| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **165575** | A. BUILDING _____ B. WING _____ | **05/20/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| **MANORCARE HEALTH SERVICES-UTICA RIDGE** | **3800 COMMERCE BLVD DAVENPORT, IA 52807** |

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 0675<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | **Honor each resident's preferences, choices, values and beliefs.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, record review, and staff, physician, Police, First Responder and Medical Examiner interviews, the facility failed to provide care in accordance to Physician order [REDACTED].#10). The facility reported a census of 92 residents. Findings include: The Minimum Data Set (MDS) Assessment tool dated [DATE] revealed Resident #10 admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The resident scored 11 out of 15 points possible on the Brief Interview for Mental Status (BIMS) cognitive assessment that indicated cognitive impairment, without symptoms of [MEDICAL CONDITION], and required extensive assistance of at least 1 staff to reposition in bed, transfer to and from bed and chair, ambulation, dressing, toileting and personal hygiene. Physician order [REDACTED]. Continuous [MED]gen administered via nasal cannula (NC) at 4 liters per minute. b. [MEDICATION NAME] (a beta agonist medication that dilates the airways) 20 micrograms in 2 milliliters administered via nebulizer twice a day. c. [MEDICATION NAME] (a corticosteroid medication that reduces swelling of the airways) 0.5 milligrams in 2 milliliters administered via nebulizer twice a day. d. [MEDICATION NAME] 0.5 milligrams with [MEDICATION NAME] 2.5 milligrams (both [MEDICATION NAME][MEDICATION NAME] medications and when combined, referenced as Duo-Neb) in 3 milliliters solution administered via nebulizer every 4 hours while awake. e. [MEDICATION NAME] 2.5<br>milligrams in 3 milliliters solution administered via nebulizer every 6 hours as needed. f. Trilogy machine (a ventilator that accommodated Bi-Pap and C-Pap settings, that provides volume and pressure control through a mask applied to the nose and mouth) ensure [MED]gen bled in to the tubing, mask applied at hour of sleep in the evening, removed in the morning. A risk for respiratory impairment related to aspiration problems initiated on the Nursing Care Plan on [DATE] identified a goal to maintain a patent airway for Resident #10 and directed staff to implement the following to achieve the goal: a. Encourage deep breathing exercises. b. Evaluate lung sounds and vital signs as needed. c. Obtain pulse oximetry and report abnormal findings to the physician. d. Administer medications per physician orders. e. Elevate the head of the bed. f. Administer [MED]gen per physician orders. A Physician/Nurse Practitioner Progress Note dated [DATE] revealed the resident was [MED]gen dependent, breath sounds diminished to auscultation with cough productive of thick yellow sputum, directed the continued administration of antibiotics, [MED]gen, breathing treatments, Trilogy, and instruct resident to cough and deep breath at intervals during the day. Review of the resident's Medication Administration Record [REDACTED].m Further review showed the medication administered by Staff B, Registered Nurse (RN), at 1:02 a.m. and 5:37 a.m. on [DATE]. The MAR indicated [REDACTED]. Documentation of [MED]gen saturation levels revealed (normal value 95 to 100 percent on room air)the following levels: a. On [DATE] at 8:13 p.m., 99 percent with [MED]gen via NC. b. On [DATE] at 8:15 a.m., 96 percent with [MED]gen via NC. c. On [DATE] at 1:43 a.m., 88 percent with [MED]gen per Bi-Pap (Trilogy). d. On [DATE] at 8:00 a.m., 95 percent with [MED]gen via NC. e. On [DATE] at 12:45 p.m., 94 percent with [MED]gen via NC. f. On [DATE] at 4:09 p.m., 94 percent with [MED]gen via NC. g. On [DATE] at 1:34 a.m., 93 percent with [MED]gen via Bi-Pap. h. On [DATE] at 4:49 p.m., 97 percent with [MED]gen via NC. i. On [DATE] at 1:48 a.m., 89 percent with [MED]gen via Bi-Pap. j. On [DATE] at 4:41 p.m., 98 percent with [MED]gen via NC. k. On [DATE] at 6:51 p.m., 91 percent on room air. l. On [DATE] at 3:38 p.m., 98 percent with [MED]gen via NC. A Nurse's Note dated [DATE] at 7:22 a.m., transcribed by Staff A, Licensed Practical Nurse (LPN) stated 2 Certified Nursing Assistants (CNA's) found the resident unresponsive in the room. A Fireman in the room noticed the resident didn't look good, came out of the room and yelled the resident required CPR. The Fireman returned to the room and started compressions with facility staff assisting. The resident's time of death recorded at 7:49 a.m., and the spouse notified of the resident's death. The Facility's Self-Reported Incident described at approximately 7:00 a.m. on [DATE], the nurse that cared for the resident's room-mate realized the nebulizer treatment was completed, removed nebulizer (mask) and replaced the NC at 4 liters. At approximately 7:20 a.m. the resident observed unresponsive and CPR initiated with the resident expiring at 7:49 a.m. at the facility. Investigation by facility in progress as death was unexpected, Medical Examiner to complete an autopsy and toxicology. The facility's Medication and Treatment Administration Guidelines policy, updated ,[DATE], directed staff to complete the following: a. Medications were administered in accordance with standards of practice and state specific and federal guidelines. b. Medications were administered in accordance with the rights of medication administration that included right patient, right medication, right dose, right route, right time and right clinical indication. c. Medications that were not administered according to Physician order [REDACTED]. The facility's Oxygen Administration policy last reviewed ,[DATE] directed staff: a. Verify physician's orders [REDACTED]. c. When administered by NC, direct prongs toward floor of nostrils, hook cannula tubing behind ears and under chin, and slide adjuster upward under chin to secure cannula in place. The facility's Respiratory Nebulizer Mist Therapy policy, revised ,[DATE], directed staff: a. Verify physician's orders [REDACTED]. c. Connect one end of tubing to nebulizer and other end to aerosol unit air outlet. d. Fill nebulizer with prescribed medication. e. Connect mask to tubing. f. Apply mask to resident face. Verify nebulizer is held upright at all times to maintain prescribed medication in chamber. g. Switch aerosol unit on and direct resident to inhale mist slowly and deeply. h. Continue until prescribed medication has been aerosolized from chamber. i. Switch aerosol unit off when treatment completed. j. Assess lung fields and heart rate, document any changes. k. Rinse excess mist and medication from nebulizer and mask. l. Store dried nebulizer and mask in separate, labeled plastic bag. The Nurse Supervisor Job Description dated as last reviewed ,[DATE], described nursing responsibilities that included: a. Administers medications and treatments timely and according to facility policy. b. Receives, transcribes and carries out physician orders. c. Documents medications and treatments per facility policy. d. Documents in Nurse's Notes any exceptions to resident condition. A One-On-One Inservice Record form completed by the Administrator and Director of Nursing (DON), dated [DATE] revealed Staff B administered a 4:00 a.m. scheduled medication at 5:37 a.m Staff B instructed medications should be administered within an hour before or after the scheduled time and if the resident was asleep at 4:00 a.m. the nurse should have documented asleep. Also if the medication requested at 5:30 a.m., the nurse should have documented the as needed medication administered at that time. A statement obtained from Staff B, RN, via phone on [DATE] 15 1:32 p.m., recorded by the Administrator and DON stated: On his night shift that concluded at 6:00 a.m. on [DATE], Resident #10 had no issues and slept through the night with his Trilogy on. The nebulizer treatment was applied between 5:30 a.m. and 5:45 a.m., at that time, the Trilogy mask was removed, nebulizer mask applied, he could not remember if [MED]gen via NC was applied but that would have been part of his normal process. At that time the resident was alert and asked for water. He could not recall if the nebulizer treatment was removed prior to the time he left the facility. Observations on [DATE] revealed: a. At 7:38 a.m., Staff C, RN, started administration of an ordered Duo-Neb nebulizer treatment to Resident #1. The nurse remained at the resident's bedside, the medication administration was completed at 7:43 a.m., then the nurse washed the nebulizer tubing and placed it in a plastic bag stored in the resident's room. b. At 1:27 p.m., Staff D, LPN, started administration of an ordered Duo-Neb nebulizer treatment to Resident #2. The nurse remained at the resident's bedside, the medication administration was completed at 1:35 p.m., then the nurse washed the nebulizer tubing and placed it in a plastic bag stored in the resident's room. Staff interviews revealed: On [DATE] at 7:16 p.m., Staff E, RN, stated she worked the day shift (6:00 a.m. to 2:00 p.m.) on [DATE], between 6:45 a.m. and 7:00 a.m. |

