologic and psychosocial needs and well-being of residents, provide care to residents, monitor and assist CNA's with personal resident care duties, administer medication to residents according to the Public Health Code, Nursing Department Policies, and standards and procedures as prescribed by the physician, perform comprehensive and focused nursing assessments in conjunction with changes in condition and scheduled programs, and adheres to the Nurse Practice Act.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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** This citation pertains to intake number MI 249. Based on interview and record review, the facility failed to maintain complete and accurate medical records for 6 of 8 residents (Resident #1, Resident #3, Resident #4, Resident #5, Resident #6, and Resident #8), resulting in incomplete medical records, inaccurate medical records, and the potential for providers not having an accurate and complete picture of the resident's stay at the facility. Findings include: Clear, accurate, and accessible documentation is an essential element of safe, quality, evidence-based nursing practice . Documentation of nurses' work is critical as well for effective communication with each other and with other disciplines. It is how nurses create a record of their services for use by payors, the legal system, government agencies, accrediting bodies, researchers, and other groups and individuals directly or indirectly involved with health care. It also provides a basis for demonstrating and understanding nursing's contributions both to patient care outcomes and to the viability and effectiveness of the organizations that provide and support quality patient care . If patient documentation is not timely, accurate, accessible, complete, legible, readable, and standardized, it will interfere with the ability of those who were not involved in and are not familiar with the patient's care to use the documentation. (ANA's (American Nursing Association) Principles for Nursing Documentation- Guidance for Registered Nurses, 2010, www.nursingworld.org). Resident #4 A review of Resident #4's Admission Record, dated 6/16/20, revealed Resident #4 was a [AGE] year-old resident admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. A review of Resident #4's May 2020 Treatment Administration Record (TAR) revealed the following: - Maintain isolation for droplet precautions R/T (related to) covid-19. All services to be provided in room every shift signature block blank for 5/20/20 on the NOC (night) shift. - Maintain isolation for droplet precautions R/T covid-19. All services to be provided in room every shift on the NOC shift- Licensed Practical Nurse (LPN) A's initials for doing check on 5/21/20 and 5/25/20. However, LPN A stated she does not go on the COVID unit to provide care (see statements below). A review of Resident #4's May 2020 Medication Administration Record (MAR) revealed the following: - Monitoring for side effects of medications (e.g. flushing, blurred irregular heart beat/pulse, palpitations, lightheadedness, shortness of breath, excessive sweating, chest/arm pain, increased blood pressure, weight gain, agitation, distress) signature block was blank for 5/12/20 on the NOC shift. - Flush for intermittent infusion 10 ml (milliliters) NS (normal saline) before and after medication followed with 3 ml 10 units/ml (units per milliliter) [MEDICATION NAME] every 6 hours for [MEDICATION NAME] signature blocks were blank on 5/16/20, 5/19/20, 5/20/20, 5/21/20, 5/24/20, 5/25/20, 5/26/20, and 5/27/20 for the midnight (0000) time. - Meropenem (an antibiotic) 500 mg (milligrams) signature block was blank on 5/16/20 for the midnight (0000) dose. Resident #6 A review of Resident #6's Admission Record, dated 6/16/20, revealed

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F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 20) Resident #6 was a [AGE] year-old resident admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. A review of Resident #6's May 2020 Treatment Administration Record (TAR) revealed the following: - Maintain isolation for droplet precautions R/T covid-19. All services to be provided in room every shift signature block blank on 5/20/20 for NOC shift. - Maintain isolation for droplet precautions R/T covid-19. All services to be provided in room every shift for NOC shift- LPN A's initials for doing check on 5/21/20, 5/25/20, and 5/30/20. However, LPN A stated she does not go on the COVID unit to provide care (see statement. A review of Resident #6's June 2020 Treatment Administration Record (TAR) revealed the following: - Maintain isolation for droplet precautions R/T covid-19. All services to be provided in room every shift signature block blank on 6/7/20 for NOC shift. A review of Resident #4's May 2020 Medication Administration Record (MAR) revealed the following: - Monitor laceration to right upper lip for healing and signs/symptoms of infection for NOC shift- LPN A's initials for doing the check on 5/21/20, 5/25/20, and 5/30/20. However, LPN A stated