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

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

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| F 0675<br><br>**Level of harm** - Immediate jeopardy<br><br>**Residents Affected** - Few | (continued... from page 1)<br>as she provided care to Resident #10's room mate (Resident #11), she heard the nebulizer and saw the nebulizer mask on Resident #10 with the treatment completed. She noted the [MED]gen not on the resident, the cannula tubing laid over the overbed table connected to the concentrator and not on the resident. She stated the resident's color was dusky (dark blue-purple) as she removed the nebulizer mask and applied the [MED]gen via NC. When the ambulance arrived for Resident #11, she could not recall if Resident #10's skin was warm or cool, and the resident did not respond as she applied the [MED]gen (per ambulance report, arrived at the resident's room at 6:53 a.m. on [DATE]). Staff E stated she had cared for Resident #10 before, he was [MED]gen dependent, she always administered his nebulizer treatments via mask applied over his [MED]gen cannula, and removed the mask when the treatment was completed, after about 10 to 12 minutes. On [DATE] at 1:14 p.m., Staff A, LPN, stated she was assigned to the resident on the [DATE] day shift. Staff B, RN, stated he had just given the resident's breathing treatment and didn't communicate anything unusual in his change of shift report to her and she hadn't seen or assessed the resident yet. Sometime between 7:00 a.m. and 7:30 a.m. a Fireman said the resident required CPR and as she assisted with CPR, the resident felt cool but not cold. On [DATE] at 2:50 p.m., Staff F, CNA, stated the resident was assigned to her on the [DATE] day shift. That morning she noticed the privacy curtain partially pulled between the resident's in the room and she hadn't entered the room but could tell the resident was in bed. Staff F reported she couldn't see if his [MED]gen was on or not and hadn't seen the resident until she went in the room to get him up with Staff G, CNA, and at that time the Fireman in his room said the resident didn't look good. On [DATE] at 12:46 p.m., Staff G, CNA, stated on [DATE] after the ambulance left with Resident #11, he went with Staff F, CNA, to get Resident #10 up, a fireman in the room said he didn't look good. Staff G reported they tried and couldn't wake the resident, the fireman yelled for staff to respond and started CPR (the ambulance left the facility with Resident #11 at 7:18 a.m. per ambulance record). On [DATE] at 9:56 a.m., Staff H, Emergency Medical Technician (EMT) and a Fireman from the local fire department stated on [DATE] after the ambulance loaded Resident #11 for transport, he returned to the room around 7:22 a.m. and thought the resident didn't look good, the resident didn't respond when staff tried to wake him, he felt for a pulse, couldn't find one and called out to staff for help with CPR. Staff H could not recall if the resident had [MED]gen on, and didn't think he removed [MED]gen when he started CPR. The resident felt a little cool, he checked for lividity (discoloration of the skin due to the settling and pooling of blood) but didn't find it, his legs looked discolored. At the end of CPR the resident had lividity on his thighs. On [DATE] at 10:14 a.m., Staff I, Paramedic/Fireman stated he hadn't noticed the resident until they left with the room mate (Resident #11) and thought it was odd that the resident had not responded to the commotion in the room. Staff I reported he thought maybe his face looked pale, and did not recall [MED]gen on the resident but not absolutely certain of that. On [DATE] at 12:56 p.m., Staff J, Police Detective with the local police department stated he was called to the facility on [DATE] at 8:15 a.m. for a suspicious death, evidence was collected from the resident's room, there was an ongoing investigation that may result in charges, subpoenas had been issued, the County Medical Examiner's office was involved and an autopsy would be completed. On [DATE] at 12:38 p.m., Staff K, County Medical Examiner and physician, stated the resident's death was suspicious and an autopsy was underway that morning, the resident was [MED]gen dependent and knew there was a period of time that [MED]gen was not administered prior to his death. She had conferred with the resident's spouse who reported the resident required 5 to 6 liters of [MED]gen per minute prior to his admission to the facility, and consented to the autopsy. On [DATE] at 3:04 p.m., Staff L, the resident's Pulmonology Physician of record, stated the resident was [MED]gen dependent with advanced [MEDICAL CONDITIONS], required the Trilogy respirator at night due to advanced disease beyond Bi-Pap or C-Pap support. Staff L stated if the resident had a nebulizer mask left over his mouth and nose for an hour and 15 minutes, without [MED]gen administered, his [MED]gen level would have dropped and could have caused his [MEDICAL CONDITION] and death. On [DATE] at 9:41 a.m., Staff M, CNA, stated when she worked the night shift from 10:00 p.m. on [DATE] to 6:00 a.m. on [DATE], the resident used his call light more than usual and able to communicate his needs. Staff M reported he didn't sleep well, hadn't asked for any pain medication, was scheduled for a breathing treatment at 4:00 a.m. but didn't see the nurse go in his room and not sure if he got it. She completed incontinence care of the resident at 4:45 a.m., the resident had his C-Pap mask on, and when she last checked on him at approximately 5:00 a.m., he still had the C-Pap mask on, in bed and asleep. On [DATE] at 7:12 a.m., Staff N, RN, stated she had cared for the resident, the resident needed the [MED]gen and administered his nebulizer treatments with [MED]gen on under the nebulizer mask. On the night shift, the resident wore the Trilogy mask with [MED]gen connected to it, to administer a nebulizer at that time the nurse had to remove the Trilogy mask, disconnect the [MED]gen tubing from the concentrator, attach the NC tubing to the concentrator and apply NC to the resident, then apply the nebulizer mask over the [MED]gen. On [DATE] at 8:19 p.m., Staff O, LPN, stated the resident was [MED]gen dependent, she administered his nebulizer treatments via mask with [MED]gen administered per NC under it, the resident said he didn't like the Trilogy mask, his [MED]gen saturation was 87 to 88 percent when the Trilogy mask was on with [MED]gen bled into the line as ordered, and saturations higher when [MED]gen administered via NC. On [DATE] at 1:40 p.m., Staff D, LPN, stated she stayed with a resident when nebulizer treatments were administered, unless there was an order for [REDACTED]. The DON thought there was a Medication Self-Administration Policy, but hadn't considered it as required for nebulizer treatments as many residents were alert and participative with the treatment. The Administrator stated when they questioned Staff B about the events on [DATE] and why the nebulizer wasn't administered until 5:35 a.m., the staff reported he was running behind. The Administrator stated when she went to the resident's room to look at the equipment and investigate the incident on the morning of [DATE], the police had already removed the items as evidence. On [DATE] at 1:25 p.m., the DON stated she expected nurses to administer all medications and treatments as ordered by the physician unless contraindicated and should then seek clarification from the prescriptive physician. On [DATE] at 3:22 p.m., Staff B, RN, refused an interview without legal representation. As of 4:30 p.m. on [DATE] and after repeated requests, the staff member's attorney had not made arrangements for an interview with the Iowa Department of Inspections & Appeals (DIA) or the local police department. On [DATE], the State Agency informed the facility of the Immediate Jeopardy situation found at the facility. On [DATE] the facility abated the Immediate Jeopardy. The facility provided education to the Nursing Staff on proper administration of Nebulizer treatments with continuous [MED]gen. |