she does not go on the COVID unit to provide care. - Monitor laceration to right upper lip for healing and signs/symptoms of infection signature block was blank for 5/20/20, 5/23/20, 5/24/20, and 5/26/20 on the NOC shift. - Medication side effect monitoring- LPN A's initials for doing the check on 5/21/20, 5/25/20, & 5/30/20. However, LPN A stated she does not go on the COVID unit to provide care. - Medication side effect monitoring signature block was blank on 5/20/20, 5/23/20, 5/24/20, and 5/26/20- for the NOC shift. A review of Resident #4's June 2020 Medication Administration Record (MAR) revealed the following: - Monitor laceration to right upper lip for healing and signs/symptoms of infection signature block was blank on 6/7/20 for the NOC shift. - Medication side effect monitoring signature block was blank on 6/7/20 for the NOC shift. - Check PVR (post void residual- amount of urine still in the bladder after the resident urinated) signature block was blank on 6/7/20 for 2300. - Check PVR signature block was blank on 6/8/20 for 0300. During an interview on 6/15/20 at 7:15 AM, the Director of Nursing (DON) stated she was aware there were nurses that did not want to work the COVID unit. She stated the nurses had verbalized they didn't want to go on that unit at night unless they had to. The DON stated they (the facility) have had staffing shortages, especially nurses on the COVID unit. The DON stated that when they have a shortage of nurses to work the COVID unit, then they have a dedicated nursing assistant working the COVID unit alone and a nurse that works a non-COVID unit and will also cover the COVID unit. During a second interview on 6/16/20 at 10:40 AM, the DON indicated that if a box on the MAR and/or TAR is not initialed, then the medication and/or treatment was not done by the nurse. A review of LPN A's written statement, dated 6/8/20, revealed LPN A refused to work on the COVID unit (wing). LPN A wrote, she had multiple health issues and (I) am considered high risk for the COVID 19 virus. If I were to go past the safe barrier of the COVID 19 unit I would have been putting myself at serious risk of contracting the [MEDICAL CONDITION]. This is something I preferred not to do. I definitely prefer to remain health & feeling well. For these reasons I said no when asked if I would work the COVID wing. If I had gone past the safe barrier into the isolation unit (COVID unit)I don't believe I would have been permitted to return to the South hall to care and give medication to the healthy residents of that hall and continue my shift. There are 3 nurses on the night shift and 3 nursing desks I did not feel that those nurses could be allowed in the isolation unit and then return to care for the residents on the other wings due to the possible contamination of COVID-19. A review of the Director of Nursing's (DON) e-mail, dated 5/23/20, revealed the DON was aware LPN A has made it very clear she is not willing to jeopardize her health by working the COVID unit. A review of Clinical Nursing Skills and Techniques (Perry and Potter), dated 2014, revealed, Accurate documentation reflects the quality of care and provides evidence of each health care team member's accountability in giving care . Because the nursing process directs a nurse's approach to patient care, documentation needs to reflect this process. Nurses record assessment data, changes in patient's condition, nursing interventions, and an evaluation of the patient's progress toward established outcomes. Prompt documentation of this data increases accuracy and promotes effective communication to all members of the health care team. (Chapter 4, p. 61). A review of Clinical Nursing Skills and Techniques (Perry and Potter), dated 2010, revealed, Accurate documentation enhances medication safety. Nurses need to document appropriately before and after giving medications . After administering a medication, record the name of the ordered medication, the time of administration, and the dosage, route, and frequency as soon as possible . After administering a medication, record the following information on the MAR (medication administration record) or other appropriate form (e.g. nurses' notes) required by the institution: medication name, dose, route of administration, time of administration . (Chapter 20- Safe Medication Preparation, pp. 520-524). Resident #1 According to the Minimum Data Set (MDS) Assessment, dated 5/28/20, Resident #1 admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. This same assessment indicated Resident #1 was moderately cognitively impaired and required extensive assistance of one person for moving in bed, dressing, eating, and hygiene needs including bathing and using the toilet. An Admission Record dated 6/17/20 indicated Resident #1 was diagnosed with [REDACTED]. Review of Resident #1's May 2020 Medication and Treatment Administration Record revealed the following: -Pain assessment signature box for NOC on 5/30/20 contained LPN A's initials for doing check. However, LPN A stated she does not go on the COVID unit to provide care (see written statement dated 6/8/20). -Monitoring for side effects of medications (e.g. blurred vision, altered mental status, irregular heartbeat, etc.) signature box for NOC on 5/30/20 contained LPN A's initials for doing check. However, LPN A stated she does not go on the COVID unit to provide care (see LPN A's written statement dated 6/8/20). Review of Resident #1's June 2020 Medication and Treatment Administration Record revealed the following: -Pain assessment signature block for NOC on 6/6/20 was blank. - Monitoring for side effects of medications (e.g. flushing, blurred vision, dry mouth, altered mental statues, irregular heartbeat, etc.) signature block for NOC on 6/7/20 was blank. -Med Pass 2.0 (a nutritional supplement) signature block for 2100 on 6/4/20 was blank. -Palm protector to remain in place except for bathing/hygiene signature block for NOC on 6/7/20 was blank. Resident #3 According to the MDS Assessment, dated 6/5/20, Resident #3 admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. This same assessment indicated Resident #3 was cognitively intact and required extensive assistance of two staff members for moving in bed, transferring, dressing, and hygiene needs including using the bathroom. Review of Resident #3's May 2020 Medication and Treatment Administration Record revealed the following: -[MEDICATION NAME] solution 650 mg (milligrams) signature block was blank for 0000 (midnight) on 5/31/20. Review of Resident #3's June 2020 Medication and Treatment Administration Record revealed the following: -[MEDICATION NAME] (an antibiotic) Ointment signature block was blank for NOC (night) on 6/11/20. -Infection Note: [MEDICAL CONDITION] around G tube (a feeding tube in the stomach) site signature block was black for NOC on 6/10/20. -Monitor pain every shift signature block was blank for NOC on 6/11/20. -Enteral feed order three times a day flush G tube with 80 ml water signature block was blank for 1800 on 6/1/20. -Enteral feed order three time a day via G tube 1 hour after meals bolus 240 ml [MEDICATION NAME] (a nutritional supplement) 1.5 signature block was blank for 1800 on 6/1/20. -Assess lung sounds and bowel sounds every shift signature block was blank on 6/6/20 and 6/10/20 for eve (evening). Resident #8 According to the MDS Assessment, dated 5/30/20, Resident #8 admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. This same assessment indicated Resident #8 cognitively intact and required extensive assistance of two staff members for moving in bed, transferring, dressing, and other hygiene needs including using the bathroom. Review of Resident #8's May 2020 Medication and Treatment Administration Record revealed the following: -Monitor open areas to coccyx and right buttock for signs of infection and deterioration signature block for NOC on 5/30/20 contained LPN A's initials for doing check. However, LPN A stated she does not go on the COVID unit to provide care (see LPN A's written statement dated 6/8/20). -Monitoring for side effects of medications signature block was blank for NOC on 5/26/20; for NOC on 5/25/20 and 5/30/20 contained LPN A's initials for doing check. However, LPN A stated she does not go on the COVID unit to provide care (see LPN A's written statement dated 6/8/20). -[MEDICATION NAME] HCL Solution 25 milligrams per milliliter signature block 0000 was blank on both 5/26/20 and 5/27/20. Review of Resident #8's June 2020 Medication and Treatment Administration Record revealed D5W (an intravenous infusion for low sodium) signature block 2100 for 6/4/20 was blank. Resident #5 Review of the Face Sheet and Minimum Data Set (MDS) note dated 6/4/20 revealed Resident #5 was readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Resident #5 required the assistance of 2 staff for bed mobility and 1-2 for all other activities of daily living. The Brief Interview for Mental Status (BIMS), reflected a score of 0 out of 15 which represents Resident #2 had severe cognitive impairment. According to the Medication Administration Record (MAR) for June 2020, Resident #5 had an order for [REDACTED]. The June 2020 MAR reflected that it was given 30 times between 6/2/20 and 6/14/20. The narcotic count down sheet for [MEDICATION NAME]-[MEDICATION NAME] 10-325 mg was requested for 6/2/20-6/14/20 via email from the NHA and the DON on 6/24/20 at 10:58 AM and 12:43 AM. This Surveyor received count down sheets covering 5/24/20-6/1/20 and 6/15/20-6/17/20. This missing information was clarified with the facility. The facility was unable to locate and provide the countdown sheet for review before the exit of this survey. The facility failed to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235290	A. BUILDING _____ B. WING _____	06/24/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MISSION POINT NSG & PHY REHAB CTR OF GREENVILLE	828 E WASHINGTON ST GREENVILLE, MI 48838

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 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 21) maintain a complete and accurate medical record for reconciling controlled substance medications.