| F 0880<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, record review, resident and staff interviews, the facility failed to follow infection control guidelines for prevention of COVID-19 [MEDICAL CONDITION] transmission in long-term care facilities as mandated and established by the Center's for Disease Control (CDC) and the Centers for Medicare and Medicare Services (CMS), for admissions of new or returning residents, and for residents required to attend appointments outside of the facility, for 6 of 11 resident records reviewed (Resident's #3, #4, #7, #8, #10 and #11). The facility reported a census of 92 residents. Findings include: The CMS QSO (Quality, Safety & Oversight)-20-14-NH (Nursing Home) document dated 3/13/20, that provided guidance for infection control and prevention of COVID-19 infections in nursing homes, directed facilities when possible, dedicate a unit/wing exclusively for any residents coming or returning from the hospital. This can serve as a step-down unit where they remain for 14 days with no symptoms (instead of integrating as usual on short-term rehab floor, or returning to long-stay original room). The CMS QSO-20-28-NH document dated 4/24/20, that provided continued guidance for infection control and prevention of COVID-19 infections in nursing homes, recommended the following: 1. Nursing homes work with State and local leaders to designate separate facilities or units within a facility to separate COVID-19 negative residents from COVID-19 positive residents and individuals with unknown COVID-19 status. 2. Facilities should first dedicate space to care for residents with confirmed COVID-19, such as a dedicated floor, unit, wing, or other facility. In addition, facilities should create a plan, which could include placement in separate observation areas or in single rooms, for: a. New admissions and readmissions whose COVID-19 status is unknown. b. Residents who develop symptoms prior to being diagnosed with [REDACTED]. Facilities should consult with their local or state health department for questions about cohorting COVID-19 patients in nursing homes. 4. When residents were required to attend appointments outside the facility, the facility should help arrange for the resident to attend the appointment by taking precautions to minimize the risk of transmission of COVID-19 (e.g. giving the resident a surgical mask to wear while attending the appointment). Also, the facility should monitor the resident upon return for fever and signs and symptoms of respiratory infection for 14 days after the outside appointment (preferably in a space dedicated for observation of asymptomatic residents). The facility's Coronavirus Disease 2019 (COVID-19) Policy dated current as of 5/5/20, directed that a resident who had no known risk of exposure to COVID-19 who had a recent history of fever may be admitted when they have been afebrile without the intervention of antipyretics (medication to reduce a fever) for greater than 24 hours. Once admitted , the resident should be placed on respiratory precautions and contact isolation until 14 days had passed from the initial onset of their flu |

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| F 0880<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | (continued... from page 2)<br>like symptoms. 1. A hospital discharge summary report dated 4/20/20 revealed Resident #11 with [DIAGNOSES REDACTED]. The document directed the resident's admission to a Skilled Nursing Facility on 4/20/20, with orders to continue [MEDICAL TREATMENT] treatments at the [MEDICAL TREATMENT] Center 3 times per week on Monday, Wednesday and Friday. Review of Wound<br>Culture Reports completed 4/22/20, from specimens collected from the left foot on 4/16/20 revealed a light growth of Staphylococcus Aureus not [MEDICAL CONDITION] resistant, a scant growth of Pseudomonas Aeruginosa and a light growth of Peptostreptococcus, all required treatment with antibiotics. Physician order [REDACTED]. Cleanse bilateral feet with normal saline, cover with [MEDICATION NAME] dressing, then calcium alginate, cover with a 4 by 4 gauze pad and secure with rolled gauze every other day. b. Apply a double layer of Xeroform gauze to left lower leg, cover with a protective dressing daily. No orders noted to isolate the resident upon the 4/20/20 admission to the facility and the resident's record lacked any documentation that the he was ever isolated as required. A 4/23/20 Physician order [REDACTED]. A Nurse's Note (NN) transcribed on 4/28/20 at 1:13 p.m. described the resident left the facility at 7:30 a.m. for a scheduled arteriogram, returned at 1:00 p.m. NN transcribed on 4/30/20 at 7:56 a.m. described the resident left the facility for an appointment at the infusion center where 2 untis of red blood cells would be administered. NN transcribed on 4/30/20 at 4:13 p.m. described the resident returned after blood transfusion. 