F 0867 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake number MI 249. Based on observation, interview and record review the facility failed to ensure the Quality Assessment Assurance (QAA) and Performance Improvement (PI) committees appropriately identified deficient practices and developed and implemented appropriate plans of action to correct the identified quality deficiencies by auditing the progress to ensure compliance. This deficient practice resulted in the lack of a licensed nurse (on the midnight shift) to oversee the care and services provided to the residents who resided on the COVID unit, where the facility failed to ensure assessments, monitoring, medications, and treatments were provided around the clock by a licensed nurse. All residents who resided on the COVID unit had the potential for serious harm, injury, and ongoing neglect. Findings include: The facility designated a unit for COVID residents by closing off an entire hallway within the building. Closed double fire doors secured the area and staff posted signage indicating it was a restricted area. After passing through the double doors, the first rooms across from each other staff used as a nursing station and the other room was a supply storage area. Past these rooms staff had placed an opaque plastic barrier leading to resident rooms and care areas. The plastic wall had a zippered opening staff used to enter and exit the quarantined area. The hallway space, vestibule between the double fire doors and plastic wall, staff used to don and doff (put on and take off) personal protective equipment (PPE). Staff observed on 6/15/20 at approximately 6:35 AM, donning a N-95 respirator, face shield, gown, foot covers, and gloves and perform hand hygiene appropriately, prior to entering the COVID unit through the zippered door. This surveyor was not able to visualize residents until entering the COVID unit and walking down the hallway. The facility provided a copy of the Facility Assessment Tool with most recent assessment or updates of 3/11/20, 4/13/2020, 5/19/2020, 6/23/2020 for review. The document reflected the plan was last reviewed by QAA/QAPI committee in April 2020, The purpose of the assessment is to determine what resources are necessary to care for residents competently during day-to-day operations and emergencies. Use this assessment to make decisions about your direct care staff needs, as well as your capabilities to provide services to the residents in your facility. Using a competency-based approach focuses on ensuring that each resident is provided care that allows the resident to maintain, or attain their highest practicable physical, mental, and psychosocial well-being .How do we determine if we have sufficient staffing? Consider the following: Gather input from residents, family members, and/or resident representatives, CNA's, Licensed nurses providing direct care, and the local long-term care ombudsman about how well the current staffing plan has been working and any concerns, and make sure to consider this information when developing the staffing plan . The facility provided copies of the actual hours worked on each unit from 5/6/20 to 6/17/20 for review. The schedules reflect either a blank or dashes in for the name of the North Nurse (COVID Unit) assigned on the following dates: 5/6/20 to 5/16/20, 5/18/20 to 5/26/20, 5/30/20, 5/31/20, 6/6/20, 6/7/20, 6/8/20. The record reflected that there was no nurse assigned for 25 of 42 days. On 5/23/20 to 5/31/20, 6/6/20, 6/7/20, and 6/8/20 only one CNA was assigned to care for all the residents on the COVID Unit despite resident care plans reflecting the need for 2 staff assistance required for ADL's (activities of daily living). The facility provided a copy of nursing staff education that was provided on 6/5/20. The education reflected, 1) The key to the medication cart on the COVID hall is NEVER to be left on top of the medication cart. The key should always remain with the nurse. If there is not a night nurse on schedule, then the day shift nurse needs to return the key to the South hall night shift nurse. 2) The controlled medications need to be counted at the end of each shift, just as we do on every other unit in the building. If there is not another nurse to count with, you still need to count. The narcotic count sheet will be placed in the front of the narcotic book on the COVID hall. Facility policy Controlled Substances Storage, dated 6/10, read, At each shift change or when keys are transferred, a physical inventory of all controlled substances, including refrigerated items, is conducted by two licensed nurses and is documented, this does not reflect the education provided on 6/5/20. Review of Narcotic Count Sheet, dated 6/5/20 through 6/14/20 (after the education), there were six (6/7, 6/8, 6/9, 6/11, 6/12, and 6/13) out of nine days when there was not a shift to shift narcotic count for the COVID unit done by an oncoming and an off going nurse. During an interview on 6/23/20 at 1:34 PM, the NHA stated that there were no audit reports following the education to monitor compliance. During that same interview on 6/23/20 at 1:34 PM, the NHA responded to the following concerns: 1. Staffing levels beginning 5/6/20: the NHA responded that staffing was challenging for night shift on the COVID unit and that it was improving since another full-time nurse was hired. This full-time nurse along with a part time nurse still left the COVID unit short a nurse at least one night weekly. 2. CNA assessing and implementing physician orders [REDACTED]. The NHA stated that she was not sure that a CNA administering oxygen would be considered a medication error. An email from the NHA, dated 6/24/20 at 11:00 AM, read The facility did not complete a medication error incident report regarding the O2 (oxygen) initiation. This investigation was requested and not provided by the exit of this survey. 