2. The Minimum Data Set (MDS) Assessment tool dated 4/25/20 revealed Resident #10 admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The resident required extensive assistance of at least 1 staff to reposition in bed, transfer to and from bed and chair, ambulation, dressing, toileting and personal hygiene. Physician order [REDACTED]. Droplet isolation precautions for possible secondary COVID exposure, discontinued on 4/29/20. b. [MEDICATION NAME] 100 mg administered oral 2 times daily, discontinued on 4/30/20. c. [MEDICATION NAME] (an antibiotic) 500 mg administered oral every 8 hours, discontinued on 4/30/20. d. [MEDICATION NAME] (a steroid that inhibits inflammation and allergic reaction) 10 mg administered oral daily. Review of Nurse's Notes entries revealed: On 4/26/20 at 1:52 p.m., Staff O, Registered Nurse (RN) described the resident had a cough, breath sounds diminished in the right and left upper and lower lobes, and the resident currently in airborne respiratory isolation. On 4/2920 at 8:14 a.m., Staff A, Licensed Practical Nurse (LPN) described the resident had a cough and short of breath, breath sounds diminished in the right and left upper and lower lobes, and the resident not in airborne respiratory isolation. On 4/30/20 at 11:50 a.m., Staff P, RN described the resident had a cough and short of breath, breath sounds of rhonchi (congestion) in the right and left upper and lower lobes, and the resident not in airborne isolation. Review of facility documents revealed the resident transferred out of the room he was admitted to on 4/21/20, and into the room of Resident #11 on 4/29/20, 8 days after admission to the facility. When asked on 5/11/20 at 3:55 p.m. for the facility's current COVID Isolation Policy, in reference to the CDC, CMS and QSO practices of 14 days isolation for new admissions, Staff Q, the Facility's Corporate Nurse, stated those were guidelines and not mandates. During an interview on 5/11/20 at 8:13 a.m., the Director of Nursing (DON) stated residents admitted to the facility from a hospital COVID unit, but who did not have a COVID infection, were placed in droplet precaution isolation, and residents admitted from a non-COVID hospital unit were placed in a regular room without isolation as long as they did not have any COVID symptoms per the standard questions, and her understanding was that the hospitals tested every patient for COVID. During an interview on 5/14/20 at 1:25 p.m., the Administrator and DON stated resident's admitted from a COVID unit at the hospital were placed in precautionary isolation for 7 days at the facility, then evaluated individually as to whether or not they could come out of isolation, and Resident #10 was assessed as able to come out of isolation after 8 days. 3. The 4/23/20 MDS Assessment tool revealed Resident #3 admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Physician order [REDACTED]. Droplet precaution isolation for possible COVID exposure, discontinued on 5/5/20. b. [MEDICATION NAME] (a strong antibiotic) 500 mg administered oral every 8 hours, discontinued 4/20/20. c. [MEDICATION NAME] 100 mg administered oral 2 times daily, discontinued 4/20/20. c. [MEDICAL TREATMENT] at Fresenius at 10:40 a.m. on Monday, Wednesday and Friday. The resident was discharged and transferred to the hospital on [DATE]. 4. The 5/1/20 MDS Assessment tool revealed Resident #4 admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Physician order [REDACTED]. Droplet precaution isolation secondary to COVID exposure, discontinued on 5/5/20. b. [MEDICAL TREATMENT] at Davita on Tuesday, Thursday and Saturday. Review of facility documents revealed Resident #4 placed in Resident #3's room on 4/25/20 admission, 8 days after Resident #3's admission to the room, then on 5/5/20, 10 days after Resident #4's admission, both Resident's #3 and #4 were taken out of isolation, and transferred together to another room that day. Nurse's Notes (NN) transcribed on 5/14/20 at 12:35 p.m. by Staff R, RN, stated resident educated to wear mask to and from [MEDICAL TREATMENT] and while in the lobby for a ride. NN transcribed on 5/14/20 at 5:15 p.m. stated the resident was discharged to home as planned. During an interview on 5/20/20 at 2:36 p.m., Staff T, RN and Regional Director of Operations, reviewed the facility census on 4/25/20 and stated the reason Resident #4 was admitted to Resident #3's room was likely due to lack of bed availability, and the hospitals wouldn't like it if the facility couldn't admit someone. 5. The 4/11/20 MDS Assessment revealed Resident #7 admitted to the facility 6/30/16 with [DIAGNOSES REDACTED]. The resident scored 15 out of 15 points on the Brief Interview for Mental Status (BIMS) cognitive assessment, without impairment or symptoms of [MEDICAL CONDITION], and required extensive assistance of at least 1 staff for transfers to and from bed and chair, locomotion in wheel chair on and off the unit, dressing, bathing, toileting and personal hygiene, and unable to ambulate. A physician's orders [REDACTED]. Nurse's Notes transcribed on 5/11/20 at 4:04 p.m. by Staff S, RN, the facility's Infection Prevention Nurse, stated resident educated to wear a mask in the halls and when out of facility for [MEDICAL TREATMENT]. Observations revealed: a. On 5/11/20 at 9:16 a.m., Resident #7 seated in a wheel chair in the foyer/lobby area without a face mask on as she waited for transport to [MEDICAL TREATMENT]. Resident #5 was also seated in a wheel chair in the area with a face mask on as he awaited transport to a different [MEDICAL TREATMENT] location. b. On 5/11/20 at 9:28 a.m., Resident #7 remained seated in foyer area without a face mask on, the receptionist was seated at her desk in the area at the time. c. On 5/11/20 at 2:46 p.m., Resident #7 was unloaded from the transport service van returning from [MEDICAL TREATMENT] and wore a face mask. During an interview on 5/11/20 at 3:22 p.m., the resident stated she never wore a mask to [MEDICAL TREATMENT] because nobody had ever asked her to or told her she needed to do that. Once at [MEDICAL TREATMENT], they made her wear a face mask and gave her a mask to wear. During an interview on 5/20/20 at 12:33 p.m., Staff T, RN, stated if [MEDICAL TREATMENT] resident's did not wear face masks when they left for [MEDICAL TREATMENT], Staff S, the Infection Preventionist Nurse that should have addressed that as it occurred. 6. The 4/30/20 MDS Assessment tool revealed Resident #8 admitted from the hospital on [DATE] for skilled therapy services, with [DIAGNOSES REDACTED]. The resident scored 14 out of 15 points possible on the Brief Interview for Mental Status (BIMS) cognitive assessment, without cognitive impairment or symptoms of [MEDICAL CONDITION], and required assistance of 1 staff for transfers to and from bed and chair, ambulation, dressing, toileting and personal hygiene. Review of the resident's records failed to show an order for [REDACTED].#7's room, and remained there until she was transferred to a different room on 5/12/20. A Notification of Room/Roommate Change form documented the resident's transfer was required for medical management that included isolation. During an interview on 5/14/20 at 2:11 p.m., Staff S, RN, the facility's Infection Prevention Nurse, stated new admissions were placed in precautionary isolation for 72 hours to monitor, then stated it might be 14 days, he wasn't certain and would have to check on that. Staff S stated most admissions were to the skilled level upstairs and trusted the Nursing Supervisors there to know the protocols for new admissions, they could call him with questions about infection control and residents were supposed to wear a mask if they left for an appointment, but did not require isolation. During an interview on 5/20/20 at 12:33 p.m., Staff T, RN and Regional Director of Operations stated prior to that date, the facility was required to isolate new admissions for 72 hours, if the resident remained free of COVID symptoms for 72 hours, they were removed from isolation then. Staff T stated on the day before, she sent the corporate office information related to COVID isolation practices as directed by CMS and the CDC, and had requested that they allow the facility to follow the process in Iowa that required 14 days of isolation for admissions. |