3. Nurse staffing on the COVID unit: the NHA responded that she had known there was an issue with staffing on the COVID unit. The NHA stated that CNA's were qualified to assess and monitor resident care needs and that staffing the COVID unit with a nurse was challenging. The NHA stated that the facility continued to admit residents to the COVID unit despite not having midnight licensed nurses scheduled on the COVID unit. During a follow up email on 6/24/20 at 11:00 AM the NHA reported, The only uncovered shift was the evening of May 31, 2020 in which the nurse refused, due to personal reasons, to enter the COVID unit. 4. Narcotic Counts and Medication Storage: The NHA denies performing audits to monitor compliance. In a follow up email on 6/24/20 at 11:00 AM, the NHA reported, Audits created to ensure continued compliance. Initial audit completed for narcotics proved that medications were properly accounted for. A list of all narcotics was requested and received from pharmacy. All proof of use forms reviewed by Regional Clinical Director with no concerns of missing medications identified. All quantities of narcotics on the COVID units matched what was delivered from the pharmacy. A copy of these audits were requested at this time and was not provided by the end of the survey. 5. Missed physician orders: The NHA denied having a Resident chart audit performed to ensure no additional orders were missed and denied having an investigation regarding missed physician orders. However, per an email received on 6/24/20 at 11:00 AM, the NHA reported, New admissions have been reviewed to ensure all appointments have been reviewed/scheduled if deemed essential. Audits created to ensure continued compliance. Education initiated for Clinical Care Coordinators regarding the follow-up on resident appointments. A copy of these audits were requested at this time and not provided by the end of the survey. 6. Resident #1's medication error, [MEDICATION NAME] given at half the ordered dose multiple times and admission by the administering nurse: the NHA replied, this was not identified as a medication error; however, it was determined to be an error in documentation. During an interview on 6/15/20 at 7:15 AM, the Director of Nursing (DON) stated they (the facility) was aware of concerns with the staff. The DON stated she was aware of issues with the nurses not wanting to work on the COVID unit. She stated the nurses did not want to go onto the COVID unit at night unless they had to be down there. She stated because of this, the facility had worked with the care providers to change medication administration times so that the majority of medications (especially those given only once a day) were scheduled to be given during the first 12 hours of the day. That way there would be a minimum amount of medications that had to be given during the night shift on the COVID unit. During an interview on 6/15/20 at 7:15 AM, the DON stated one night (5/31/20) a resident on the COVID unit requested a pain medication and Licensed Practical Nurse (LPN) A had an aide (later discovered to be certified nursing assistant (CNA) J) bring the resident and the medication cart to the plastic barrier that separated the COVID unit from the rest of the facility because she (LPN A) did not want to physically go on the COVID unit. She stated the nurse (LPN A) watched the aide open the medication cart, remove the medication (a narcotic) from the medication cart, LPN A verified the medication and the dosage, and the aide administered the medication to the resident while the nurse watched. The DON stated she had written the nurse (LPN A) up for having the aide give the narcotic to a resident. She stated when the incident occurred, the facility was short a night nurse and there was not a nurse that was specifically assigned only to the COVID unit. The DON stated there was a dedicated aide that worked the COVID unit and a nurse would cover the COVID unit that also worked on a non-COVID unit. A review of the DON's e-mail, dated 5/23/20, revealed the DON was aware LPN A has made it very clear she is not willing to jeopardize her health by working the COVID unit. A review of LPN A's written statement, dated 6/8/20,

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	235290	A. BUILDING _____ B. WING _____	**06/24/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MISSION POINT NSG & PHY REHAB CTR OF GREENVILLE	**828 E WASHINGTON ST GREENVILLE, MI 48838**

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F 0867 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 22) revealed LPN A refused to work on the COVID unit (wing). LPN A wrote, she had multiple health issues and (I) am considered high risk for the COVID 19 virus. If I were to go past the safe barrier of the COVID 19 unit I would have been putting myself at serious risk of contracting the [MEDICAL CONDITION]. This is something I preferred not to do. I definitely prefer to remain health & feeling well. For these reasons I said no when asked if I would work the COVID wing. If I had gone past the safe barrier into the isolation unit (COVID unit)I don't believe I would have been permitted to return to the South hall to care and give medication to the healthy residents of that hall and continue my shift. There are 3 nurses on the night shift and 3 nursing desks I did not feel that those nurses could be allowed in the isolation unit and then return to care for the residents on the other wings due to the possible contamination of COVID-19.